

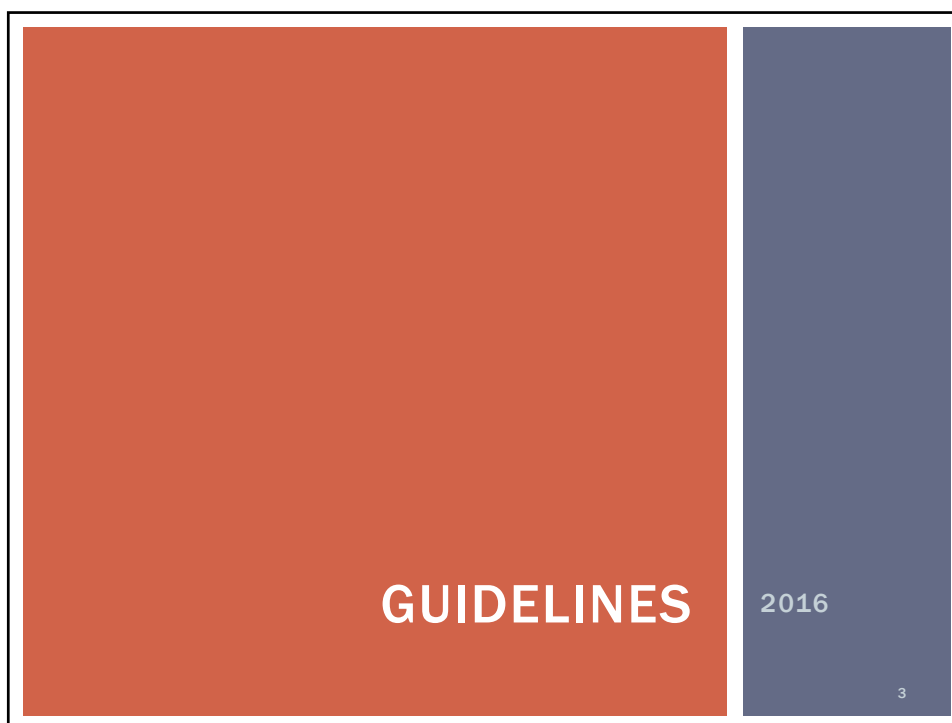
**ICD-10-PCS CODING WORKSHOP**  
**ILHIMA 2016 ANNUAL MEETING**  
APRIL 29, 2016

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AHIMA-Approved ICD-10-CM/PCS Trainers

## LEARNING OBJECTIVES

- Review 2016 ICD-10-PCS guideline changes
- Discuss select *Coding Clinic* changes
- Apply root operation definitions and guidelines to case studies
- Discuss various procedures

2



## MULTIPLE PROCEDURES B3.2.B

The same root operation is repeated in multiple body parts, and those body parts are separate and distinct body parts classified to a single ICD-10-PCS body part value.

*Example:* Excision of the sartorius muscle and excision of the gracilis muscle are both included in the upper leg muscle body part value, and multiple procedures are coded.

## EXCISION OF MULTIPLE UTERINE FIBROIDS

- **Q:** When a patient has removal of 34 uterine fibroids, is one code or 34 assigned?
- **A:** This is not coded multiple times since the excisions are not done on a separate body part
  - The phrase "different body sites" in the guideline refers to distinct body parts, not different locations within the same body part
  - The example in the guideline uses different, distinct body part values (e.g., excision of the sartorius muscle and excision of the gracilis muscle)
- **Only one code is assigned**
- *Coding Clinic, Fourth Quarter 2014: Page 16*

5

SECTION X

New for  
October 2015

6

## ICD-10-PCS SECTIONS

<ul style="list-style-type: none"> <li>0 Medical and Surgical</li> <li>1 Obstetrics</li> <li>2 Placement</li> <li>3 Administration</li> <li>4 Measurement and Monitoring</li> <li>5 Extracorporeal Assistance and Performance</li> <li>6 Extracorporeal Therapies</li> <li>7 Osteopathic</li> </ul>	<ul style="list-style-type: none"> <li>8 Other Procedures</li> <li>9 Chiropractic</li> <li>B Imaging</li> <li>C Nuclear Medicine</li> <li>D Radiation Therapy</li> <li>F Physical Rehabilitation and Diagnostic Audiology</li> <li>G Mental Health</li> <li>H Substance Abuse Treatment</li> <li>X New Technology</li> </ul>
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7

## SECTION X STRUCTURE

- 1 • Letter X
- 2 • Body system/region value
- 3 • Root operation value
- 4 • Body part value
- 5 • Approach value
- 6 • Device/substance/technology value
- 7 • Information indicating the year created

8

## GENERAL INFORMATION SECTION X

- Does not introduce any new coding concepts or unusual guidelines
- Uses same root operation and body part values as other sections

<i>Section</i>	<b>X</b>	New Technology
<i>Body System</i>	<b>W</b>	Anatomical Regions
<i>Operation</i>	<b>0</b>	Introduction: Putting in or on a therapeutic, diagnostic, nutritional, physiological, or prophylactic substance except blood or blood products

<i>Body Part</i>	<i>Approach</i>	<i>Device / Substance / Technology</i>	<i>Qualifier</i>
<b>3</b> Peripheral Vein <b>4</b> Central Vein	<b>3</b> Percutaneous	<b>2</b> Ceftazidime-Avibactam Anti-infective <b>3</b> Idarucizumab, Dabigatran Reversal Agent <b>4</b> Isavuconazole Anti-infective <b>5</b> Blinatumomab Antineoplastic Immunotherapy	<b>1</b> New Technology Group 1

9

## GENERAL INFORMATION SECTION X

Seventh character used exclusively to indicate the new technology group

Group number or letter changes each year

<i>Section</i>	<b>X</b>	New Technology
<i>Body System</i>	<b>2</b>	Cardiovascular System
<i>Operation</i>	<b>C</b>	Extirpation: Taking or cutting out solid matter from a body part

<i>Body Part</i>	<i>Approach</i>	<i>Device / Substance / Technology</i>	<i>Qualifier</i>
<b>0</b> Coronary Artery, One Site <b>1</b> Coronary Artery, Two Sites <b>2</b> Coronary Artery, Three Sites <b>3</b> Coronary Artery, Four or More Sites	<b>3</b> Percutaneous	<b>6</b> Orbital Atherectomy Technology	<b>1</b> New Technology Group 1

10

## GENERAL INFORMATION SECTION X

- There are no special coding instructions or requirements
- All codes will have the same qualifier

<i>Section</i>	<b>X</b>	New Technology		
<i>Body System</i>	<b>R</b>	Joints		
<i>Operation</i>	<b>2</b>	Monitoring: Determining the level of a physiological or physical function repetitively over a period of time		
<i>Body Part</i>		<i>Approach</i>	<i>Device / Substance / Technology</i>	<i>Qualifier</i>
<b>G</b> Knee Joint, Right <b>H</b> Knee Joint, Left		0 Open	2 Intraoperative Knee Replacement Sensor	1 New Technology Group 1

11

## CODING INSTRUCTION

### Index

- Name of new technology device, substance or technology included as main term

Ceftazidime-Avibactam Anti-infective XW0

New Technology  
Ceftazidime-Avibactam

All codes listed under main term "New Technology"

### Tables

- Located in X Section

12

# PROCEDURES

13

## EXCISION

**Excision—Root operation B**

Definition: Cutting out or off, without replacement, a portion of a body part

Explanation: The qualifier Diagnostic is used to identify excision procedures that are biopsies

Examples: Partial nephrectomy, liver biopsy

Excision is coded when a portion of a body part is cut out or off using a sharp instrument. All root operations that employ cutting to accomplish the objective allow the use of any sharp instrument, including but not limited to

- Scalpel
- Wire
- Scissors
- Bone saw
- Electrocautery tip

Source: ICD-10-PCS Reference Manual, 2016. CMS.

14

## EXTRACTION

### Extraction—Root operation D

Definition: Pulling or stripping out or off all or a portion of a body part by the use of force

Explanation: The qualifier Diagnostic is used to identify extraction procedures that are biopsies

Examples: Dilation and curettage, vein stripping

Extraction is coded when the method employed to take out the body part is pulling or stripping. Minor cutting, such as that used in vein stripping procedures, is included in Extraction if the objective of the procedure is nevertheless met by pulling or stripping. As with all applicable ICD-10-PCS codes, cutting used to reach the procedure site is specified in the approach value.

Source: ICD-10-PCS Reference Manual, 2016. CMS.

15

## EXCISIONAL AND NONEXCISIONAL DEBRIDEMENT – P. 3-8

- Coding Clinic defines debridement as removal of devitalized or contaminated tissue from a traumatic or infected lesion until the surrounding healthy tissue is exposed
- Excisional debridement of the skin or subcutaneous tissue is the surgical removal or cutting away of this tissue, necrosis, or slough
- Classify to root operation of "Excision"
- *Coding Clinic*, Third Quarter 2015

16



## EXCISIONAL AND NONEXCISIONAL DEBRIDEMENT – P. 3-8

- Use of a sharp instrument does not always indicate excisional debridement
- Minor removal of loose fragments with scissors or using a sharp instrument to scrape away tissue is not an excisional debridement
- Excisional debridement involves the use of a scalpel to remove devitalized tissue
- The documentation should indicate the type of debridement
  - Query provider if documentation not clear
- *Coding Clinic, Third Quarter 2015*

17

## EXCISIONAL AND NONEXCISIONAL DEBRIDEMENT – PGS. 3-8

- Nonexcisional debridement is nonoperative brushing, irrigating, scrubbing, or washing
- Most nonexcisional débridements classify to root operation “Extraction”
- *Coding Clinic, Third Quarter 2015*

18

## EXCISIONAL DEBRIDEMENT OF SKIN OF BUTTOCK DOCUMENTED – PG. 3

- **Question:** Excisional debridement of skin of buttock documented. How is this coded?
- **Answer:** 0HB8XZZ, Excision of buttock skin, external
- *Coding Clinic, Third Quarter 2015*

19

## EXCISIONAL DEBRIDEMENT OF COCCYX INCLUDING BONE – PG. 4

- **Question:** Excisional debridement in the coccyx area down into the bone.
- **Answer:** 0QBS0ZZ, Excision of coccyx, open approach.
- **Coding Guideline: Overlapping body layers B3.5**
  - If the root operations Excision, Repair or Inspection are performed on overlapping layers of the musculoskeletal system, the body part specifying the deepest layer is coded.
- *Coding Clinic, Third Quarter 2015*
- ICD-10-PCS Official Guidelines for Coding and Reporting, 2016

20

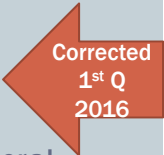
## DEBRIDEMENT USING KNIFE DISSECTION - PG. 4

- **Question:** Does knife dissection mean the same as excisional debridement?
- **Answer:** No, knife dissection is not sufficient to code "Excision"
  - Query the physician for more information
- Excisional debridement is assigned when the provider documents "excisional debridement"
- *Coding Clinic, Third Quarter 2015*

21

## VERSAJET DEBRIDEMENT - PG. 5

- **Question:** How is VersaJet debridement of skin and subcutaneous tissue of upper right thigh coded?
- **Answer:** OJDLOZZ, Extraction of right upper leg, subcutaneous tissue and fascia, open approach
  - VersaJet is coded as nonexcisional debridement
- **Question:** How is digressive debridement of a sacral decubitus ulcer coded when performed by physical therapy with pulse lavage?
- **Answer:** OHD6XZZ, Extraction of back skin, external approach
  - Mechanical lavage, pulsatile lavage, mechanical irrigation and high-pressure irrigation is classified as nonexcisional debridement
- *Coding Clinic, Third Quarter 2015*



Corrected  
1<sup>st</sup> Q  
2016

22

## DEBRIDEMENT OF BONE, FASCIA, OR MUSCLE - PGS. 7-8

- **Question:** Can "debridement of bone, fascia or muscle," be reported as excisional debridement?
- **Answer:** Coders cannot assume that the debridement of bone, fascia, or muscle is always excisional.
- ICD-10-PCS does not provide a default if the debridement is not specified as "excisional" or "nonexcisional."
- *Coding Clinic, Third Quarter 2015*

23

## AUDIENCE PARTICIPATION

According to Coding Clinic, which is an excisional debridement?

1. Digressive debridement with pulse lavage
2. Debridement of skin and subcutaneous tissue with VersaJet debrider
3. Removal of skin with scissors
4. Sharp debridement of bone
5. Knife dissection of subcutaneous tissue
6. Debridement of muscle
7. Excisional debridement of skin

24

## INSERTION OF CERVICAL CERCLAGE - PGS. 30-31

- **Question:** When coding cervical cerclage for incompetent cervix, is the cerclage considered a device?
- **Answer:** 0UVC7ZZ, Restriction of cervix, via natural or artificial opening
- The cerclage is a suture, which is not classified as a device, but considered to be a surgical supply.
- *Coding Clinic, Third Quarter 2015*

25

## REMOVAL OF CERVICAL CERCLAGE - PG. 30

- **Question:** How is the removal of a transvaginal placement of cervical cerclage coded?
- **Answer:** 0UCC7ZZ, Extirpation of matter from cervix, via natural or artificial opening
- **Question:** How is hysteroscopic removal of cerclage coded?
- **Answer:** 0UCC8ZZ, Extirpation of matter from cervix, via natural or artificial opening endoscopic
  - A cerclage is a suture, not a device
- *Coding Clinic, Third Quarter 2015*

26

## OPEN EVACUATION OF SUBDURAL HEMATOMA - PGS. 10-11

- **Question:** A subdural hematoma was evacuated by creating a subtemporal burr hole and then a parietal burr hole was placed with evacuation of both sites. These burr holes were extended to connect them to evacuate the entire exposed brain.
- **Answer:** 00C40ZZ, Extirpation of matter from subdural space, **open** approach
- *Coding Clinic, Third Quarter 2015*

27

## HEMATOMA

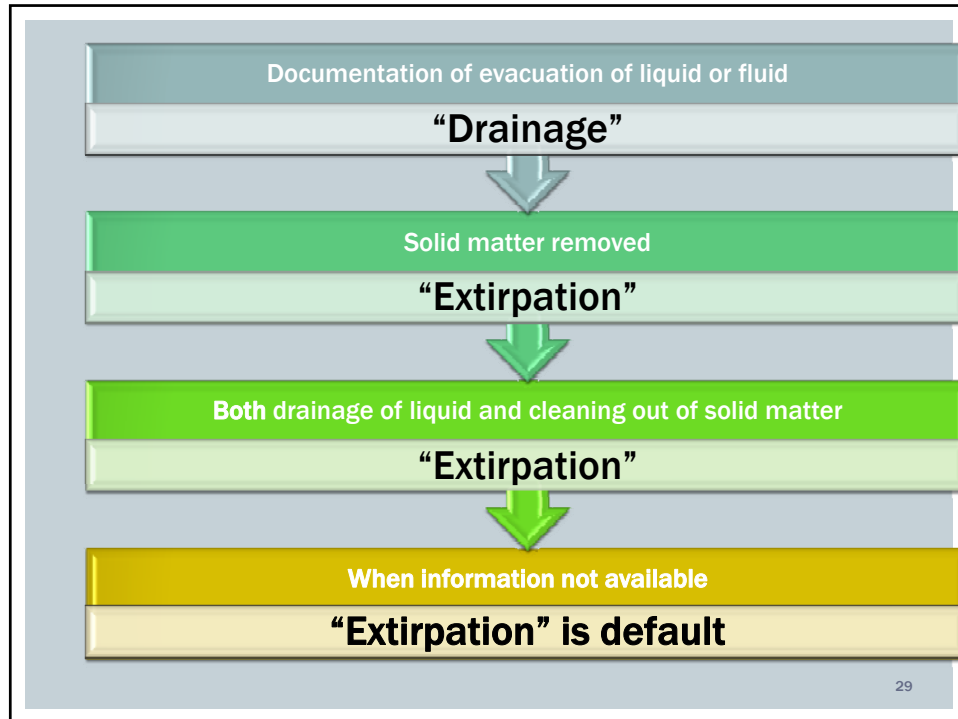
Localized collection of blood outside vessel

Subdural hematoma either acute (subacute) or chronic

Acute subdural hematoma - solid or gelatinous clot

Chronic subdural hematoma - liquid matter rather than solid

28



## PERCUTANEOUS DRAINAGE OF SUBDURAL HEMATOMA – PGS. 11-12

- **Question:** How is drainage via burr hole of liquefied subdural hematoma coded? The drainage device was left in place.
- **Answer:** 009430Z, Drainage of subdural space with drainage device, percutaneous approach
  - The root operation "Extirpation" is used when removal of solid matter is documented. If only liquid is removed, "Drainage" is coded. If both drainage of fluid and cleaning out of solid matter is done, code **ONLY** the root operation "Extirpation."
- *Coding Clinic*, Third Quarter 2015

## SWAN GANZ CATHETERIZATION – PG.35

- **Question:** How is insertion of Swan Ganz catheter to monitor pulmonary artery pressure coded?
- **Answer:** 02HP32Z, Insertion of monitoring device into pulmonary trunk, percutaneous approach
  - Assign only the code for placement
  - Assign pulmonary artery trunk unless documentation states other site
  - The monitoring is included in the code
- *Coding Clinic, Third Quarter 2015*

31

## SWAN GANZ CATHETERIZATION – PG.35

- **For previously placed monitor, assign (if desired):**
  - 4A1239Z, Monitoring of cardiac output, percutaneous approach; or
  - 4A133B3, Monitoring of arterial pressure, pulmonary, percutaneous approach
- **Do not assign code for right heart cath unless there is documentation that there was diagnostic heart cath performed**
- *Coding Clinic, Third Quarter 2015*

32



## BEARING SURFACE FOR HIP REPLACEMENT

If specific type of bearing surface is not available in

- provider's documentation
- manufacturer's product information/sticker

Assign "J" synthetic substitute for the device OR

Query the provider for clarification

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33

## DRUG-COATED BALLOON ANGIOPLASTY IN PERIPHERAL VESSELS – PG. 4

- New ICD-10-PCS codes created to identify the use of drug-coated balloons in peripheral angioplasty
  - Distinguish from traditional angioplasty
- Qualifier value "1 Drug-Coated Balloon"
- Table 047 Dilatation of Lower Arteries
- Available for all vessels in the table
- Drug-coated balloons are not considered devices, because they are not left in the body after the procedure!
- *Coding Clinic*, Fourth Quarter 2015

34

## TABLE 047

<i>Section</i>	0 Medical and Surgical		
<i>Body System</i>	4 Lower Arteries		
<i>Operation</i>	7 Dilation: Expanding an orifice or the lumen of a tubular body part		
<i>Body Part</i>	<i>Approach</i>	<i>Device</i>	<i>Qualifier</i>
<b>K</b> Femoral Artery, Right	<b>0</b> Open	<b>4</b> Intraluminal Device, Drug-eluting	<b>1</b> Drug-Coated Balloon
<b>L</b> Femoral Artery, Left	<b>3</b> Percutaneous	<b>D</b> Intraluminal Device	<b>Z</b> No Qualifier
<b>M</b> Popliteal Artery, Right	<b>4</b> Percutaneous Endoscopic	<b>Z</b> No Device	
<b>N</b> Popliteal Artery, Left			

35

## DRUG-COATED BALLOON ANGIOPLASTY IN PERIPHERAL VESSELS

- **Question:**
- How is angioplasty of the femoral artery using a drug-coated balloon with stent placement coded?
- **Answer:** 047K3D1, Dilation of right femoral artery with intraluminal device using drug-coated balloon, percutaneous approach
- *Coding Clinic*, Fourth Quarter 2015

36

## VASCULAR ACCESS DEVICES – PG. 26

- Body part value based on **end placement of device, not point of entry**
- *Coding Clinic, Fourth Quarter 2015*

37

## PERIPHERALLY INSERTED CENTRAL CATHETER

- PICC inserted into a peripheral vein in the arm
  - Cephalic vein
  - Basilic vein
  - Brachial vein
- Advanced toward the heart through larger veins, until tip rests in distal superior vena cava or cavoatrial junction
- **02HV33Z**, Insertion of infusion device into superior vena cava (or cavoatrial junction), percutaneous approach.
- *Coding Clinic, Fourth Quarter 2015*

38

## CENTRAL VENOUS CATHETER (CVC)

Inserted into larger, deeper veins

- Subclavian
- Jugular
- Femoral veins

Advanced into the right atrium or superior vena cava

Usually performed in the subclavian vein by a subclavicular approach.

- Another site is the internal jugular vein
- Femoral rarely used

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39

Vein punctured by needle

Guide wire passed through needle and positioned

- Usually in the superior vena cava, and needle removed

Dilator and sheath passed over wire and catheter positioned

- Dilator and sheath removed

Catheter not totally implanted under skin

- Most inserted percutaneously
- No subcutaneous pocket created

Central venous catheter inserted into left internal jugular vein with tip in right atrium

- **02H633Z**, Insertion of infusion device into right atrium, percutaneous approach.

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40

## CENTRAL VENOUS CATHETER

- Hickman
- Broviac
- Triple lumen
- Double lumen

41

## TOTALLY IMPLANTABLE CENTRAL VENOUS ACCESS DEVICE

- An injection port and a catheter system
  - Implanted port
  - Venous access port
  - Port-A-Cath
- Port inserted subcutaneously into chest area without any portion exiting the skin
- Catheter inserted into one of the main veins of upper chest (subclavian, internal jugular or superior vena cava) and tunneled through the subcutaneous tissue
- Tip advanced into point in superior vena
  - Other end connected to port

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42

**TOTALLY IMPLANTABLE CENTRAL VENOUS ACCESS DEVICE**

**Examples of totally implantable access ports include**

**Port-a-cath**

**Medi-port**

**Groshong port**

*Coding Clinic, Fourth Quarter 2015* 43

**TOTALLY IMPLANTABLE CENTRAL VENOUS ACCESS DEVICE**

**Code assignment for placement of the infusion portion of the device is based on end placement**

<p><b>02H633Z,</b> Insertion of infusion device into right atrium, percutaneous approach</p>	<p><b>0JH60XZ,</b> Insertion of vascular access device into chest subcutaneous tissue and fascia, open approach.</p>	<p><b>02HV33Z,</b> Insertion of infusion device into superior vena cava, percutaneous approach</p>	<p><b>0JH60XZ,</b> Insertion of vascular access device into chest subcutaneous tissue and fascia, open approach.</p>
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44

## AUDIENCE PARTICIPATION

Under fluoroscopic guidance entry was made into the right internal jugular vein and the central venous catheter is threaded into the superior vena cava.

What is the correct code?

1. 06H033Z
2. 02HV33Z
3. 05HM33Z
4. 02HV03Z

45

## OBSTETRIC PERINEAL LACERATIONS

First degree—Involve perineal skin and extension into the vagina as vaginal mucosa

• 0HQ9XZZ, Repair perineum skin, external approach, for repair of a first degree perineal laceration

Second degree—Involve perineal body and deeper tissues

• 0KQMOZZ, Repair perineum muscle, open approach, for repair of a second degree perineal laceration

Third degree—Extend into capsule and muscle of anal sphincter

• 0DQROZZ, Repair anal sphincter, open approach, for repair of a third degree perineal laceration.

Fourth degree—Extending through the sphincter and into the anal/rectal mucosa

• 0DQPOZZ, Repair rectum, open approach, for the repair of the fourth-degree tear.

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46

## LYMPH NODES – RADICAL RESECTION

- If chain of lymph nodes is excised, code to resection
- If partial lymph node chain done, code to excision
- If intent is to remove all lymph nodes in an area, code as resection.
  - A radical resection implies removal of all lymph nodes.
  - Modified radical is removal of all nodes and is coded as resection.
  - Radical procedures involve cutting out everything within a designated anatomic boundary.
- Sampling of lymph nodes, such as sentinel nodes is coded as excision.

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47

## LYMPH NODES SELECTIVE EXCISION

- **Question:** How is removal of lymph nodes from the right paratracheal stations 2, 4R, 7, 9, and 10R
- **Answer:** Some lymph node positions were removed and some left intact. This implies excision (selective removal of lymph nodes), rather than resection.
- Examples indicating lymph node excision:
  - Sampling
  - Biopsy
  - Sentinel node
  - Isolated nodes

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48



## LYMPH NODES - LEVELS

- **Question:** During the axillary dissection, the provider removed level 1, level 2 and parts of level 3 axillary lymph nodes.
- **Answer:** Each lymph node level is considered a chain.
- When the intent is to remove an entire chain of lymph nodes, “Resection” is coded.
- The axillary lymph nodes are all considered a single body part and therefore multiple procedure codes would not be assigned

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49

## MULTIPLE/SINGLE TREATMENT

- **Question:** Hemodialysis was performed on three separate days. Should the single or multiple duration value be assigned?
- **Answer:** Hemodialysis is an example of “Multiple” planned repeated treatments
- 5A1D60Z Performance of urinary filtration, Multiple
- The duration value (“Single” versus “Multiple”) is assigned based on documentation of a single (continuous) treatment or multiple (separate) treatments

50

## ICD-10-CM/PCS IMPLEMENTATION- 6 MONTHS IN

51

## PCS IS STILL THE “NEW” SYSTEM

## RESOURCES FOR CORRECT CODING

- **PCS System Itself**
  - Introduction to PCS
- **Official Guidelines**
  - Conventions
  - Medical and Surgical Section
  - Obstetrics Section
  - New Technology Section
  - Selecting the Principal Procedure
- **Reference Manual**
- **Coding Clinic**
  - Since 4Q 2012

## ICD-10-PCS SYSTEM

- **7 characters**
  - Section
  - Body System
  - Root Operation
  - Approach
  - Device
  - Qualifier
- **17 sections**
- **Medical and Surgical – Most coding from this section**
  - 3<sup>rd</sup> character for the root operation
  - 31 root operations to reflect the intent of the procedure
  - Divided into 9 groups
    - Based on attributes

## ROOT OPERATIONS THAT TAKE OUT SOME OR ALL OF A BODY PART

- Excision—Cutting out or off, without replacement, a portion of a body part
- Resection—Cutting out or off, without replacement, all of a body part
- Detachment—Cutting off all or part of the upper or lower extremities
- Destruction—Physical eradication of all or a portion of a body part by the direct use of energy, force, or a destructive agent
- Extraction—pulling or stripping out or off all or a portion of a body part by the use of force

## ROOT OPERATIONS THAT TAKE OUT SOLIDS/FLUIDS/GASES

- Drainage—Taking or letting out fluids and/or gases from a body part
- Extirpation—Taking or cutting out solid matter from a body part
- Fragmentation—Breaking solid matter in a body part into pieces

## ROOT OPERATIONS INVOLVING CUTTING OR SEPARATION ONLY

- Division—Separating, without taking out, a body part
- Release—Freeing a body part from an abnormal physical constraint by cutting or by the use of force

## ROOT OPERATIONS THAT PUT IN/PUT BACK

- Transplantation—Putting in or on all or a portion of a living body part taken from another individual or animal to physically take the place and/or function of all or a portion of a similar body part
- Reattachment—Putting back in or on all or a portion of a separated body part to its normal location or other suitable location
- Transfer—Moving, without taking out, all or a portion of a body part to another location to take over the function of all or a portion of a body part
- Reposition—Moving to its normal location or another suitable location all or a portion of a body part

## ROOT OPERATIONS THAT ALTER THE DIAMETER/ROUTE OF A TUBULAR BODY PART

- Restriction—Partially closing an orifice or the lumen of a tubular body part
- Occlusion—Completely closing an orifice or the lumen of a body part
- Dilation—Expanding an orifice or the lumen of a tubular body part
- Bypass—Altering the route of passage of the contents of a tubular body part

## ROOT OPERATIONS THAT ALWAYS INVOLVE A DEVICE (CONTINUED)

- Insertion—Putting in a non-biological device that monitors, assists, performs, or prevents a physiological function but does not physically take the place of a body part
- Removal—Taking out or off a device from a body part
- Revision—Correcting, to the extent possible, a portion of a malfunctioning or the position of a displaced device

## ROOT OPERATIONS THAT ALWAYS INVOLVE A DEVICE (CONTINUED)

- **Change**—Taking out or off a device from a body part and putting back an identical or similar device in or on the same body part without cutting or puncturing the skin or a mucous membrane
- **Replacement**—Putting in or on biological or synthetic material that physically takes the place of all or a portion of a body part
- **Supplement**—Putting in or on a biological or synthetic material that physically reinforces and/or augments the function of a portion of a body part

## ROOT OPERATIONS INVOLVING EXAMINATION ONLY

- **Inspection**—Visually and/or manually exploring a body part
- **Map**—Locating the route of passage of electrical impulses and/or locating functional areas in a body part

## ROOT OPERATIONS THAT DEFINE OTHER REPAIRS

- Control—Stopping, or attempting to stop, postprocedural bleeding
- Repair—Restoring, to the extent possible, a body part to its normal anatomic structure and function

## ROOT OPERATIONS THAT DEFINE OTHER OBJECTIVES

- Fusion—Joining together portions of an articular body part rendering the articular body part immobile
- Alteration—Modifying the anatomic structure of a body part without affecting the function of the body part
- Creation—Making a new structure that does not physically take the place of a body part

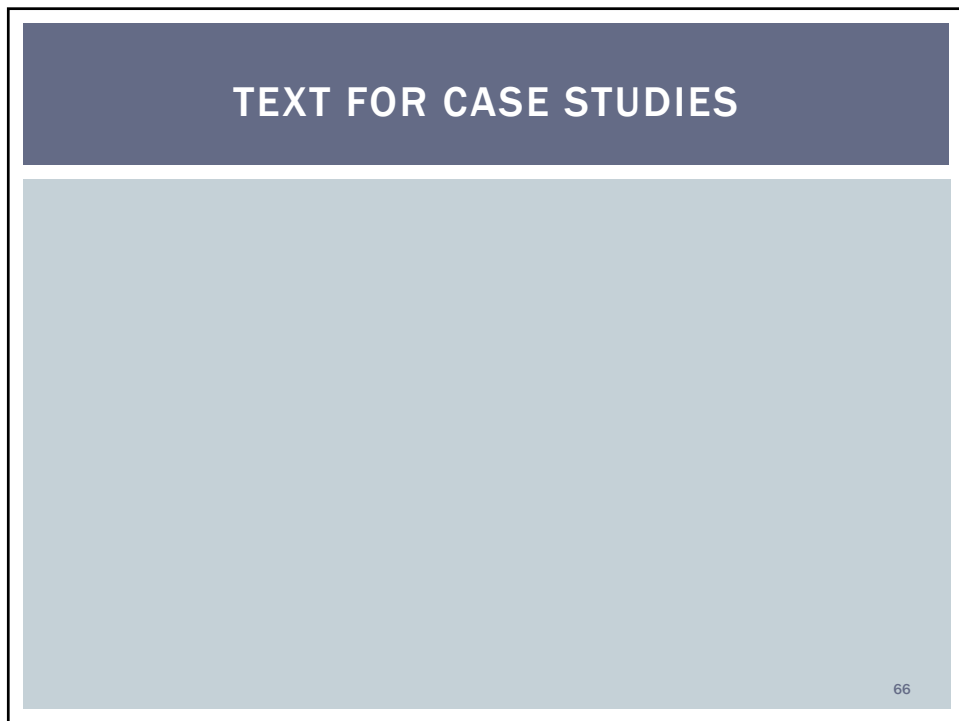




A slide with a red background on the left and a dark blue vertical bar on the right. The text "CASE STUDIES" is centered in white on the red background. The number "65" is in the bottom right corner of the dark blue bar.

**CASE STUDIES**

65



A slide with a dark blue header bar at the top containing the text "TEXT FOR CASE STUDIES" in white. Below the header is a large light blue area. The number "66" is in the bottom right corner.

**TEXT FOR CASE STUDIES**

66

## CHAPTER 8 CODE BUILDING EXERCISES

### #1

PRE- and POSTOPERATIVE DIAGNOSIS: Subdural hematoma, left hemisphere  
 OPERATION PERFORMED: 1. Evacuation of subdural hematoma 2. Implantation of a subdural externalized shunt

DESCRIPTION OF OPERATION: The patient was brought to the operating room in the supine position after induction of general endotracheal anesthesia. The head was placed in a gel donut on a horseshoe. Frontal areas were shaved, prepped and draped in standard sterile fashion using a Loban drape. A long line of incision was marked bilaterally in the frontal region, and infiltrated with 1/2 percent lidocaine with 1:200,000 epinephrine. The skin incision was made in the frontal region down to the pericranium. Subperiosteal dissection was carried out. A burr hole was created and a craniectomy was extended.

The dura was opened and the dural leaflets were obtained. The subdural fluid was drained under pressure. This was collected and sent for routine studies. The subdural space without difficulty. This was now brought out through the original Subdural space was copiously irrigated with normal saline until the egress was clear. A 35-cm ventriculostomy catheter was brought into the field and inserted into burr hole, tunneled under the skin and brought out of the skin through a separate incision. This was then secured to the skin and connected to an externalized drainage bag. Attention was directed to reconstruction of the cranial opening. The reconstruction was carried out using the Lorenz plating system and titanium microscrews for cranioplasty. The wound was irrigated and closed in the usual fashion using 2-0 Vicryl for the deeper layers and staples for the skin. Sterile dressings were applied.

67

## C. 8 #1 QUESTIONS

- 1.1. Which root operation is assigned for the evacuation of the subdural hematoma?

68

## HEMATOMA

- Localized collection of blood outside vessel
- Subdural hematoma either acute (subacute) or chronic
- Acute subdural hematoma - solid or gelatinous clot
- Chronic subdural hematoma - liquid matter rather than solid

69

Documentation of evacuation of liquid or fluid

**“Drainage”**

↓

Solid matter removed

**“Extirpation”**

↓

Both drainage of liquid and cleaning out of solid matter

**“Extirpation”**

↓

When information not available

**“Extirpation” is default**

70

## CHAPTER 8 #1 QUESTIONS CONTINUED

- 1.2. Is a separate code assigned for the externalized shunt?
- 1.3. Is a separate code assigned for the craniectomy?
- 1.4. A Lorenz plating system and titanium microscrews are used to perform a cranioplasty. Is a code for the insertion of an internal fixation device into the skull assigned for this case?
- 1.5. What code(s) would be assigned?

71

# 009400Z

<i>Section</i>	0	Medical and Surgical	
<i>Body System</i>	0	Central Nervous System	
<i>Operation</i>	9	Drainage: Taking or letting out fluids and/or gases from a body part	
<i>Body Part</i>	<i>Approach</i>	<i>Device</i>	<i>Qualifier</i>
0 Brain	0 Open	0 Drainage Device	Z No Qualifier
1 Cerebral Meninges	3 Percutaneous		
2 Dura Mater	4 Percutaneous Endoscopic		
3 Epidural Space			
4 Subdural Space			
5 Subarachnoid Space			
6 Cerebral Ventricle			
7 Cerebral Hemisphere			
8 Basal Ganglia			
9 Thalamus			
A Hypothalamus			
B Pons			
C Cerebellum			
D Medulla Oblongata			
F Olfactory Nerve			
G Optic Nerve			
H Oculomotor Nerve			
J Trochlear Nerve			
K Trigeminal Nerve			
L Abducens Nerve			

72

## CHAPTER 10 CODE BUILDING EXERCISE #1

- **PREOPERATIVE DIAGNOSIS:** Dyspnea  
**POSTOPERATIVE DIAGNOSIS:** Mucus plug in right upper lobe bronchus
- **PROCEDURE:** Bronchoscopy
- **INDICATION:** Rule out inhaled foreign body and pneumonia
- **PROCEDURE DESCRIPTION:** The flexible bronchoscope was passed through the oral cavity. A very large mucus plug was noted in the right upper lobe bronchus and this was cleared with a balloon using pullback. The tracheobronchial tree was examined and no other obstructions or foreign bodies were found.

73

## CHAPTER 10 CODE BUILDING EXERCISE #1- QUESTIONS

- **1.1.** Is the mucus plug part of the patient's body part or is it an abnormal byproduct of a bodily function?
- **1.2.** Which group of root operations would be used to select the root operation for coding?
- **1.3.** Which root operation is assigned?
- **1.4.** What code(s) would be assigned?

74

## OBC48ZZ

<i>Section</i>	<b>0</b>	Medical and Surgical		
<i>Body System</i>	<b>B</b>	Respiratory System		
<i>Operation</i>	<b>C</b>	Extirpation: Taking or cutting out solid matter from a body part		
<i>Body Part</i>		<i>Approach</i>	<i>Device</i>	<i>Qualifier</i>
1 Trachea		<b>0</b> Open	<b>Z</b> No Device	<b>Z</b> No Qualifier
2 Carina		<b>3</b> Percutaneous		
3 Main Bronchus, Right		<b>4</b> Percutaneous Endoscopic		
4 Upper Lobe Bronchus, Right		<b>7</b> Via Natural or Artificial Opening		
5 Middle Lobe Bronchus, Right		<b>8</b> Via Natural or Artificial Opening Endoscopic		
6 Lower Lobe Bronchus, Right				
7 Main Bronchus, Left				
8 Upper Lobe Bronchus, Left				
9 Lingula Bronchus				

75

## CHAPTER 11 CODE BUILDING EXERCISES

### #1

- **PREOPERATIVE DIAGNOSIS:** Re-occluded arteriovenous graft
- **POSTOPERATIVE DIAGNOSIS:** Re-occluded arteriovenous graft
- **OPERATION PERFORMED:** Open graft thrombectomy
- **HISTORY:** An 84-year-old man with history of end-stage renal disease. He has a right brachial artery axillary vein arterial venous PTFE conduit.
- **DESCRIPTION OF PROCEDURE:** Right arm was prepped and draped in usual sterile fashion. Local lidocaine was infiltrated into the graft. A cutdown was made with sharp dissection to expose the graft. I then cross-clamped the graft, made a graftotomy and removed the clot. The inflow was restored and strongly pulsatile. I then closed the graftotomy with a 6-0 Prolene. The surgical incision was irrigated with Bacitracin laden saline and closed in layers of PDS followed by 4-0 Monocryl and Dermabond to the skin.

76

## CHAPTER 11 CODE BUILDING EXERCISES #1 QUESTIONS

- 1.1. Where is the thrombus (clot) located?
- 1.2. From which root operation group is the root operation selected and which root operation is it?
- 1.3. What is the device value and why?
- 1.4. What code(s) would be assigned?

77

## 03WY0JZ

<i>Section</i>	<b>0</b> Medical and Surgical		
<i>Body System</i>	<b>3</b> Upper Arteries		
<i>Operation</i>	<b>W</b> Revision: Correcting, to the extent possible, a portion of a malfunctioning device or the position of a displaced device		
<i>Body Part</i>	<i>Approach</i>	<i>Device</i>	<i>Qualifier</i>
<b>Y</b> Upper Artery	<b>0</b> Open <b>3</b> Percutaneous <b>4</b> Percutaneous Endoscopic <b>X</b> External	<b>0</b> Drainage Device <b>2</b> Monitoring Device <b>3</b> Infusion Device <b>7</b> Autologous Tissue Substitute <b>C</b> Extraluminal Device <b>D</b> Intraluminal Device <b>J</b> Synthetic Substitute <b>K</b> Nonautologous Tissue Substitute <b>M</b> Stimulator Lead	<b>Z</b> No Qualifier

78

## CHAPTER 13 CODE BUILDING EXERCISES #1

**PREOPERATIVE DIAGNOSIS:** Right upper lobe lung mass

**POSTOPERATIVE DIAGNOSIS:** Right upper lobe lung mass

**PROCEDURE:** Right thoracoscopic upper lobe apical segmentectomy and lymph node biopsy of level 7 lymph nodes

**DESCRIPTION OF OPERATION:** The patient was brought to the operating room and all lines were placed and anesthesia administered. We then put the patient in the right-side-up position with all pressure points being padded. I placed a 5 mm trocar. I had good visualization of the lung. There was a lesion noted on the apical portion of the upper lobe that correlated with our CT scan.

To that end, we placed all our other ports appropriately. We followed the arterial and venous distributions of the RUL and performed an apical segmentectomy. I sent this to pathology for frozen section. We then proceeded with our lymph node biopsies, sampling the level 7 lymph nodes and also sent those for frozen. The pathologist called into the room stating the lung lesion, scar tissue, and lymph nodes were negative.

We irrigated and also sprayed Progel, as an air leak sealing adjunct, as well as FloSeal into the dissection bed posteriorly. A chest tube, which was placed under direct vision, was secured and placed through the 50 mm port site. The trocars were removed. All sponge and lap counts, instrument counts were correct. The wounds were closed in three layers in a standard fashion with Dermabond to the skin

79

## CHAPTER 13 CODE BUILDING EXERCISES #1 QUESTIONS

- 1.1. Is a segmentectomy the removal of some or all of the right upper lobe of the lung?
- 1.2. What root operation is assigned for the segmentectomy?
- 1.3. Research the level 7 lymph nodes and determine where the level is located. What body part value is assigned?
- 1.4. What code(s) would be assigned?

80



# 0BBC4ZX

<i>Section</i>	<b>0</b> Medical and Surgical		
<i>Body System</i>	<b>B</b> Respiratory System		
<i>Operation</i>	<b>B</b> Excision: Cutting out or off, without replacement, a portion of a body part		
<i>Body Part</i>	<i>Approach</i>	<i>Device</i>	<i>Qualifier</i>
1 Trachea	<b>0</b> Open	<b>Z</b> No Device	<b>X</b> Diagnostic
2 Carina	<b>3</b> Percutaneous		<b>Z</b> No Qualifier
3 Main Bronchus, Right	<b>4</b> Percutaneous Endoscopic		
4 Upper Lobe Bronchus, Right	<b>7</b> Via Natural or Artificial Opening		
5 Middle Lobe Bronchus, Right	<b>8</b> Via Natural or Artificial Opening Endoscopic		
6 Lower Lobe Bronchus, Right			
7 Main Bronchus, Left			
8 Upper Lobe Bronchus, Left			
9 Lingula Bronchus			
<b>B</b> Lower Lobe Bronchus, Left			
<b>C</b> Upper Lung Lobe, Right			
<b>D</b> Middle Lung Lobe, Right			
<b>F</b> Lower Lung Lobe, Right			
<b>G</b> Upper Lung Lobe, Left			
<b>H</b> Lung Lingula			
<b>J</b> Lower Lung Lobe, Left			
<b>K</b> Lung, Right			
<b>L</b> Lung, Left			
<b>M</b> Lungs, Bilateral			

81

# 07B74ZX

<i>Section</i>	<b>0</b> Medical and Surgical		
<i>Body System</i>	<b>7</b> Lymphatic and Hemic Systems		
<i>Operation</i>	<b>B</b> Excision: Cutting out or off, without replacement, a portion of a body part		
<i>Body Part</i>	<i>Approach</i>	<i>Device</i>	<i>Qualifier</i>
0 Lymphatic, Head	<b>0</b> Open	<b>Z</b> No Device	<b>X</b> Diagnostic
1 Lymphatic, Right Neck	<b>3</b> Percutaneous		<b>Z</b> No Qualifier
2 Lymphatic, Left Neck	<b>4</b> Percutaneous Endoscopic		
3 Lymphatic, Right Upper Extremity			
4 Lymphatic, Left Upper Extremity			
5 Lymphatic, Right Axillary			
6 Lymphatic, Left Axillary			
<b>7</b> Lymphatic, Thorax			
8 Lymphatic, Internal Mammary, Right			
9 Lymphatic, Internal Mammary, Left			

82

## CHAPTER 15 CODE BUILDING EXERCISE #2

Diagnosis : Torn anterior cruciate ligament of the right knee

Procedure : Reconstruction of the anterior cruciate ligament using patellar tendon graft

Indications : This is a 31-year-old male who sustained an ACL injury to his right knee during a surfing accident.

DESCRIPTION: The patient was placed under general anesthesia. The right knee was prepped and draped with the limb free. Tourniquet was applied to the thigh. Arthroscopic ports were placed and we found that the anterior cruciate ligament was torn away from the wall lateral femoral condyle It was quite lax as well. Using a shaver, the ligament was trimmed and all the soft tissue was removed from around and up into the notch.

The arthroscopy was terminated. The tourniquet was elevated. An incision was made from the mid patella to the tibial tubercle, with dissection carried down to the patellar tendon. The middle third of the patellar tendon, approximately 10 to 11 mm, was harvested with bone plugs from tibia and patella. The patellar and tibial portions were marked and a small saw was used to cut the bone plugs from each end. The patellar defect was smoothed and tendon defect was approximated and closed.

83

## CHAPTER 15 CODE BUILDING EXERCISE #2 (CONTINUED)

The guide for the tibial tunnel was then put in place just in front of the posterior tibial tendon. A 10-mm channel was reamed with a bulldog reamer. The bone posterior to this was reamed for the plug plus 5 mm. The passer was put through the guide, and the guide was removed. The tendon graft was passed up into the channel and seemed to fit well. A biodegradable plug screw was set in place in the femur. This was approximately 9 × 25 mm. The position and tightness were excellent, and drawer test at this point was trace, as was the Lachman. There was no impingement of the graft with extension, and no change in the length. The 9 × 25 mm tibial plug screw was put into place. This, again, was quite tight, and the Lachman test was just a trace positive. The joint moved well and was irrigated with arthroscopic fluid. The wound was irrigated and the subcutaneous tissues were closed with 2-0 Vicryl. The skin was closed with 4-0 nylon, as was each of the ports.

Dressing was applied as well as a Bledsoe brace.

84

## CHAPTER 15 CODE BUILDING EXERCISE #2 QUESTIONS

- 2.1. What is the intent of this procedure?
- 2.2. Is there an ICD-10-PCS table for replacement of ligaments?
- 2.3. What action should you take if the root operation table that describes the procedure is not found?
- 2.4. Are the bone plugs coded separately for this procedure? Why or why not?
- 2.5. Is the arthroscopy coded separately for this procedure? Why or why not?
- 2.6. Are there any other procedures to code?
- 2.7. What code(s) should be assigned?

85

## OMUN07Z

**Section**      **0** Medical and Surgical  
**Body System**    **M** Bursae and Ligaments  
**Operation**      **U** Supplement: Putting in or on biological or synthetic material that physically reinforces and/or augments the function of a portion of a body part

Body Part	Approach	Device	Qualifier
0 Head and Neck Bursa and Ligament	0 Open	7 Autologous Tissue Substitute	Z No Qualifier
1 Shoulder Bursa and Ligament, Right	4 Percutaneous Endoscopic	J Synthetic Substitute	
2 Shoulder Bursa and Ligament, Left		K Nonautologous Tissue Substitute	
3 Elbow Bursa and Ligament, Right			
N Knee Bursa and Ligament, Right			
P Knee Bursa and Ligament, Left			

86

# OLBQ0ZZ

<b>Section</b>	<b>0</b>	Medical and Surgical	
<b>Body System</b>	<b>L</b>	Tendons	
<b>Operation</b>	<b>B</b>	Excision: Cutting out or off, without replacement, a portion of a body part	
<b>Body Part</b>	<b>Approach</b>	<b>Device</b>	<b>Qualifier</b>
0 Head and Neck Tendon	0 Open	Z No Device	X Diagnostic
1 Shoulder Tendon, Right	3 Percutaneous		Z No Qualifier
2 Shoulder Tendon, Left	4 Percutaneous Endoscopic		
<b>Q Knee Tendon, Right</b> <b>R Knee Tendon, Left</b>			

87

# OSJC4ZZ

<b>Section</b>	<b>0</b>	Medical and Surgical	
<b>Body System</b>	<b>S</b>	Lower Joints	
<b>Operation</b>	<b>J</b>	Inspection: Visually and/or manually exploring a body part	
<b>Body Part</b>	<b>Approach</b>	<b>Device</b>	<b>Qualifier</b>
0 Lumbar Vertebral Joint	0 Open	Z No Device	Z No Qualifier
2 Lumbar Vertebral Disc	3 Percutaneous		
3 Lumbosacral Joint	4 Percutaneous Endoscopic		
4 Lumbosacral Disc	X External		
5 Sacrococcygeal Joint			
6 Coccygeal Joint			
7 Sacroiliac Joint, Right			
8 Sacroiliac Joint, Left			
9 Hip Joint, Right			
B Hip Joint, Left			
C Knee Joint, Right			
D Knee Joint, Left			

88

## CHAPTER 16 CODE BUILDING EXERCISES #2

**DIAGNOSIS:** Status post prior lumbar laminectomies and spinal fusions at multiple levels from T12 to L4 with severe stenosis L4-L5 and severe degenerative disks, L4-S1 with bilateral radiculopathy

**OPERATIONS PERFORMED:**

1. Decompressive lumbar laminectomy, facetectomy and foraminotomy of L4-5, L5-S1
2. Lumbar discectomy, L4-L5 and L5-S1, replaced with interbody device
4. Posterior spinal instrumentation, L4-S1
5. Posterolateral spinal fusion, L4-S1
6. Use of autograft and allograft

**COMPLICATIONS:** Dural tear, repaired

**INDICATIONS:** This 62-year-old female had a prior successful surgical fusion for degenerative scoliosis. The patient did well until recently when she began complaining of increasing back pain and buttock pain. She again failed conservative treatment for several months.

89

## CHAPTER 16 CODE BUILDING EXERCISES #2 CONTINUED

The patient was brought to the operating table. General anesthesia was administered and the patient was placed in a prone position on Jackson table. The back was prepped and draped in sterile fashion. A midline skin incision was made below the previous incision site to expose the spinous process of L4, L5, and S1, and the L4-L5 transverse processes bilaterally were visualized. The hardware was also cleared of the soft tissues in its distal part. At this point, the decompressive laminectomy was carried out by removing the lamina and performing facetectomy, and foraminotomies. Upon attempting to do this, we did encounter a dural tear, which was repaired satisfactorily with 4-0 nylon with Gelfoam overlay. The discectomy was carried out with curets and disk shavers at L4-L5 and L5-S1, with the dura and the S1 nerve roots retracted. Morselized bone graft obtained from the removal of the spinous processes, laminae, and facets was placed into Staxx expandable cage at L4-L5 and expanded to 9 mm. The same process was repeated at L5-S1 with the Staxx expanded to 8 mm. We proceeded with a posterior spinal instrumentation and we placed 7.0 screws. The posterolateral spinal fusion was done by abutting the fusion mass from the prior surgery, which was found to be satisfactory. Autograft bone graft was placed in and augmented with allograft, followed by placement of the screws and a rod through the rod connectors. Final x-rays were taken and found to be very satisfactory. Closure was then performed with 0 Vicryl in interrupted fashion. 2-0 Vicryl was used for subcutaneous tissue. Skin was closed with 3-0 Monocryl subcuticularly.

90

## CHAPTER 16 CODE BUILDING EXERCISES #2 QUESTIONS

- 2.1. What was the objective of this procedure?
- 2.2. The surgeon performed the procedure on the anterior column first and then the posterior column. What qualifiers will be assigned for the codes for the procedures?
- 2.3. The procedures were performed on both lumbar joints and lumbosacral joints. Which body part values will be assigned for the codes for the procedures?
- 2.4. Which guideline helps determine the device value assigned for these procedures?
- 2.5. Are the decompressive laminotomies, facetectomies, and foraminotomies coded separately?
- 2.6. Which body part does the body part key advise you to use for the dural repair?
- 2.7. What code(s) should be assigned?

91

## OSG00AJ, OSG30AJ, OSG0071, OSG3071

<i>Section</i>	<b>0</b> Medical and Surgical		
<i>Body System</i>	<b>S</b> Lower Joints		
<i>Operation</i>	<b>G</b> Fusion: Joining together portions of an articular body part rendering the articular body part immobile		
<i>Body Part</i>	<i>Approach</i>	<i>Device</i>	<i>Qualifier</i>
<b>0 Lumbar Vertebral Joint</b>	<b>0 Open</b>	<b>7 Autologous Tissue Substitute</b>	<b>0 Anterior Approach, Anterior Column</b>
<b>1 Lumbar Vertebral Joints, 2 or more</b>	<b>3 Percutaneous</b>	<b>A Interbody Fusion Device</b>	<b>1 Posterior Approach, Posterior Column</b>
<b>3 Lumbosacral Joint</b>	<b>4 Percutaneous Endoscopic</b>	<b>J Synthetic Substitute</b>	<b>J Posterior Approach, Anterior Column</b>
		<b>K Nonautologous Tissue Substitute</b>	
		<b>Z No Device</b>	

92

00QTOZZ			
<i>Section</i>	0	Medical and Surgical	
<i>Body System</i>	0	Central Nervous System	
<i>Operation</i>	Q	Repair: Restoring, to the extent possible, a body part to its normal anatomic structure and function	
<i>Body Part</i>	<i>Approach</i>	<i>Device</i>	<i>Qualifier</i>
0 Brain	0 Open	Z No Device	Z No Qualifier
1 Cerebral Meninges	3 Percutaneous		
2 Dura Mater	4 Percutaneous Endoscopic		
6 Cerebral Ventricle			
7 Cerebral Hemisphere			
8 Basal Ganglia			
9 Thalamus			
A Hypothalamus			
B Pons			
C Cerebellum			
D Medulla Oblongata			
F Olfactory Nerve			
G Optic Nerve			
H Oculomotor Nerve			
J Trochlear Nerve			
K Trigeminal Nerve			
L Abducens Nerve			
M Facial Nerve			
N Acoustic Nerve			
P Glossopharyngeal Nerve			
Q Vagus Nerve			
R Accessory Nerve			
S Hypoglossal Nerve			
T Spinal Meninges			
W Cervical Spinal Cord			
X Thoracic Spinal Cord			
Y Lumbar Spinal Cord			

THANK YOU!!

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95

## QUESTIONS

96