ICD-10-PCS: Let's Code, Part II

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Agenda

- Coding questions answered
- ICD-10-PCS Coding
- Wrap-up of ICD-10-CM/PCS Coding

ICD-10-PCS Coding Questions

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Coding Questions . . . .

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- Open Choledocholithotomy (with T-tube drainage)
  - *Would the T-tube drainage be coded separately?*
- No. . .the T-tube drainage is integral to the open choledocholithotomy
- Coding Guideline B6.1b
  - *Materials such as sutures, ligatures, radiological markers and temporary post-operative wound drains are considered integral . . .*

Coding Questions . . . .

- ERCP (with low osmolar contrast)
  - *Should another code be assigned? 0FJB8ZZ?*
- Yes . . . Code 0FJB9ZZ should be assigned to indicate the Diagnostic ERCP
- Code BF111ZZ can be assigned if coded to that degree of specificity. Normally the fluoroscopy portion of procedures is captured by the facility chargemaster

Coding Questions . . . .

- Nuss procedure for correction of pectus excavatum
  - *Should the root operation be reposition or supplement?*
- The correct root operation for this procedure should be supplement.
- The procedure is generally completed with a percutaneous endoscopic approach
- Code: 0WU84JZ

Coding Questions . . . .

- The Nuss procedure corrects pectus excavatum by placing a curved steel bar under the sternum. This serves to pop out the depression in the chest.
- The bar corrects the depression and can be removed after a minimum of 2 years.

Coding Questions . . . .

- Thoracoscopic excision of mediastinal tumor
  - *What is the PCS code for thorascopic excision of mediastinal tumor?*
- Code <u>0WBC4ZZ</u> (or 0WBC4ZX if this was a biopsy)

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Coding Questions . . . .

- Right ureteroureterostomy
  - *Is bypass or reposition to correct root operation?*
- A right ureterourterostomy is coded using the root operation **Bypass**
- The correct ICD-10-PCS table for this procedure is 0T1
- GEMs – 56.75 to table 0T1

Coding Questions . . . .

- Radical abdominal hysterectomy, BSO, PALND, & BPLND
  - *Should 0UTC0ZZ be assigned for resection of the cervix?*
- Yes . . . If the documentation includes the removal of the cervix code 0UTC0ZZ should be assigned as an additional diagnosis
- Generally, radical abdominal hysterectomy includes removal of the cervix

Coding Questions . . . .

- Pubovaginal sling with TVT-O
  - *Is supplement or reposition the root operation for the pubovaginal sling with TVT-O?*
- Supplement is the correct root operation for this procedure
- 0TUD0JZ – open approach with a synthetic substitute device

Coding Questions . . .

- Archbar (left subcondylar mandible) and intermaxillary wiring (right parasymphyseal mandible)
  - *What's the correct PCS code(s)?*
- Without more specific documentation, this case is difficult to code.
  - Were the fractures reduced?
  - Was the fixation internal or external?

Coding Questions . . .

- With fracture reduction:
  - Root Operation: Reposition
  - Device Character: Internal or External Fixation Device
  - Table: 0NS
- Without fracture reduction (fixation only):
  - Root Operation: Insertion
  - Device Character: Internal or External Fixation Device
  - Table: 0NH

Coding Questions . . .

- Thoracic aorta clamp, extracorporeal bypass and exploratory laparotomy to check bleeding
  - *Can code 5A1221Z be assigned only for the extracorporeal bypass? Would there be an additional code 5A1935Z?*
- For 2012, there are 2 codes required for Cardiopulmonary bypass – 5A1221Z and 5A1935Z
- Change made for 2013 - One code only – 5A1221Z

Coding Questions . . .

- Radical cystectomy and Studer pouch
  - *In this case, the purpose of the surgery is excision of the tumor, should an additional PCS code be assigned for excision of the tumor?*
- No – the ‘removal of the tumor’ is inherent in the ‘replacement’ procedure.

Coding Questions . . .

- Reconstruction of ACL, right
  - Is replacement, supplement or repair the root operation of reconstruction of ACL (for right knee ACL rupture)?
- There is not enough documentation to correctly code this case.
- For example: ACL reconstruction done with a patellar tendon graft would be coded to “Transfer” – 0LXQ0ZZ

Coding Questions . . .

- Removal of implanted devices from bone
  - *Is Removal the root operation for removal of implanted devices from bone?*
- Yes – the root operation ‘Removal’ should be used for removing implanted devices from bone

Coding Questions . . .

- Right Tibia open reduction with internal fixation (ORIF) with bone cement augmentation?
  - *What is the correct PCS code for this procedure?*
- 0QSG04Z
  - *No separate code assigned for the bone cement augmentation*

ICD-10-PCS Coding

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ICD-10-PCS Scenario #1

- Laparoscopic inguinal hernia repair, right

- 0YQ54ZZ
- Rationale: There is no indication that mesh was used for this repair; therefore the root operation Repair is used. The inguinal area of the body is categorized to the Anatomical Regions, Lower Extremities. The laparoscopic approach identified with ‘4’

Scenario #1, continued

Section	Medical and Surgical	0
Body System	Anatomical Regions, Lower Extremities	Y
Root Operation	Repair	Q
Body Part	Inguinal Region, Right	5
Approach	Percutaneous Endoscopic	4
Device	No Device	Z
Qualifier	No Device	Z

ICD-10-PCS Scenario #2

- Left frontal temporoparietal craniotomy and evacuation of subdural hematoma

- 00C40ZZ
- Rationale: The root operation Extirpation is used to code the evacuation of the subdural hematoma. The craniotomy is the open approach for the procedure. The body part value is 4, Subdural space because the hematoma was located subdurally. There are no device or qualifier values for this case.

Scenario #2, continued

Section	Medical and Surgical	0
Body System	Central Nervous System	0
Root Operation	Extirpation	C
Body Part	Subdural Space	4
Approach	Open	0
Device	No Device	Z
Qualifier	No Device	Z

ICD-10-PCS Scenario #3

- The surgeon performs a reversal of a pervious lip augmentation procedure by making an incision along the length of both lips, inside the mouth. A strip of tissue is removed from each lip to thin the lips and pull them inward. The incisions are sutured closed. How is this coded?
  A. 0CQ1XZZ, 0CQ0XZZ
  B. 0CQ10ZZ, 0CQ00ZZ
  C. 0C01XZZ, 0C00XZZ
  D. 0CB10ZZ, 0CB00ZZ

Scenario #3, continued

- C. 0C01XZZ, 0C00XZZ
- Rationale: The procedure description does not state that this procedure was done for medical reasons. Therefore, the assumption is that the patient was unsatisfied with the previous lip augmentation and is again requesting cosmetic surgery. Therefore, the root operation Alteration is coded. The only option that includes the root operation Alteration is option C.

Scenario #3, continued

Section	Medical and Surgical	0
Body System	Mouth and Throat	C
Root Operation	Alteration	0
Body Part	Lower Lip	1
Approach	External	X
Device	No Device	Z
Qualifier	No Device	Z

Scenario #3, continued

Section	Medical and Surgical	0
Body System	Mouth and Throat	C
Root Operation	Alteration	0
Body Part	Upper Lip	0
Approach	External	X
Device	No Device	Z
Qualifier	No Device	Z

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ICD-10-PCS Scenario #4

- Open aortocoronary artery bypass graft of three coronary arteries using left autologous greater saphenous vein, harvested endoscopically.

- 021209W
- 06BQ4ZZ

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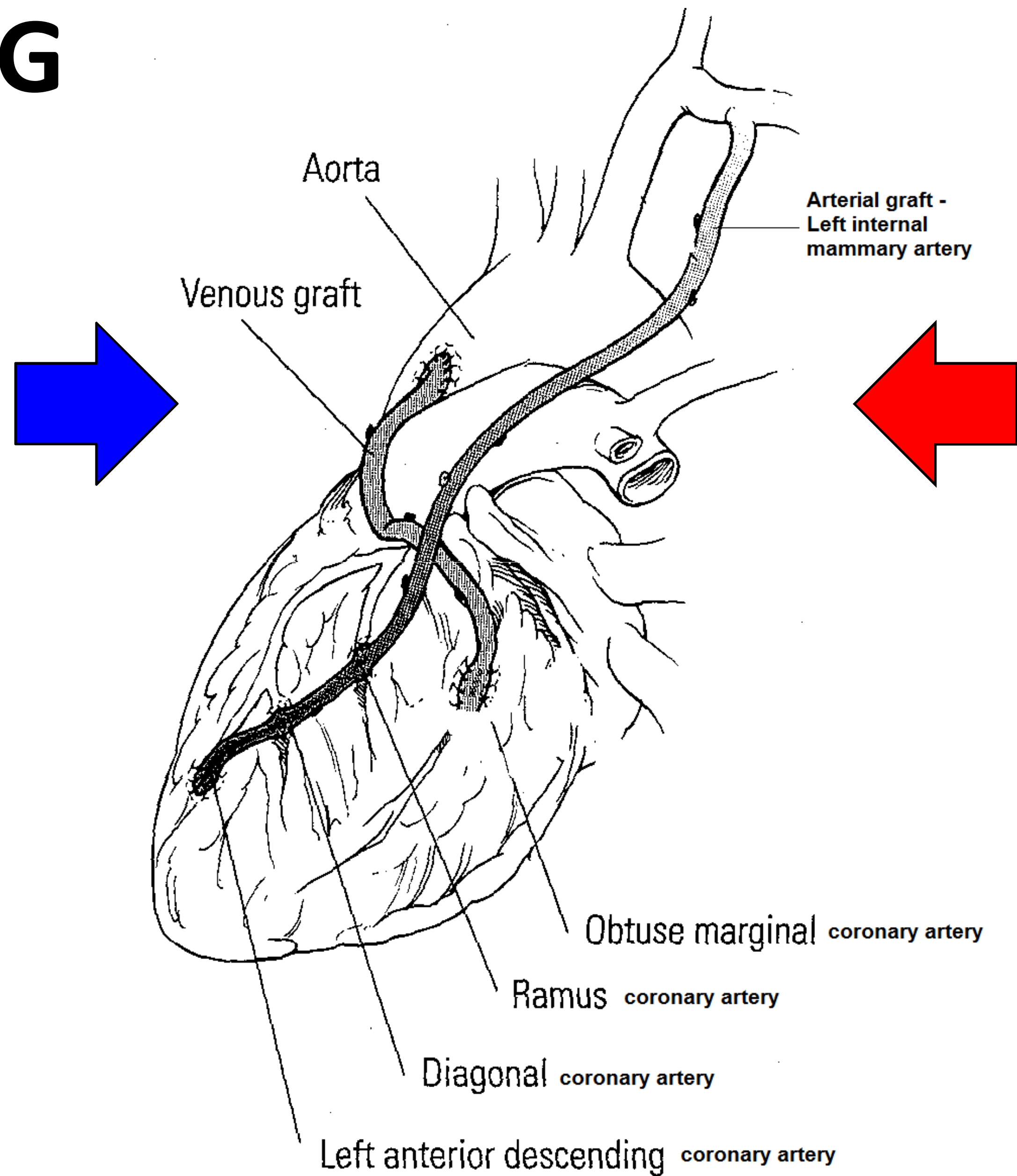
Scenario #4, continued

- There were three coronary arteries bypass, so the body part is ‘2’. Autologous venous tissue was used, so the device value is ‘9’. Bypass procedures have special coding guidelines. Review Coding Guideline B3.6b. In coronary arteries, the qualifier specifies the vessel bypassed from (aorta).

Scenario #4, continued

Section	Medical and Surgical	0
Body System	Heart and Great Vessels	2
Root Operation	Bypass	1
Body Part	Coronary Artery, Three Sites	2
Approach	Open	0
Device	Autologous Venous Tissue	9
Qualifier	Aorta	W

CABG



ICD-10-PCS Scenario #5

- Lumbar single level complete discectomy (L4-L5), posterolateral lumbar single level arthrodesis (L4-L5), posterior lumbar nonsegmental instrumentation (L4-L5). What are the correct procedure codes?

Scenario #5, continued:

- 0ST20ZZ
- 0SG00Z1
- 0SH00CZ
- Rationale: The root operation Resection is used for the discectomy because the disc is completely removed. One lumbar vertebral joint is fused using a posterior approach to the posterior spine. Non-segmental instrumentation is a spinal stabilization device that is coded with the root operation Insertion and the device value C, Spinal stabilization device, pedicle-based, because posterior non-segmental instrumentation is pedicle-based.

Scenario #5, continued

Section	Medical and Surgical	0
Body System	Lower Joints	S
Root Operation	Resection	T
Body Part	Lumbar Vertebral Disc	2
Approach	Open	0
Device	No Device	Z
Qualifier	No Qualifier	Z

Scenario #5, continued

Section	Medical and Surgical	0
Body System	Lower Joints	S
Root Operation	Fusion	G
Body Part	Lumbar Vertebral Joint	0
Approach	Open	0
Device	No Device	Z
Qualifier	Anterior Approach, Anterior Column	1

Scenario #5, continued

Section	Medical and Surgical	0
Body System	Lower Joints	S
Root Operation	Insertion	H
Body Part	Lumbar Vertebral Joint	0
Approach	Open	0
Device	Spinal Stabilization Device, Pedicle-based	C
Qualifier	No Qualifier	Z

Bringing it together. . .
ICD-10-CM/PCS
Coding Cases

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Scenario #1

- This is a 26-year-old patient who has had a previous cesarean section and it planning a VBAC for this delivery. She is admitted in her 39th week in labor with the fetus in cephalic position and no rotation necessary. The labor continues to progress and five hours later she is taken to delivery. During the delivery she is fatigued, so mid forceps are required over a midline episiotomy which is subsequently repaired. A single liveborn infant is delivered. Assign correct diagnosis and procedure codes.

Scenario #1, continued

- O75.8 Pregnancy, complicated by, fatigue, during labor and delivery
- O34.21 Delivery, vaginal, following previous cesarean section delivery
- Z3A.39 Pregnancy, weeks of gestation, 39 weeks
- Z37.0 Outcome of delivery, single liveborn

Scenario #1, continued:

- 10D07Z4 Extraction, Products of Conception, Mid Forceps (10D07Z4)
- 0W8NXZZ Division, Perineum, Female (0W8NXZZ)

  Episiotomy, *see* Division, Perineum, Female (0W8N)

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Scenario #2

- Postoperative Diagnosis:
  - Rectal prolapse
  - Tubular adenoma of sigmoid colon, biospies x2
  - Sigmoid diverticulosis
  - Nonspecific colitis
- Procedure:
  - Colonoscopy performed to the level of the cecum

Scenario #2 continued:

- Procedure: Endoscope was passed through the rectal verge and advanced to the level of the cecum. The scope was then slowly retracted with a circular tip motion. There was mild nonspecific colitis noted. The patient also had significant sigmoid diverticulosis and several small polyps in the sigmoid colon area. Two of the small polyps were biopsied using the cold biopsy forceps and sent to pathology for examination. The remainder of the exam was unremarkable.

Scenario #2 continued:

- D12.5 Adenoma – *see also* Neoplasm, benign, by site. Neoplasm Table: intestines, large, colon, sigmoid
- K62.3 Prolapse, prolapsed, rectum (mucosa) (sphincter)
- K57.30 Diverticulosis, large intestine
- K52.9 Colitis (acute) (catarrhal) (chronic) (noninfectious) (hemorrhagic)

Scenario #2 continued:

- 0DBN8ZX Excision, Colon, Sigmoid (0DBN)
- 0DBN8ZX Excision, Colon, Sigmoid (0DBN)

  Biopsy, *see* Excision with qualifier Diagnostic

The procedure code 0DBN8ZX is coded twice because two areas of the sigmoid colon were biopsied. ICD-10-PCS Coding Guideline B3.2b

What's Next?

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Coder Training

- Create a timeline
  - Training timeline leading up to implementation
  - Consider all training needs for staff
- Include all training steps
  - Assessments
  - Biomedical Sciences
  - ICD-10-CM training
  - ICD-10-PCS training

Coder Training

- Get coding staff involved in developing training for the team
- FUN
  - Make training fun
  - Use games (Jeopardy, etc.) to mix up the training

Thank you!

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