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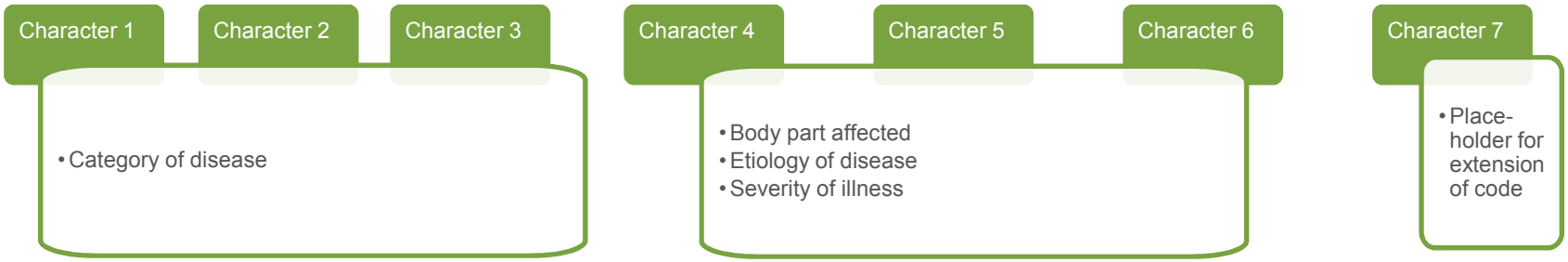
Plastic Surgery
ICD-10 Analysis

Plastics– The Hard Way with ICD-10

Z42 Encounter for plastic and reconstructive surgery following medical procedure or healed injury Z41.1 Encounter for cosmetic surgery V45.83 Breast implant removal status 798.86 Personal history of breast implant removal V43.82 Breast replacement T85.40 Capsular contracture of breast implant	T85.44 Capsular contracture of breast implant T85.42XS Displacement of breast prosthesis and implant, sequela T85.43XS Leakage of breast prosthesis and implant, sequela T85.44XS Capsular contracture of breast implant, sequela T85.42 Displacement of breast prosthesis and implant T85.43 Leakage of breast prosthesis and implant
T85.41XA Breakdown (mechanical) of breast prosthesis and implant, initial encounter T85.41XD Breakdown (mechanical) of breast prosthesis and implant, subsequent encounter T85.41XS Breakdown (mechanical) of breast prosthesis and implant, sequela Z45.81 Encounter for adjustment or removal of breast implant T85.42XA Displacement of breast prosthesis and implant, initial encounter T85.42XD Displacement of breast prosthesis and implant, subsequent encounter	T84.43XA Leakage of breast prosthesis and implant, initial encounter T85.43XD Leakage of breast prosthesis and implant, subsequent encounter T85.44XA Capsular contracture of breast implant, initial encounter T85.44XD Capsular contracture of breast implant, subsequent encounter T85.49XS Other mechanical complication of breast prosthesis and implant, sequela T85.41 Breakdown (mechanical) of breast prosthesis and implant
T85.49 Other mechanical complication of breast prosthesis and implant T85.49XA Other mechanical complication of breast prosthesis and implant, initial encounter T85.49XD Other mechanical complication of breast prosthesis and implant, subsequent encounter H02.33 Blepharochalasis right eye H02.36 Blepharochalasis left eye H02.31 Blepharochalasis right upper eyelid	H02.34 Blepharochalasis left upper eyelid H02.35 Blepharochalasis left lower eyelid H02.523 Blepharophimosis right eye H02.526 Blepharophimosis left eye H02.521 Blepharophimosis right upper eyelid H02.522 Blepharophimosis right lower eyelid H02.32 Blepharochalasis right lower eyelid
H02.524 Blepharophimosis left upper eyelid H02.525 Blepharophimosis left lower eyelid H02.3 Blepharochalasis T86.82 Complications of skin graft (allograft) (autograft) T86.820 Skin graft (allograft) rejection T86.822 Skin graft (allograft) (autograft) infection T86.821 Skin graft (allograft) (autograft) failure	
T85.613 Breakdown (mechanical) of artificial skin graft and decellularized allodermis T85.623 Displacement of artificial skin graft and decellularized allodermis T85.693 Other mechanical complication of artificial skin graft and decellularized allodermis T85.623S Displacement of artificial skin graft and decellularized allodermis, sequela T85.613A Breakdown (mechanical) of artificial skin graft and decellularized allodermis, initial encounter T85.613D Breakdown (mechanical) of artificial skin graft and decellularized allodermis, subsequent	

ICD 10 – CM

- Diagnosis classification system developed by the Centers for Disease Control and Prevention for use in all U.S. health care treatment settings
- ICD 10 CM codes can have 3, 4, 5, 6 or 7 characters (alphanumeric)



H02.31	H02 - disorders of eyelid	3 – Blepharochalasis	4 – Right upper eyelid

A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures

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ICD-10 Made Simple For Those That Have Coders- DOCUMENT!

Acuity- acute, chronic, intermittent

Severity- mild, moderate, severe

Etiology- trauma, diabetes, renal failure, exercise or infection induced

Location- where is it- be specific about which joint, chest, femur, posterior thorax

Laterality- which side is it? Left, right, both?

Detail: Present on admission status, associated symptoms (hypoxia, loss of consciousness), additional medical diagnoses, initial versus subsequent encounter

If you like mnemonics

Any: Acuity
Small: Severity
Error: Etiology
Loses: Location
Large: Laterality
Dollars: Detail- which encounter, sequelae, associated symptoms, present on admission

Case Study – Breast Hypertrophy/Reduction Mammoplasty

Alice is a 39 year old, 140lb, female, with breast hypertrophy who was admitted for a bilateral central mound breast reduction for therapeutic reasons. She has headache, neck, shoulder, and back pain for the last three years, that is unrelieved by 6-month trial of analgesic intervention, physical therapy, posture changes and supportive devices. Bra strap ridges and cutting observed on preop examination. Patient photographed for presurgical history.

950 gm of tissue was removed from the right breast, and 870 gm of tissue from the left breast. Two 7-French drains placed.

Example- Breast Hypertrophy/Reduction Mammaplasty

ACUITY	chronic
SEVERITY	moderate to severe
ETIOLOGY	N/A
LOCATION	breast
LATERALITY	bilateral
DETAILS	Condition causing headache, neck, shoulder, back pain, and bra strap indentation
ALL PUT TOGETHER	1. Chronic moderate to severe bilateral breast hypertrophy causing headache, neck, shoulder, back pain and bra strap indentation

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Case Study – Localized Adiposity / Liposuction

The patient is a 37 year old female, who complains of her fat deposits in the neck and submental area. She has prominent smile lines and some loss of fullness of the upper lip. Diagnosis is submental fat deposits, perioral rhytids.

For the procedure (submental liposuction and 1 ml Juvederm perioral), the patient is marked in the upright position, 1 g Ancef was given IV. The face was prepped with Betadine and draped in standard fashion after induction of general anesthetic with LMA. After time-out, 1% Xylocaine with 1:100,000 epinephrine 10 ml was infiltrated in the submental area. A 50 ml of tumescent fluid was infiltrated in the submental neck area comprised of tumescent solution made from 1 L of normal saline, 50 ml of 1% plain Xylocaine and 1 amp of epinephrine. After waiting for several minutes for hemostatic effect, the submental upper neck and jaw areas were suctioned with a 2 mm cannula for approximately 25 ml of aspirate. The wound was closed with 5-0 nylon and Steri-Strips. A compression dressing of ABD and conform and JawBra was applied. 1ml Juvederm Ulta XC with infiltrated nasolabial creases, marionette lines, oral commissures, and upper lip vermilion border. Estimated blood loss negligible. Final sponge, needle, and instrument counts x2 were correct.

Example- Localized Adiposity / Liposuction Mammaplasty

ACUITY	chronic
SEVERITY	mild
ETIOLOGY	N/A
LOCATION	Fat deposits to neck, submental area and perioral rhytids
LATERALITY	Perioral, bilateral, multiple locations
DETAILS	Specific rhytids include, nasolabial creases, marionette lines, oral commissures, and upper lip vermilion border
ALL PUT TOGETHER	1. Chronic, mild fat deposits to neck, submental area with perioral rhytids to nasolabial creases, marionette lines, oral commissures, and upper lip vermilion border

Case Study – Blepharochalasis

The patient is a 54 year old female, who complains of excess skin of upper lids and difficulty seeing peripherally. She has undergone a peripheral vison test and failed. She now has decided to have the excess skin removed. The patient is healthy otherwise. No fever, chills, nausea, or vomiting. The patient is a candidate for bilateral upper lid blepharochalasis.

The patient was anesthetized with general anesthesia. The face was prepped and draped in aseptic manner. Then a line that was previously marked, was injected with 1% lidocaine with epinephrine. After marking, the lines were excised on the right side, removing the skin and excess muscle on the upper lid. The septum was then opened and the excess fat central medial compartments were removed. After good hemostasis, the lateral incision was closed with a running 6-0 nylon sutures followed by subcuticular closure of 5-0 nylon on the medial and central. Attention was turned to the left eye where the same procedure was performed. At completion, ointment was placed in the eyes, compressive dressings, and a 2 inch cling was placed around the eye. The patient tolerated the procedure well.

Example- Blepharochalasis Mammoplasty

ACUITY	chronic
SEVERITY	moderate to severe
ETIOLOGY	N/A
LOCATION	upper eyelid
LATERALITY	bilateral
DETAILS	Affecting peripheral vision
ALL PUT TOGETHER	1. Chronic, moderate to severe blepharochalasis to bilateral upper eyelids affecting peripheral vision.

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Case Study – Scar Revision / Z Plasty

The patient is a 40 year old male, who injured. In November of 2012, the patient had surgical procedures for facial fractures. The wounds healed well, but he had some scar contractures which have not relented since the surgery and has been admitted today for revision of the large wounds to the right orbit area. Excision of the scar tissue of the right orbit occurred. 3 cm x 3 mm with a Z-plasty of the right orbit. Excision scar of the right cheek 3 cm x 2 to 3 mm with complex closure 3 cm.

Example- Scar Revision / Z Plasty:

ACUITY	N/A
SEVERITY	moderate
ETIOLOGY	Contractures due to scarring from facial injury and subsequent surgical repair
LOCATION	Orbital area and cheek
LATERALITY	right
ALL PUT TOGETHER	1. Moderate scarring and contractures to right orbital area and cheek

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Case Study – Operative Wound Repair

The patient is a 40 year old male, who injured. In November of 2012, the patient had surgical procedures for facial fractures. The wounds healed well, but he had some scar contractures which have not relented since the surgery and has been admitted today for revision of the large wounds to the right orbit area. Excision of the scar tissue of the right orbit occurred. 3 cm x 3 mm with a Z-plasty of the right orbit. Excision scar of the right cheek 3 cm x 2 to 3 mm with complex closure 3 cm.

Example- Operative Wound Repair

ACUITY	N/A
SEVERITY	moderate
ETIOLOGY	Contractures due to scarring from facial injury and subsequent surgical repair
LOCATION	Orbital area and cheek
LATERALITY	right
DETAILS	Affecting peripheral vision
ALL PUT TOGETHER	1. Moderate scarring and contractures to right orbital area and cheek

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Case Study – Septo-Rhinoplasty

The patient is a 40 year old male, who injured. In November of 2012, the patient had surgical procedures for facial fractures. The wounds healed well, but he had some scar contractures which have not relented since the surgery and has been admitted today for revision of the large wounds to the right orbit area. Excision of the scar tissue of the right orbit occurred. 3 cm x 3 mm with a Z-plasty of the right orbit. Excision scar of the right cheek 3 cm x 2 to 3 mm with complex closure 3 cm.

Example- Septo-Rhinoplasty

ACUITY	N/A
SEVERITY	moderate
ETIOLOGY	Contractures due to scarring from facial injury and subsequent surgical repair
LOCATION	Orbital area and cheek
LATERALITY	right
DETAILS	Affecting peripheral vision
ALL PUT TOGETHER	1. Moderate scarring and contractures to right orbital area and cheek

Documentation Analysis

ICD-10 has a specific root operation to represent all cosmetic procedures. Alteration is coded for all procedures performed solely to improve appearance. All methods, approaches, and devices used for the objective of improving appearance are coded here.

Because some surgical procedures can be performed for either medical or cosmetic purposes, coding for Alteration requires diagnostic confirmation that the surgery is in fact performed to improve appearance. This should be clearly documented in the medical records.

Language of some surgical codes made specific –
Z41.1 – Encounter for cosmetic surgery
Z41.9 – Encounter for procedure for purposes other than remedying health state, unspecified
Z42.1 – Encounter for breast reconstruction following mastectomy
Z42.8 – Encounter for other plastic and reconstructive surgery following medical procedure or healed injury

Depending on documentation a cosmetic or therapeutic procedure will get coded. The procedures coded basis cosmetic surgery or medically necessary, might have an impact on the DRG.

Documentation Analysis

There are visit specific characters in diagnosis coding to indicate initial or subsequent visit, which need to match with the procedure codes (especially in burns, scar revision etc.)
Procedures should clearly specified the body part and laterality. Procedures done on muscle of thorax, trunk, abdomen need to specify laterality as left thorax, right thorax, left abdomen etc.
Extent of removal of breast should be specified along with associated procedures as lymphadenectomy, biopsy, insertion of tissue expander etc.
Debridement should specify type of tissue excised, laterality of body part and type of debridement done as excisional or non-excisional.
Use of grafts should specify type of graft material used as autologous, nonautologous, synthetic tissue etc.
Sex change operations are the only procedures coded under Creation procedures. These are defined as: Making a new genital structure that does not take over the function of a body part. Examples include: Creation of vagina in a male or Creation of penis in a female.

Procedures Involving Devices

Root operations	Value	Definition	Examples
Insertion	H	Putting in a non-biological appliance that monitors, assists, performs, or prevents a physiological function but does not physically take the place of a body part	Insertion of central venous catheter, insertion of dual chamber pacemaker, percutaneous placement of brachytherapy seeds into prostate
Replacement	R	Putting in or on biological or synthetic material that physically takes the place and/or function of all or a portion of a bod part	Knee joint replacement, bone graft, free skin graft, free TRAM flap, phacoemulsification with intraocular lens implant
Supplement	U	Putting in or on biological or synthetic material that physically reinforces and or augments the function of a portion of a body part	Herniorrhaphy using mesh, mitral valve ring annuloplasty etc.
Removal	P	Taking out or off a device from a body part. Removal procedures are coded only for taking out the device placed in a previous replacement procedure.	Removal of drainage tube, tracheostomy tube, feeding tube; K-wire removal, neurostimulator removal
Change	2	Taking out or off a device from a body part and putting back a similar/identical device without cutting or puncturing the skin and mucus membrane. All change procedures would be coded using the approach “External”.	Urinary catheter change, gastrostomy tube change
Revision	W	Correcting, to the extent possible, a portion of a malfunctioning device or the position of a displaced device	Adjustment of position of pacemaker lead, recementing of hip prosthesis

Important Documentation for Procedures

Root Operation: Specifies the primary objective of the procedure
Ex: drainage, excision, resection

Body Part: The specific organ or site on which the procedure is performed

Approach: The technique/method used to access the operative site
Ex: Open, percutaneous, external, endoscopic

Devices: Any device or material that remains at the site upon completion of the procedure

Qualifier: Unique character for specific procedures
Ex: diagnostic, therapeutic

Common Procedures for Wound Management

Procedures	Root Operation	Definition + Examples	Description
Suturing	Repair	Restoring, to the extent possible, a body part to its normal anatomic structure and function e.g. Suture of laceration	Repair is almost Not elsewhere classified kind of root operation. Repair root operation
Hemostasis post procedure	Control	Stopping, or attempting to stop, post-procedural bleeding e.g. Control of post-tonsillectomy or post prostatectomy hemorrhage.	Other examples include ligation of arterial bleeders, cautery with blood clot evacuation, and drainage at previous operative site to stop bleeding. If an attempt to stop postprocedural 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.
Reattachment	Reattachment	Putting back in or on all or a portion of a separated body part to its normal location or other suitable location E.g. reattachment of the finger, hand, avulsed kidney etc.	Reattachment procedures can be performed on a variety of body parts, not limited to those that are musculoskeletal. Specific qualifiers are provided for the body parts upper tooth and lower tooth to indicate whether a single tooth, multiple teeth, or all teeth were reattached
Flap surgeries	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 e.g. Skin pedicle flap transfer, tendon transfer etc.	The body part transferred remains connected to its vascular and nervous supply Unlike ICD-9-CM, the ICD-10-PCS procedure code specifies the deepest layer of tissue involved and site of the advancement flap – subcutaneous tissue, and fascia.
Pressure	Compression	Putting pressure on a body region e.g. Placement of a pressure dressing on abdominal wall	
Dressing	Dressing	Putting material on a body part for protection e.g. Application of sterile dressing to the head wound	

Breast Procedures

Procedure	Body system	Operation	Body Part	Approach/ Duration	Device	Qualifier
Augmentation Mammoplasty	H - Skin & Breast	0 - Alteration for cosmetic	T - Breast, Right U - Breast, Left V -Breast, Bilateral	0 - Open 3 - Percutaneous X - External	7 - Autologous Tissue Substitute J - Synthetic Substitute K - Nonautologous Tissue Substitute Z – No Device	Z - No qualifier
Breast Tissue expander removal/insertion	H - Skin & Breast	H - Insertion P – Removal Q - Repair	T - Breast, Right U - Breast, Left V - Breast, Bilateral W - Nipple, Right X - Nipple, Left	0 - Open 3 - Percutaneous 7 – Natural or artificial opening 8 - Natural or artificial opening, endoscopic X- External	N – Tissue expander	Z – No Qualifier
TRAM, free	H - Skin & Breast	R – Replacement	T - Breast, Right U - Breast, Left V -Breast, Bilateral	0 – Open	7 - Autologous Tissue Substitute	5 – Latismus dorsi Myocutaneous flap 6 - Transverse Rectus Abdominis Myocutaneous Flap etc.
TRAM, pedicled	K – Muscle	X – Transfer	K - Abdomen Muscle Right L - Abdomen Muscle, Left	0 - Open 4 – Percutaneous Endoscopic	Z – No Device	6 - Transverse Rectus Abdominis Myocutaneous Flap Etc.
Breast Implant Removal/revision	H - Skin & Breast	W – Revision P – Removal	T - Breast, Right U - Breast, Left	0 - Open 3 - Percutaneous	7 - Autologous Tissue Substitute J - Synthetic Substitute K - Nonautologous Tissue Substitute	Z – No Qualifier

Z41.1 is the encounter code specific to cosmetic surgery; Z42.1 is encounter for breast reconstruction following mastectomy and Z 42.8 is for other plastic and reconstructive surgery following medical procedure or healed injury

Associated Breast Procedures

Procedure	Body system	Operation	Body Part	Approach/ Duration	Device	Qualifier
Mammectomy	H - Skin & Breast	B – Excision (partial) T – Resection (complete)	T - Breast, Right U - Breast, Left V -Breast, Bilateral Y – Supernumerary Breast	0 - Open 3 - Percutaneous 7 - Via Natural or Artificial Opening 8 - Via Natural or Artificial Opening Endoscopic X - External	Z – No Device	Z – No Qualifier
Mastopexy	H - Skin & Breast	S – Reposition Q - Repair	T - Breast, Right U - Breast, Left V -Breast, Bilateral	0 – Open 3 - Percutaneous X - External	Z – No Device	Z – No Qualifier
Lymphadenectomy	7 - Lymphatic and Hemic Systems	B - Excision T - Resection	5 - Lymphatic, Right Axillary 6 - Lymphatic, Left Axillary 8 - Lymphatic, Internal Mammary, Right 9 - Lymphatic, Internal Mammary, Left	0 - Open	Z – No Device	X – Diagnostic Z – No Qualifier
Removal of thorax muscle (pectoralis major)	K- Muscle	B - Excision T - Resection	H – Thorax muscle Right J – Thorax muscle Left	0 - Open	Z – No Device	X – Diagnostic Z – No Qualifier
Breast biopsy	H - Skin & Breast	B – Excision	T - Breast, Right U - Breast, Left V - Breast, Bilateral W - Nipple, Right X - Nipple, Left Y - Supernumerary Breast	0 - Open 3 - Percutaneous	Z – No Device	X – Diagnostic Z – No Qualifier

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Cleft Palate Procedures

Procedure	Body system	Operation	Body Part	Approach/ Duration	Device	Qualifier
Palatoplasty with bone graft	C – Mouth & Throat	U – Supplement	2 – Hard Palate	0 – Open	7 - Autologous Tissue Substitute K - Nonautologous Tissue Substitute	Z – No Qualifier
Palatoplasty with implant	C – Mouth & Throat	U – Supplement	2 – Hard Palate 3 – Soft Palate	0 - Open 3 - Percutaneous X - External	J - Synthetic Substitute	Z – No Qualifier
Palatorrhaphy	C – Mouth & Throat	U – Supplement	2 – Hard Palate 3 – Soft Palate	0 - Open 3 - Percutaneous X - External	Z - No device	Z - No qualifier
Pharyngeal muscle flap	K- Muscle	X – Transfer	4 - Tongue, Palate, Pharynx Muscle	0 - Open 4 - Percutaneous Endoscopic	Z - No device	0 - Skin 1 - Subcutaneous Tissue 2 - Skin and Subcutaneous Tissue Z - No Qualifier
Soft palate lengthening	C – Mouth & Throat	X – Transfer	3 - Soft Palate 4 - Buccal Mucosa	0 - Open X – External	Z - No device	Z - No qualifier
Repair	C – Mouth & Throat	Q – Repair	2 – Hard Palate 3 – Soft Palate	0 - Open 3 - Percutaneous X - External	Z - No device	Z - No qualifier

Cleft Lip Procedures

Procedure	Body system	Operation	Body Part	Approach/ Duration	Device	Qualifier
Supplement Procedure	C – Mouth & Throat	U – Supplement	0 – Upper Lip	0 - Open X - External	7 - Autologous Tissue Substitute J - Synthetic Substitute K - Nonautologous Tissue Substitute	Z - No Qualifier
Transfer Procedure	C – Mouth & Throat	X – Transfer	0 – Upper Lip	0 - Open X - External	Z - No device	Z - No qualifier
Repair	C – Mouth & Throat	Q – Repair (suturing)	0 – Upper Lip	0 - Open X - External	Z - No device	Z - No qualifier

Cleft Lip & Cleft Palate Repair

Diagnosis	ICD 10 Procedure Codes
Cleft Lip	0CQ00ZZ Repair Upper Lip, Open Approach
	0CQ03ZZ Repair Upper Lip, Percutaneous Approach
	0CQ0XZZ Repair Upper Lip, External Approach

Diagnosis	ICD 10 Procedure Codes
Cleft Palate	0CQ20ZZ Repair Hard Palate, Open Approach
	0CQ23ZZ Repair Hard Palate, Percutaneous Approach
	0CQ2XZZ Repair Hard Palate, External Approach
	0CQ30ZZ Repair Soft Palate, Open Approach
	0CQ33ZZ Repair Soft Palate, Percutaneous Approach
	0CQ3XZZ Repair Soft Palate, External Approach

Plastic Surgery Procedures

Procedure	Body system	Operation	Body Part	Approach/ Duration	Device	Qualifier
Augmentation Mammoplasty	Breast	Alteration for cosmetic	Breast	Open, percutaneous	Autologous, nonautologous, synthetic substitute	No qualifier
Septorhinoplasty	Nose	Use of graft, tissue transfer, suture	Septum, turbinate	Open, endoscopic	Autologous, nonautologous, synthetic substitute	No qualifier
Scar revision	Skin	Excision, graft, z-plasty etc	Skin	External	For graft use Autologous, nonautologous, synthetic substitute	No qualifier
Blepharochalasis	Eye	Alteration for cosmetic Reposition for therapeutic	Eyelid with laterality	Open, percutaneous	For graft use Autologous, nonautologous, synthetic substitute	No qualifier
Liposuction	Subcutaneous tissue and fascia	Alteration for cosmetic Extraction for therapeutic	Body part as anterior neck, left thigh etc.	Open, percutaneous	No device	No qualifier
Skin grafting	Skin	Replacement	Body part	External	Autologous, nonautologous	Full thickness or partial thickness

ICD-10 Made Simple – DOCUMENT!

Acuity- acute, chronic, intermittent

Severity- mild, moderate, severe

Etiology- trauma, diabetes, renal failure, exercise or infection induced

Location- where is it- be specific about which joint, chest, femur, posterior thorax

Laterality- which side is it? Left, right, both?

Detail: Present on admission status, associated symptoms (hypoxia, loss of consciousness), additional medical diagnoses, initial versus subsequent encounter

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For any questions: