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## **ICD-10 Troubleshooting: Outpatient Tips from Coders to Coders**

Spring 2016

### **About the Presenter**

#### **Stacy Hardin, CCS, AHIMA Approved ICD 10 CM/PCS Trainer**

Stacy joined RMC in 2006, and is currently Regional Coding Manager for RMC. In this role Stacy performs coding quality reviews for RMC Clients, as well as internal staff reviews. Stacy has over 20 years' experience in the Health Information Management field and has held various positions of Coder, Coding Compliance Coordinator and HIM Director. Stacy is multi-talented with inpatient and outpatient skills and a wonderful educator and trainer. Stacy has been a vital part of development and implementation RMC's ICD-10 training program and participates in ongoing teaching of staff and clients. Stacy enjoys conducting audits, researching coding issues, and providing education to coders. Stacy has been pursuing her Associates Degree in HIM and will sit for her RHIT exam in 2016. Stacy is also an AHIMA approved ICD-10-CM/PCS Train the Trainer with experience in coding and auditing of ICD-10-CM and PCS. Additionally, Stacy is active in AHIMA and TxHIMA



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## RMC's Disclaimer

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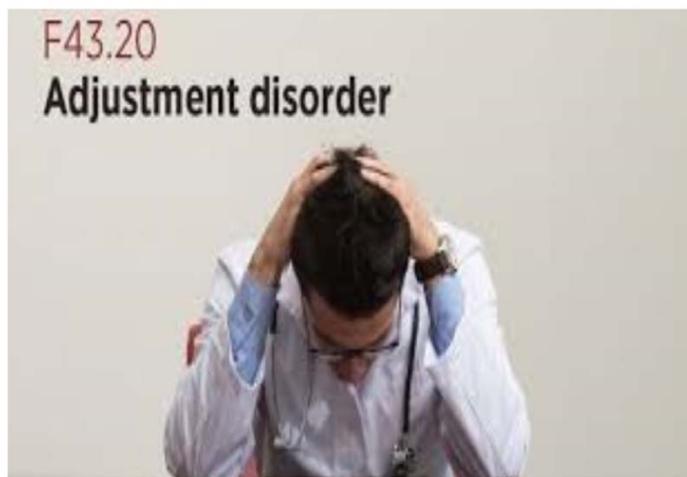
## So... How are YOU doing??



Photo Credit: Connie Calvert

## ICD 10 Post Implementation

F43.20  
Adjustment disorder



Ref 1



## ICD-10 – Does the Fun Ever Stop?

- Dual coding
  - Questions coming in
  - Didn't know what we didn't know
  - Now finding the gaps
  - Differences, similarities, challenges
  - Where do we go for answers??
    - Guidelines
    - ICD 10 Handbook
    - Coding Clinic
    - Peers/Colleagues
- \*\*Be prepared for revisions – changes to advice\*\*



## Guidelines and Conventions



## Excludes 1

Please see the "Interim advice on excludes 1 note on conditions unrelated" (next slide) posted to the NCHS website with the ICD-10-CM guideline documents. Apparently Excludes1 does not ALWAYS mean the 2 conditions cannot be reported together.....they cannot be reported together when they are RELATED. But if unrelated, per this document, they can still both be reported.

Ref: *Coding Clinic*, Fourth Quarter 2015: Page 40



## AHA Coding Clinic

- In 2012, Coding Clinic's for ICD-10-CMS/PCS began
- Every effort was made to carry over the ICD-9-CM guidelines and concepts into ICD-10-CM, unless there was a specific change in ICD-10-CM that precluded the incorporation of the same concept into ICD-10-CM. However, some of the guidelines in ICD-9-CM included information that may have been clinical in nature and therefore not appropriate for coding guidelines.
- However, there are no plans to translate all previous issues of Coding Clinic for ICD-9-CM into ICD-10-CM/PCS since many of the questions published arose out of the need to provide clarification on the use of ICD-9-CM and would not be readily applicable to ICD-10-CM/PCS
  - Care should be exercised as ICD-10-CM has new combination codes as well as instructional notes that may or may not be consistent with ICD-9-CM.



## Applying Past Issues of Coding Clinic for ICD-9-CM to ICD-10-CM

- In general, clinical information and information on documentation best practices published in Coding Clinic were not unique to ICD-9-CM, and remain applicable for ICD-10-CM with some caveats. For example, *Coding Clinic* may still be useful to understand clinical clues when applying the guideline regarding not coding separately signs or symptoms that are integral to a condition. Users may continue to use that information, as clues—not clinical criteria.
- As far as previously published advice on documentation is concerned, documentation issues would generally not be unique to ICD-9-CM, and so long as there is nothing new published in *Coding Clinic for ICD-10-CM and ICD-10-PCS* to replace it, the advice would stand.
- every attempt was made to remain as consistent with the ICD-9-CM guidelines as possible, unless there was a change inherent to the ICD-10-CM classification.

For more information Ref: *Coding Clinic*, Fourth Quarter 2015: Page 20



## Code Set Freeze

There are no new/revised ICD-10-CM diagnosis codes, or changes to the ICD-10-CM Official Guidelines for Coding and Reporting for fiscal year (FY) 2016, because of the partial code set freeze in preparation of ICD-10 implementation. The following link is to the current ICD-10-CM guidelines:

[http://www.cdc.gov/nchs/data/icd/10cmguidelines\\_2016\\_Final.pdf](http://www.cdc.gov/nchs/data/icd/10cmguidelines_2016_Final.pdf)

Effective October 1, 2015, there have been limited code updates to the ICD-10-PCS code sets to capture new technologies as required by section 503(a) of Pub. L. 108-173. The ICD-10 Coordination and Maintenance Committee has continued to meet twice yearly during the partial freeze. At these meetings, the public agreed that new ICD-10-PCS procedure codes should be created based on the need to capture new technology. On October 1, 2016 (one year after implementation of ICD-10), regular updates to ICD-10-CM and ICD-10-PCS will begin.



**ICD-10-CM**



## Retained Myringotomy Tubes

When myringotomy tubes are placed it is expected that they will eventually fall out on their own without any intervention as part of the natural course. However occasionally these tubes do not fall out and will require removal by the provider. Therefore documentation of “retained” myringotomy tube would be coded as a mechanical complication - T85.698A would be the appropriate code.



## Hematuria Due to Traumatic Foley Catheter Placement

This scenario would require 3 codes:

T83.83XA Hemorrhage of genitourinary prosthetic devices, implants and grafts, initial encounter.

R31.9 Hematuria, unspecified

Y84.6 Urinary catheterization as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at time of the procedure.

See Instructional Notes T80 - T88 - Use additional code to identify specific condition resulting from the complication (hematuria)



## Diabetes with Associated Conditions

Per the Official Coding Guidelines for ICD-10-CM, the term "with" means "associated with" or "due to," when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List.

ICD-10-CM assumes a cause-and-effect relationship between diabetes and certain diseases of the kidneys, nerves, and circulatory system. These assumed cause-and-effect relationships may differ between ICD-9-CM and ICD-10-CM.

- Reference: Coding Clinic 1Q 2016, Page 11



## Diabetes with Associated Conditions

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- **Do not code as a Diabetic complication if documentation clearly states that a condition other than diabetes is the cause.**

Reference: Coding Clinic 1Q 2016, Page 11



## Diabetes with Associated Conditions

Diabetes, type 2 **E11.9**

with

- amyotrophy **E11.44**
- arthropathy NEC **E11.618**
- autonomic (poly) neuropathy **E11.43**
- cataract **E11.36**
- Charcot's joints **E11.610**
- chronic kidney disease **E11.22**
- circulatory complication NEC **E11.59**
- complication **E11.8**
  - specified NEC **E11.69**
- dermatitis **E11.620**
- foot ulcer **E11.621**
- gangrene **E11.52**
- gastroparesis **E11.43**



## Diabetes with Associated Conditions

- glomerulonephrosis, intracapillary **E11.21**
- glomerulosclerosis, intercapillary **E11.21**
- hyperglycemia **E11.65**
- hyperosmolarity **E11.00**
  - with coma **E11.01**
- hypoglycemia **E11.649**
  - with coma **E11.641**
- ketoacidosis (Coding Clinic for ICD-9-CM 1Q 2013) **E13.10**
  - with coma (Coding Clinic for ICD-9-CM 1Q 2013) **E13.11**
- kidney complications NEC **E11.29**
- Kimmelsteil-Wilson disease **E11.21**
- mononeuropathy **E11.41**
- myasthenia **E11.44**
- necrobiosis lipoidica **E11.620**
- nephropathy **E11.21**
- neuralgia **E11.42**



## Diabetes with Associated Conditions

- neurologic complication NEC [E11.49](#)
- neuropathic arthropathy [E11.610](#)
- neuropathy [E11.40](#)
- ophthalmic complication NEC [E11.39](#)
- oral complication NEC [E11.638](#)
- periodontal disease [E11.630](#)
- peripheral angiopathy [E11.51](#)
  - with gangrene [E11.52](#)
- polyneuropathy [E11.42](#)
- renal complication NEC [E11.29](#)
- renal tubular degeneration [E11.29](#)



## Diabetes with Associated Conditions

- retinopathy [E11.319](#)
  - with macular edema [E11.311](#)
  - nonproliferative [E11.329](#)
    - with macular edema [E11.321](#)
    - mild [E11.329](#)
      - » with macular edema [E11.321](#)
    - moderate [E11.339](#)
      - » with macular edema [E11.331](#)
    - severe [E11.349](#)
      - » with macular edema [E11.341](#)
  - proliferative [E11.359](#)
    - with macular edema [E11.351](#)
- skin complication NEC [E11.628](#)
- skin ulcer NEC [E11.622](#)



## Diabetes with Osteomyelitis

### ICD-9

- Per AHA Coding Clinic, First Quarter 2004, page 14-15 “ICD-9-CM assumes a relationship between diabetes and osteomyelitis when both conditions are present, unless the physician has indicated in the medical record that the acute osteomyelitis is totally unrelated to the diabetes.”

### ICD-10

- Per AHA Coding Clinic, Fourth Quarter 2013, page 114, ICD-10-CM does not presume a linkage between diabetes and osteomyelitis. The provider will need to document a linkage or relationship between the two conditions before it can be coded as such.



## Dehydration with Hypo/Hyponatremia

### ICD-9

- When viewing the Alphabetic Index, “dehydration” indexes to 276.51.
- There are indentations with the subentry terms “with hypernatremia 276.0” and “with hyponatremia 276.1.
- Only 1 code is assigned.

### ICD-10

- According to AHA Coding Clinic, First Quarter 2014, page 7 two codes are required to fully capture dehydration with hypernatremia (E86.0 and E87.0) and dehydration with hyponatremia (E86.0 and E87.1).
- Coders should follow the index, which leads to coding both the dehydration and hypernatremia/hyponatremia separately.



## Rehab

- In ICD-10 there is no equivalent for V57.89
- The sequelae of the CVA would be the principal diagnosis
- If patient is admitted to rehab following an injury, the fracture code would be assigned as the principal diagnosis with the appropriate 7<sup>th</sup> character (subsequent encounter). Do not assign an aftercare Z code.
- If a patient is admitted to a nursing home for deconditioning, code the symptoms of the deconditioning, such as gait disturbance, weakness, etc.



## Rehab

- If the admission to rehab is strictly for convalescence and there is no other definitive diagnosis, assign code Z51.89 (Encounter for other specified aftercare), as the first-listed diagnosis.
- If the patient was transferred to a nursing home for convalescence and strengthening following coronary artery bypass surgery assign code Z48.812, Encounter for surgical aftercare following surgery on the circulatory system), as the principal diagnosis. The condition that was treated surgically if still present would be coded. Assign also codes for any symptoms such as weakness, gait disturbance, pain, etc., as additional diagnoses. You may also assign Z95.1, presence of aortocoronary bypass graft, to indicate the surgery for which aftercare is being performed.

*See Coding Clinic, Fourth Quarter 2012 page 90 and Fourth Quarter 2013 page 127 for other examples*



## Decompensated Heart Failure

- The general definition of decompensated can be applied when assigning ICD-10-CM codes as well.
- The appropriate diagnosis code for documentation of “chronic systolic heart failure, currently decompensated ”would be code I50.23 (Acute on chronic systolic heart failure, for decompensated systolic heart failure).
- See Coding Clinics, Second Quarter 2013, page 33 and Third Quarter 2008, page 12



## Watch Out For!

- Per AHA Coding Clinic, Fourth Quarter 2014, page 21 the physician documents “right heart failure, **decompensated** cor pulmonale secondary to severe pulmonary hypertension” in his final diagnostic statement. How should acute cor pulmonale be coded when there is **no** documentation of pulmonary embolism?



## Watch Out For!

- Assign secondary diagnosis code I27.81 (Cor pulmonale, chronic) and I27.2
- ICD-10-CM's Index references code I27.2 under "pulmonary hypertension with cor pulmonale." Unfortunately the Index under "pulmonary hypertension with acute cor pulmonale" leads to code I26.09, Other pulmonary embolus with acute cor pulmonale. In this case, code I26.09 is not appropriate since the patient does not have a pulmonary embolism.
- The National Center for Health Statistics (NCHS), the organization responsible for ICD-10-CM, will consider a future C&M proposal to modify the codes describing pulmonary embolism with cor pulmonale.



## Ulcers of Skin with Gangrene

### L89 & L97

\*\*\*Assign I96 first when gangrene is present\*\*\*

Ex) I96 + L89.153 – Sacral PU stg 3 w/ gangrene

When gangrene present with ulcer or injury, code gangrene 1<sup>st</sup>, followed by code for ulcer/injury as additional. code. See Instructional Notes in Tabular

Cellulitis described as gangrenous is classified to I96.



## Tabular Example

### L89 Pressure ulcer

#### Includes:

bed sore

decubitus ulcer

plaster ulcer

pressure area

pressure sore

Code first any associated gangrene (I96)



## Tabular Example

### L97 Non-pressure chronic ulcer of lower limb, not elsewhere classified

#### Includes:

chronic ulcer of skin of lower limb NOS

non-healing ulcer of skin

non-infected sinus of skin

trophic ulcer NOS

tropical ulcer NOS

ulcer of skin of lower limb NOS

#### Code first any associated underlying condition, such as:

any associated gangrene (I96)

atherosclerosis of the lower extremities (I70.23-, I70.24-, I70.33-, I70.34-,

I70.43-, I70.44-, I70.53-, I70.54-, I70.63-, I70.64-, I70.73-, I70.74-)

chronic venous hypertension (I87.31-, I87.33-)

diabetic ulcers (E08.621, E08.622, E09.621, E09.622, E10.621, E10.622,

E11.621, E11.622, E13.621, E13.622)

postphlebotic syndrome (I87.01-, I87.03-)

postthrombotic syndrome (I87.01-, I87.03-)

varicose ulcer (I83.0-, I83.2-)

#### Excludes2:

pressure ulcer (pressure area) (L89.-)

skin infections (L00-L08)

specific infections classified to A00-B99



## Tabular Example

### **I96** Gangrene, not elsewhere classified

Gangrenous cellulitis

**Excludes1:** gangrene in atherosclerosis of native arteries of the extremities ([I70.26](#))

gangrene in diabetes mellitus ([E08-E13](#))

gangrene in hernia ([K40.1](#), [K40.4](#), [K41.1](#), [K41.4](#), [K42.1](#), [K43.1-](#), [K44.1](#), [K45.1](#), [K46.1](#))

gangrene in other peripheral vascular diseases ([I73.-](#))

gangrene of certain specified sites - see Alphabetical Index

gas gangrene ([A48.0](#))

pyoderma gangrenosum ([L88](#))



## Osteomyelitis, Toe

- You can only code what is specifically documented; in this particular case correct code would be Osteomyelitis unspecified M86.9. Unfortunately since not documented as acute or chronic, toe is not an option
- CDI issue.



## Index Example

Osteomyelitis (general) (infective) (localized) (neonatal) (purulent) (septic) (staphylococcal) (streptococcal) (suppurative) (with periostitis) **M86.9**

- acute **M86.10**  
toe **M86.17-**
- chronic (or old) **M86.60**  
toe **M86.47-**



## Code Numbers

There are regulatory and accreditation directives that require providers to supply documentation in order to support code assignment. It is not appropriate for providers to list the code number or select a code number from a list of codes in place of a written diagnostic statement. ICD-10-CM is a statistical classification, per se, it is not a diagnosis. Some ICD-10-CM codes include multiple different clinical diagnoses and it can be of clinical importance to convey these diagnoses specifically in the record. Also some diagnoses require more than one ICD-10-CM code to fully convey the patient's condition. It is the provider's responsibility to provide clear and legible documentation of a diagnosis, which is then translated to a code for external reporting purposes.

While we're aware that some payers may allow submission of code numbers on lab orders, *Coding Clinic* recommends that physicians provide narrative diagnoses/signs/symptoms as the reason for ordering the test.

Ref: *Coding Clinic*, Fourth Quarter 2015: Page 34



## ICD-10-PCS



### Vascular Access Devices

Vascular access device is a rather generic term to describe sterile catheter systems used to access a vascular structure either an artery or a vein. Selection of the body part value for insertion of a vascular access device is based on the end placement of the device rather than the point of entry.

- PICC
- CVC with guidance
- CVC without guidance
- Totally Implantable Central VAD

For examples Ref : *Coding Clinic*, Fourth Quarter 2015: Page 26



## Cavoatrial Junction

### PICC lines:

- A PICC line is generally inserted in a peripheral vein in the arm (cephalic vein, basilic vein, or brachial vein, and then advanced proximally toward the heart through larger veins, until the tip rests in the distal **superior vena cava** or **cavoatrial junction**.
  - Coding Clinic allows the coders to use the imaging report for confirmation of placement.



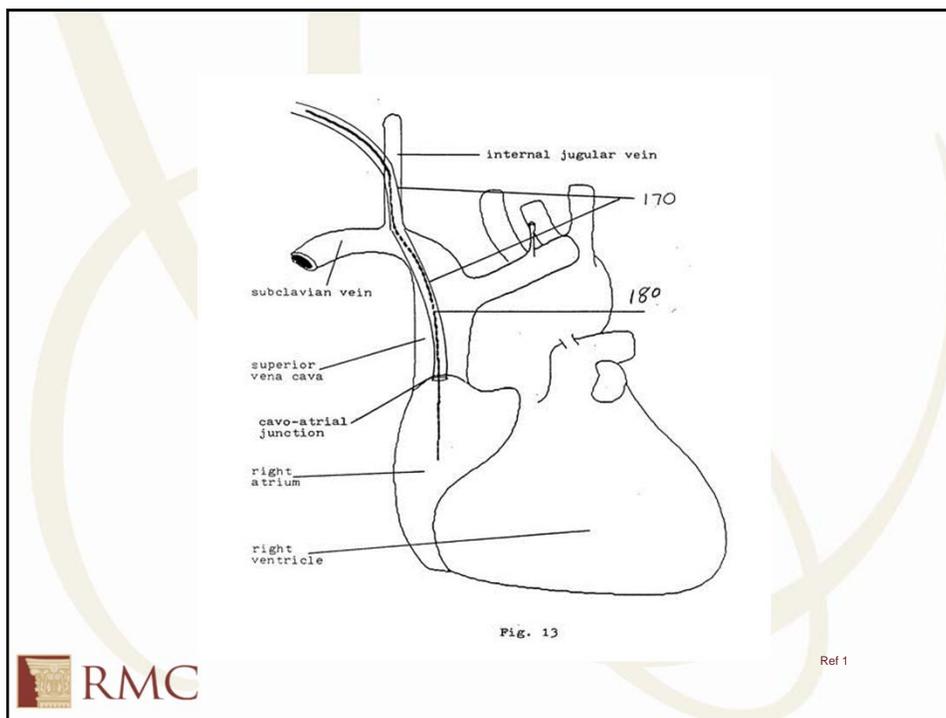
## Cavoatrial Junction

- There is no entry in the Alphabetic Index for “insertion of device in, cavoatrial junction”
- Body part key also has no entry for “cavoatrial junction” in the table.



## Cavoatrial Junction

- The cavo-atrial junction is defined as the area between the right superior vena cava and the right atrium.
- The cavo-atrial junction has not yet reached the atrium.
- Therefore, the correct end placement would be superior vena cava 02HV33Z



## TruCode Encoder

**TruCode Encoder**

Search for: 02HV33Z

Section: Medical and Surgical

Body System: Heart and Great Vessels

Operation: Insertion - Acting in a nonbiological appliance that monitors, assists, performs, or prevents a physiological function but does not physically take the place of a body part

Selected Code: **02HV33Z**

Insertion of Infusion Device into Superior Vena Cava, Percutaneous Approach

Current look in ICD-10-PCS Procedure Tables

Body Part	Approach	Device	Qualifier
4 Coronary Vein	0 Open	0 Monitoring Device, Pressure Sensor	2 No Qualifier
4 Atrium, Right	3 Percutaneous	2 Monitoring Device	
7 Atrium, Left	4 Percutaneous Endoscopic	3 Infusion Device	
A Heart		0 Intraluminal Device	
E Ventricle, Right			
L Ventricle, Left			
N Pericardium			
P Pulmonary Trunk			
Q Pulmonary Artery, Right			
R Pulmonary Artery, Left			
S Pulmonary Vein, Right			
T Pulmonary Vein, Left			
Y Superior Vena Cava			
W Thoracic Aorta			

**Research**

ICD-10 Official Guidelines

Root Operation, General Guidelines, ICD-10-PCS Official Coding Guidelines

Body Part, General Guidelines, ICD-10-PCS Official Coding Guidelines

Device, General Guidelines, ICD-10-PCS Official Coding Guidelines

Root Operation, Multiple Procedures, ICD-10-PCS Official Coding Guidelines

Root Operation, Unconcurrent Procedures, ICD-10-PCS Official Coding Guidelines

View all 8 matching titles

**Coding Advice**

The correct coding of venous catheters (percutaneous insertion central catheter) depends on the end placement of the catheter, meaning the site where the device ended up. For example, a PICC line where the infusion catheter is initially placed in the right internal jugular and then threaded into the superior vena cava would be coded to insertion of infusion device into superior vena cava, percutaneous approach (02HV33Z). Coding Clinic for ICD-10-PCS, 2012, Q2, p. 13

For infusion devices (e.g., PICC line), the body part character is based on the site in which the device ended up. When the provider's documentation does not specify the end placement of an infusion device, the imaging report may be used to identify the body part. Coding Clinic for ICD-10-PCS, 2014, Q2, p. 5

During the same operative episode, multiple procedures are coded if: (1) THE SAME ROOT OPERATION is performed on DIFFERENT BODY PARTS as defined by distinct values of the body part character, (2) THE SAME ROOT OPERATION is REPEATED in multiple body parts, and those body parts are separate and distinct body parts classified to a single body part character.

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## Contrast

- ICD-10-PCS requires coders to identify the type of contrast used for contrast based procedures.
- Current options include:
  - 0, high osmolar
  - 1, Low osmolar
  - Y, Other contrast
  - Z, none
- Contrast details can be found in medication administration records (MAR), Operative Report, and cardiac catheterization reports.

### Contrast Key

Contrast Name	Osmolality
Diatrizoate, Cysto-Conray II, Metrizoate, Ioxithalamte	High
Isovue, Omnipaque, Optiray, Oxilan, Ultravist, Xenetix, Iomeprol, Hexabrix, Iopentol	Low
Visapaque, Isovist	Other (Iso-osmolar)
*Reference: ICD-10-PCS: An Applied Approach, 2015, Kuehn, Lynn	



### Fresh Frozen Plasma

**Question:**

In ICD-10-PCS, how would you code fresh frozen plasma (FFP) transfusion? The 4<sup>th</sup> digit has a substance character that identifies frozen plasma or fresh plasma. Would one or two codes be used to accurately capture the blood transfusion?



## Fresh Frozen Plasma

### Fresh Frozen Plasma:

- Table 302-No single substance value for fresh frozen plasma.
- No official ICD-10-PCS guidelines for this situation.
- Creating many questions in coding community



## Fresh Frozen Plasma

### Answer:

Fresh Frozen plasma is synonymous with frozen. The fresh in the abbreviation refers to the product being frozen immediately.

Correct ICD-10 code would be 30233K1 (assuming its peripheral)

Seeking facility input



## TruCode Encoder

The screenshot displays the TruCode Encoder application window. The search bar at the top contains the code '30233K1'. Below the search bar, the search results are displayed, including the section 'Administration', body system 'Circulatory', and operation 'Transfusion - Putting in blood or blood products'. The selected code is '30233K1' with the description 'Transfusion of Nonautologous Frozen Plasma into Peripheral Vein, Percutaneous Approach'. A table below shows the current book in ICD-10-PCS Procedure Tabular, with columns for Body System / Region, Approach, Substance, and Qualifier. The table lists various substances and their corresponding qualifiers.

Body System / Region	Approach	Substance	Qualifier
3 Peripheral Vein	4 Open	A Stem Cells, Embryonic	4 Autologous
4 Central Vein	3 Percutaneous	G Bone Marrow	3 Nonautologous
5 Peripheral Artery		M Whole Blood	
6 Central Artery		J Serum Albumin	
7 Products of Conception, Circulatory		E Frozen Plasma	
8 Vein		L Fresh Plasma	
		N Plasma Cryoprecipitate	
		R Red Blood Cells	
		P Frozen Red Cells	
		Q White Cells	
		E Platelets	
		S Globulin	
		T Fibrinogen	
		V Antithrombotic Factors	
		W Factor IX	
		X Stem Cells, Cord Blood	
		Y Stem Cells, Hematopoietic	

The RMC logo is visible in the bottom left corner of the screenshot.

## Lysis of Adhesions

- Coders should not code adhesions and lysis thereof, based solely on mention of adhesions or lysis in an operative report. As is customary with other surgeries, it is irrelevant whether the adhesions or lysis of adhesions are included in the title of the operation. Determination as to whether the adhesions and the lysis are significant enough to code and report must be made by the surgeon.

## Lysis of Adhesions

- Continue to look for the clinical significance of the adhesions. Documentation of clinical significance by the surgeon may include, but is not limited to, the following language: numerous adhesions requiring a long time to lyse, extensive adhesions involving tedious lysis, extensive lysis, etc.
- If uncertainty exists regarding clinical significance, then query the provider.
- See Coding Clinic First Quarter 2014 page 3 and Fourth Quarter 1990 page 18-19 for additional details.



## ICD-10-PCS: Root Operation-Control

- The root term “control” specifically addresses postoperative bleeding.
- Examples of control procedures include postoperative ligation of bleeding arteries and drainage of postoperative hemorrhage.
- Control of other types of bleeding (i.e. intraoperative bleeding, are not coded using the Control root operation. See Coding Clinic, Third Quarter 2013, page 22
- Only three code tables are available for Control procedures: 0W3, 0X3, and 0Y3



## ICD-10-PCS: Root Operation-Control

- If an attempt to stop post procedural bleeding is initially unsuccessful and to stop the bleeding requires performing any of the definitive root operations Bypass, Detachment, Excision, Extraction, Reposition, Replacement, or Resection, then that root operation is coded instead of Control.
  - Ex: Resection of spleen to stop post procedural coding is coded to resection instead of control
    - \*ICD-10 Guidelines-Section B3.7



## Coding Example of When Not to Code Control

- History and Physical: patient presented with peritoneal hematoma.
- Operative Report documents hematoma of peritoneum was evacuated and drainage tube was placed.
  - ✓ This was not a post procedural hematoma
  - ✓ The objective of the procedure was to evacuate the clot
  - ✓ When following the Alphabetic Index, “evacuation, hematoma” states to see Extirpation.
  - ✓ Extirpation is defined as taking or cutting out solid matter (blood clot)



## Coding Example of When to Code Control

Pre-Operative Diagnosis: Post-tonsillectomy bleeding

Post-Operative Diagnosis: Post-tonsillectomy bleeding

Operative Procedure: Operative Control of postoperative bleeding

Findings: Patient with an arterial bleeder from right tonsillar fossa.

Description of procedure: The patient was taken to the operating room and general anesthesia was administered. A Crowe-Davis mouth gag was placed, and clots were suctioned from the pharynx. An arterial bleeder was noted and was controlled with suction artery. The stomach was then suctioned and about 200-300 mL of blood was noted. The patient was awakened and extubated and transported to the recovery room in stable condition.



## Coding Example of When to Code Control

**Answer:**

ICD-10-PCS code: 0W33XZZ (Control Bleeding in Oral Cavity and Throat, External Approach)

- The root operation control is coded because the bleeder is the result of a previous procedure. When cautery is used to stop post-op bleeding, control is the appropriate root operation. The tonsillar area is coded to the body part value 3. The approach is X (external)



## Coding Clinic, Second Quarter 2015

Page: 34

### Question:

The patient presents for decompressive lumbar laminectomy. The surgeon performed an open complete decompressive laminectomy of L3-L4, as well as superior partial laminectomy of L5, and inferior partial laminectomy of L2. What is the appropriate root operation, “Excision” or “Release”? How is this surgery coded in ICD-10-PCS?

### Answer:

Decompressive laminectomy is done to release pressure and free up the spinal nerve root. Therefore the appropriate root operation is “Release.” Assign the following ICD-10-PCS code:

**01NB0ZZ** Release lumbar nerve, open approach



## Coding Clinic: Decompressive Laminectomy

*Coding Clinic*, Fourth Quarter 2013, page 116, advised the assignment of the root operation “Excision” for decompressive laminectomy procedures. This advice was based on the ICD-10-PCS’ Index entry “Laminectomy,” which instructs see Excision. The Editorial Advisory Board for Coding Clinic revisited this advice and determined that the root operation “Release” is more appropriate.



## CASE STUDIES



### Spinal Case Study

**Pre-Op Diagnosis:** Cervical stenosis and cervical myelopathy

**Post-Op Diagnosis:** Same.

**Procedures:**

1. Anterior cervical discectomy at C3-C4, C4-C5, and C5-C6.
2. Anterior cervical cage at C3-C4, C4-C5, and C5-C6.
3. Anterior cervical fusion at C3-C4, C4-C5, and C5-C6.
4. Anterior cervical hardware at C3-C4, C4-C5, and C5-C6.
5. Microdissection with operative microscope.



## Spinal Case Study (Continued)

**Findings:** Intraoperative findings were consistent with cervical stenosis and kyphosis.

**Brief History:** The patient is a xx year old female who presents with significant signs and symptoms of severe cervical stenosis. She has failed conservative management. She now has progressive myelopathy and significant symptoms. She fully understands the risks, benefits and alternatives of surgical intervention and would like to proceed.



## Spinal Case Study (Continued)

### **Description of Procedure:**

The patient was brought to the operating theater, where general endotracheal anesthesia was induced. Once anesthesia was induced, we then prepped and draped the left side of the neck in a standard sterile fashion. We then did a left-sided approach. The left sided approach was performed. We then opened the prevertebral fascia, and got on the anterior cervical spine. We then did a discectomy of C3 and C4.



## Spinal Case Study (Continued)

### Description of Procedure (Continued):

The endplates were completely curetted off and cleaned. We then removed the posterior longitudinal ligament. We then drilled off the uncovertebral joints, as well as the neural foramina were then opened. We then decompressed the central canal. Bone was then collected and placed into a cage. An anterior cervical fusion was then done at C3-C4. The cage was then inserted in the interspace. Good fixation was obtained.



## Spinal Case Study (Continued)

### Description of Procedure (Continued):

We then went to the C4-C5 level where the discectomy was done at C4 and C5. The endplates were completely curetted off and cleaned. We went all the way back to the PLL. The PLL was removed, as well as the posterior bridging osteophytes. Bone was then collected and placed into a cage. An anterior cervical fusion was then done at C4-C5. We then went to the C5-C6 level, where the endplates of C5 and C6 were completely curetted off and cleaned. Once this was done, we then went ahead and did a discectomy at C5 and C6.



## Spinal Case Study (Continued)

### Description of Procedure (Continued):

The endplates were completely cleaned off. The posterior longitudinal ligament was removed. We then collected local bone, which was then placed into another Medtronic cage. An anterior cervical fusion was done at C5-C6. The cage was placed using fluoroscopic guidance and placed in the appropriate position.

We then corrected the kyphosis and anterolisthesis by putting on an anterior cervical plate and did some in situ correction of the anterolisthesis by placing anterior instrumentation from C3-C6. We then placed 2 bones screws into C5 and carefully pulled the vertebral body of C4 and C5 anteriorly.



## Spinal Case Study (Continued)

### Description of Procedure (Continued):

We then compressed across the whole construct, and got good lordosis. We also placed 2 screws into C3, 2 into C4, 2 into C5, and 2 into C6. Good fixation was obtained. AP and lateral x-rays confirmed excellent position of the construct.



## Spinal Case Study: Answers

### ICD-10-CM

- M48.02 (Spinal stenosis, cervical region)
- G95.9 (Disease of spinal cord, unspecified)
- M40.202 (Unspecified kyphosis, cervical region)

### ICD-10-PCS

- 0RG20A0 (Fusion 2-6 Cervical Joint with Interbody Fusion Device, Anterior Approach Anterior Column, Open)
- 0RB30ZZ (Excision of Cervical Vertebral Disc, Open Approach)
  - Only 1 code assigned for discectomy even though it is multiple levels (same root operation on the same body part site)



## PTCA/Stent Case Study

**Procedure:** Primary PTCA and stent placement

**Indications:** Acute myocardial infarction

**Procedure Description:** Following left heart catheterization, a 6-French JR4 guiding catheter with side holes provided adequate support. The mid-right coronary artery occlusion was crossed with little difficulty using a 0/0014 BMW wire. Next the lesion was dilated using a 2 x 20 Maverick balloon. Next a 3 x 23 Vision stent was deployed in the mid right coronary artery. A second 3.0 x 12 Vision stent was deployed proximal to the first stent with an intentional degree of overlap. Following successful primary PTCA and stent of the right coronary artery, there was a 0 percent residual stenosis with excellent antegrade flow. Perclose was utilized for vascular access site closure.



## PTCA/Stent Case Study: Answers

**ICD-10-CM:** I21.3 (ST elevation myocardial infarction of unspecified site)

**ICD-10-PCS:** 02703DZ (Dilation of Coronary Artery, One Site with Intraluminal Device, Percutaneous Approach)

- Vision is a bare metal stent
- 2 stents but only one distinct site (mid right coronary artery)
- Coronary arteries are classified by number of distinct sites treated, rather than number of coronary arteries or anatomic name of coronary artery.

*Multiple stents used to treat a single coronary artery lesion are identified with the device value intraluminal device or drug-eluting intraluminal device.*

*When multiple stents classified to the same device value are used to treat a single coronary artery lesion, that information is not currently captured in the ICD-10-PCS code.*



## Ophthalmology Case Study

**Pre-Op Diagnosis:** Bilateral ptosis interfering with vision

**Pre-Op Diagnosis:** Same

**Procedure:** Bilateral levator resection

**Anesthesia:** IV



## Ophthalmology Case Study (Continued)

**Operative Description:** Under IV sedation, a 50/50 mixture of 2 percent Xylocaine with 1:100,000 epinephrine and Wydase, 0.5 percent Marcaine with epinephrine and sodium bicarbonate was injected into the area of the right and left upper lids via the skin surface. The patient was then prepped and draped in the usual sterile fashion. Attention was first directed to the upper eyelids, where a marking pen and caliper were used to mark the intended skin incision. Then 0.5 Cassidys and Brown-Adson forceps were used to delineate the skin to be excised. Curved Stevens's scissors were used to excise the skin and orbicularis.



## Ophthalmology Case Study (Continued)

**Operative Description:** Hemostasis was maintained with monopolar cautery. A 4-0 Silk suture was placed in the lid margin, and the lid was placed on downward tension. The orbital septum was incised and opened for the full horizontal length of the eyelid. Then, the levator palpebrae superioris muscle was reflected from its insertion on the underlying tarsus and dissected from underlying Muller's muscle. Multiple interrupted 5-0 Dexon sutures on a 01 needle were then positioned to fashion the tarsus and brought up the levator so that the appropriate height and contour of the eyelid were achieved. The excess levator was excised.



## Ophthalmology Case Study (Continued)

**Operative Description:** The wound was closed with a running 6-0 mild chromic suture. A combination corticosteroid and antibiotic ointment was placed in the patient's eye and the wounds and ice packs were applied. Surgery was applied on the right and left eyes simultaneously to ensure symmetry. The patient left the operating room in good condition, fully awake.



## Ophthalmology Case Study (Answers)

### ICD-10-CM

H02.403 (Unspecified ptosis of bilateral eyelids)

### ICD-10-PCS

08BP0ZZ (Excision of Left Upper Eyelid, Open Approach)

08BN0ZZ (Excision of Left Upper Eyelid, Open Approach)

**Explanation:** A medical indication is given for the procedure (interfering with vision); therefore, the root operation would not be Alteration. The root operation Excision is used to code the removal of a piece of levator muscle from each eyelid. The index directs to code the eyelid body part for the levator palpebrae superioris muscle. The body part values are P, Upper Eyelid, Left and N, Upper Eyelid, Right. The approach is open and no device or qualifier values are appropriate.



## Traumatic Brain Injury Case Study

### **Chief Complaint:** Car Crash

A xx year old female driver was involved in a car crash on I-Superfast. Patient collided with a SUV. Patient was talking on cellular phone with mother prior to accident. Patient brought to ER in a coma where she is diagnosed with TBI with loss of consciousness of one hour. Glasgow coma scale was 5 on arrival in ED.



## Traumatic Brain Injury Case Study (Continued)

**Procedure:** The patient underwent endotracheal intubation and subsequently placed on mechanical ventilation

**Discharge Diagnosis:** Traumatic brain injury. Patient was transferred to trauma center for further care.



## **Traumatic Brain Injury Case Study: Answers**

### **ICD-10-CM**

S06.9X3A (Unspecified intracranial injury with LOC of 1-5 hours 59 min, initial)

R40.243 (Glasgow coma scale score 3-8)

V43.51XA (Car driver injured in collision with sport utility vehicle in traffic accident, initial encounter)

Y93.C2 (Activity, hand held interactive electronic device)

Y92.411 (Interstate highway as the place of occurrence of the external cause)



## **Traumatic Brain Injury Case Study: Answers**

### **ICD-10-PCS**

0BH17EZ (Insertion of Endotracheal Airway into Trachea, Via Natural or Artificial Opening)

5A1935Z (Respiratory Ventilation, Less than 24 Consecutive Hours)



## Adult ADD Case Study: Question

How do you code adult ADD? 3M rejects code F98.8 for age incompatibility in an adult, is there an alternative?



## Adult ADD Case Study: Answer

### **RMC Internal Answer:**

RMC will be sending to ICD 10 Ombudsman and Coding Clinic for official guidance.

Trainers recommend coding R41.840- Attention and concentration deficit until official guidance from above resources.



## Update From Ombudsman

Thank you for expressing concern with the ICD-10 Medicare Code Editor (MCE) Age Conflict- Pediatric Diagnosis code edit for ICD-10-CM code F98.8 (Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence). We are addressing this issue as part of our annual MCE updates for the FY 2017 inpatient PPS proposed rule. This proposed rule will be published in April/May 2016. Please contact your local MAC to make them aware of any claims that have been denied or rejected in error. If you need help determining contact information for the MAC serving your jurisdiction, please refer to the following link:  
<https://www.cms.gov/Medicare/Coding/ICD10/ICD-10-Provider-Contact-Table.pdf>.



## Alcohol Intoxication and Dependence Case Study: Question

Is it appropriate to code both codes for alcohol dependence with withdrawal and alcohol dependence with intoxication when both are present? I've been coding the more serious withdrawal code since I get Compliance Edits

Review documentation to determine if a more specific diagnosis code other than F10.239 (Alcohol dependence with withdrawal, unspecified) should be coded (3M edit)

Review documentation to determine if a more specific diagnosis code other than F10.229 (Alcohol dependence with intoxication, unspecified) should be coded. (3M edit)

Excludes 1 Edits: ICD10 CM tabular

Category (F1023): F10.239 should never be used at the same time



## **Alcohol Intoxication and Dependence Case Study: Answer**

It is not possible to be intoxicated and be in withdrawal at the same time so you would not code both together. However if intoxication was present on admission and several days later the PT developed withdrawal, then documentation would support coding both conditions. And due to interim advice on excludes 1 note, you may code override the edit.



## **Mismatched Body Part in Screening Colonoscopy Case Study: Question**

Example account, screening colonoscopy, polyp was found at the hepatic flexure. In ICD-10 hepatic flexure codes to transverse colon (D12.3), but according to the PCS body part key hepatic flexure codes to the ascending colon. So the problem on this account is that we have a dx of transverse polyp not matching the procedure of excision of ascending colon. What to do, what to do??



## Mismatched Body Part in Screening Colonoscopy Case Study: Answer

Recommend coding as is, sometimes the codes do not match. However the coder needs to verify that site of excision and site of polyp are indeed accurate



## What and How

Think about **what** your coding and how you're coding.

- Apply guideline for secondary dx
  - clinical evaluation; or
  - therapeutic treatment; or
  - diagnostic procedures; or
  - extended length of hospital stay; or
  - increased nursing care and/or monitoring.



## Tips

- Review coding AND documentation quality
- Feedback to CDI/Providers AND Coders
- Educate! Discuss! Educate!
- Resource for staff questions

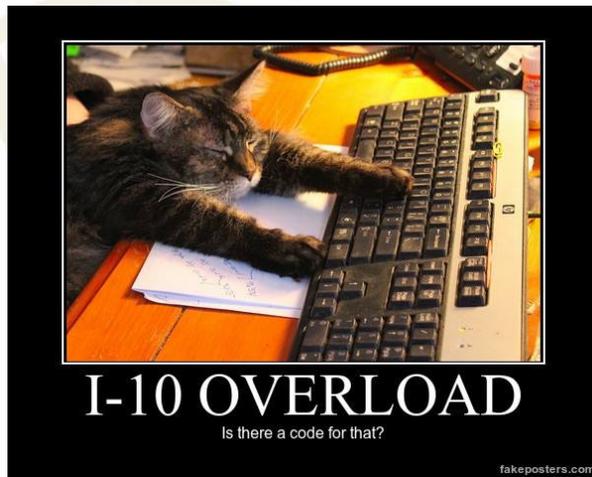


## Resources

- AHA Coding Clinic
- ICD 10 CM and PCS Coding Handbook 2016
- ICD-10-PCS: An Applied Approach, 2015, Kuehn, Lynn
- 2015 Official ICD-10-PCS Coding Guidelines and Code Tables.  
<http://cms.hhs.gov/Medicare/Coding/ICD10/2015-ICD-10-PCS-and-GEMs.html>
- AHIMA ICD-10-CM/PCS Documentation Tips. <http://bok.ahima.org/PdfView?oid=30062140>
- Ref 1: [http://www.healthcareitnews.com/sites/default/files/companion\\_images/icd10\\_2.png](http://www.healthcareitnews.com/sites/default/files/companion_images/icd10_2.png)
- Ref 2: <http://www.memes.com/meme/717099>
- Ref 3: <https://patentimages.storage.googleapis.com/US20050203457A1/US20050203457A1-20050915-D00014.png>
- Ref 4: <http://legacy.owensboro.kctcs.edu/gcaplan/anat/images/Image256.gif>
- Ref 5: <http://englishwithatwist.com/wp-content/uploads/2013/05/Blog-communication-cartoon.jpg>
- Ref 6: <https://www.pinterest.com/pin/440297301041910386/>



Thank you!!!!!!  
 Email: [stacy@rmcinc.org](mailto:stacy@rmcinc.org)



Ref 6