



ICD-10 for General Surgery

UConn Health



Just himagine what we can accomplish together.

Introductions

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Agenda

- After attending this session, participants will be able to:
 - Describe the challenges associated with ICD-10 implementation
 - Identify documentation standards necessary for complete and accurate code assignment
 - Identify the importance of physician documentation and coding
 - Identify documentation changes between ICD-9 and ICD-10

ICD-10 for Physicians

ICD-10 does *not require a change in how physicians practice medicine or treat patients.*

Rather, it demands more accurate documentation and gives physicians **more diagnostic choices to capture new data to ensure they are paid for the complex work they perform.**

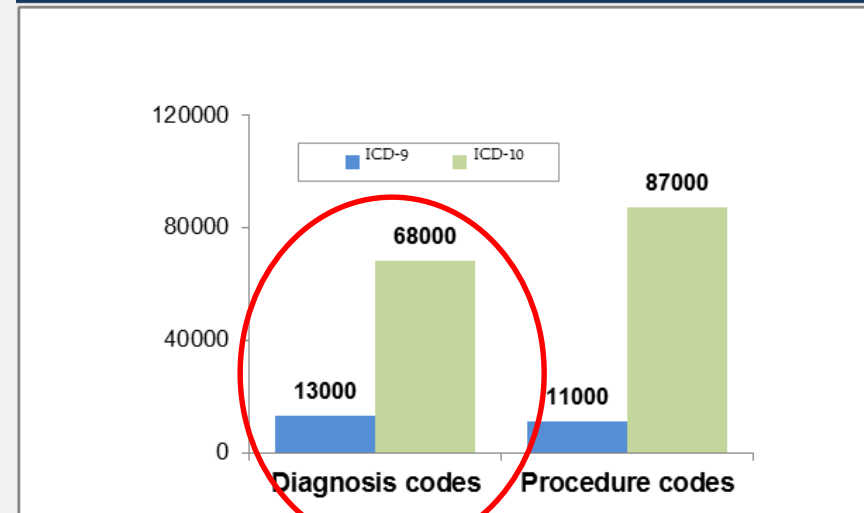
Changes to Diagnosis Codes

The most significant difference between ICD 9 and ICD 10 is the size and composition of the new codes

- ICD 9 is five digits where ICD 10 is 7 alphanumeric characters
- Re-structured classification
- Specificity and detail have been expanded

ICD 10 better describes acuity, complexity and laterality of the patients under your care

Number of ICD 9 and ICD 10 codes for diagnoses and procedures



(Source: ICD-10-CM and ICD-10-PCS Update, Thirteenth National HIPAA Summit, 9/26/2006; Rand Study, March 2004)

ICD-10 Documentation for Diagnoses

Requirements for Detailed Documentation for Diagnoses

Acuity	Stages (I, II, III, IV)
Specific site	Injury details
Laterality	Site, laterality and depth of tissue involvement
Specific type of condition	Drug reactions/interactions/adverse reactions
Episode of care	Site and artery specificity
Link must be established between manifestations and underlying diseases	
Complications of care	
Degree of severity	

Considerations

- ICD-10 requires collaboration between all members of the clinical and non-clinical healthcare team:
 - Education of CDI/coder staff
 - Template revisions
 - Query revisions



Challenges

- ICD-10 is a classification system, not a clinical language system:
 - Physician documentation - primarily directed for communication between clinicians
 - Bridging gaps between coder's classification language and physician clinical documentation

Challenges

- Documentation by the physician of specific components of a particular classification (diagnosis code) is required:
 - Test results, labs, x-rays, EKGs, echo reports, path reports, **studies performed for diagnosis are not sufficient documentation for classifying (coding) a disease/injury**
 - Coders are only allowed to use physician documentation to classify a disease/injury or procedure

Future of Documentation

- This transition is NOT just for reimbursement for hospitals
- The data collection taking place over the next 2 years – as well as 2 years following implementation – will feed initiatives impacting:
 - Measurement of patient care outcomes
 - Quality of care initiatives
 - Healthcare policy development
 - Research related to profiling providers of healthcare
 - Pay for performance initiatives
 - Justifying medical necessity



Consequences of Inadequate Documentation

Inappropriate
Payment for
Submitted
Claims

Claim Denials

Increased Risk
of Government
Audit,
Repayment
and Fines

ICD-10 Documentation Assessment Results



Methodology

- One hundred (100) records were reviewed during this assessment. The medical records were selected randomly by UConn from the top diagnosis and procedure list determined by the Kforce Healthcare to be high risk areas. The objectives of this analysis were to:
 - Assess the current level of specificity & quality of physician clinical documentation practices
 - Determine how frequently unspecified &/or non-descriptive codes were used in the current ICD-9 system
 - Determine if the documentation required to appropriately assign diagnosis & procedure codes in ICD-10-CM/PCS is present in the medical records reviewed
 - Provide recommendations for documentation improvement



30 Dx/Px Categories Reviewed

Diagnoses	Procedures
Atrial Fibrillation (427.31)	Venous cath (38.93)
Pain in Limb (729.5)	Angiocardiology of left heart structures (88.53)
Diabetes Mellitus (250.00)	Percutaneous transluminal coronary angioplasty (PTCA) (00.66)
Depression (311)	Repair of current obstetric laceration (75.69)
CHF (428.0)	Excision of intervertebral disc (80.51)
Anxiety (300.00)	Central venous catheter placement with guidance (38.97)
Tobacco use disorder (305.1)	Lumbar/lumbosacral fusion of the posterior column, posterior technique (81.07)
UTI (599.0)	Continuous invasive mechanical ventilation for less than 96 consecutive hours (96.71)
Anemia (285.9)	EGD w/bx (45.16)
Asthma (493.90)	Colonoscopy (45.23)
CAD (414.00)	Colonoscopy w/polypectomy (45.42)
CKD (585.9)	Closure of skin and subcutaneous tissue of other sites (86.59)
	Injection of therapeutic substance into joint/ligament (81.92)
	Colonoscopy w/bx (45.25)
	Injection or infusion of therapeutic or prophylactic substance (99.29)
	Diagnostic procedure on breast (85.19)
	Repair of knee (81.47)
	Endoscopy of small intestine (45.13)

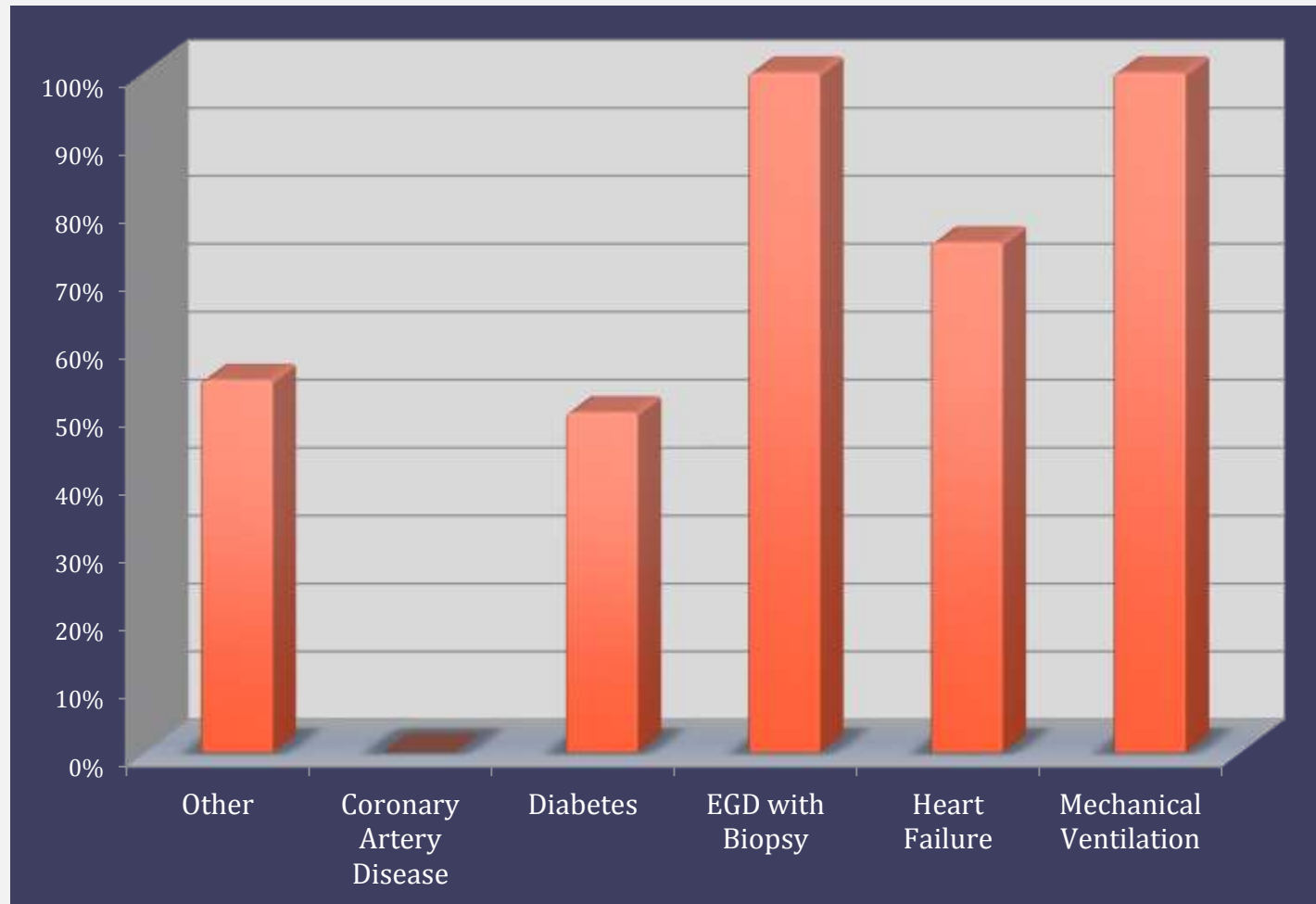
Opportunities Identified

Diagnosis or Procedure Category	Number of Diagnoses/Procedures Reviewed	Number of Documentation Opportunities Identified
Atrial Fibrillation (427.31) (Other*)	5	3
Pain in Limb (729.5) (Other*)	3	3
Diabetes Mellitus (250.00)	2	1
Depression (311)(Other*)	4	4
CHF (428.0)	4	1
Anxiety (300.00)(Other*)	2	2
Tobacco use disorder (305.1) (Other*)	4	1
UTI (599.0) (Other*)	4	1
Anemia (285.9) (Other*)	2	2
Asthma (493.90) (Other*)	4	4
CKD (585.9) (Other*)	3	3
CAD (414.00)	3	3
Venous cath (38.93) (Other*)	4	4
Angiocardiology of left heart structures (88.53) (Other*)	4	4
Percutaneous transluminal coronary angioplasty (PTCA) (00.66) (Other*)	5	4
Repair of current obstetric laceration (75.69) (Other*)	2	2
Excision of intervertebral disc (80.51) (Other*)	3	1

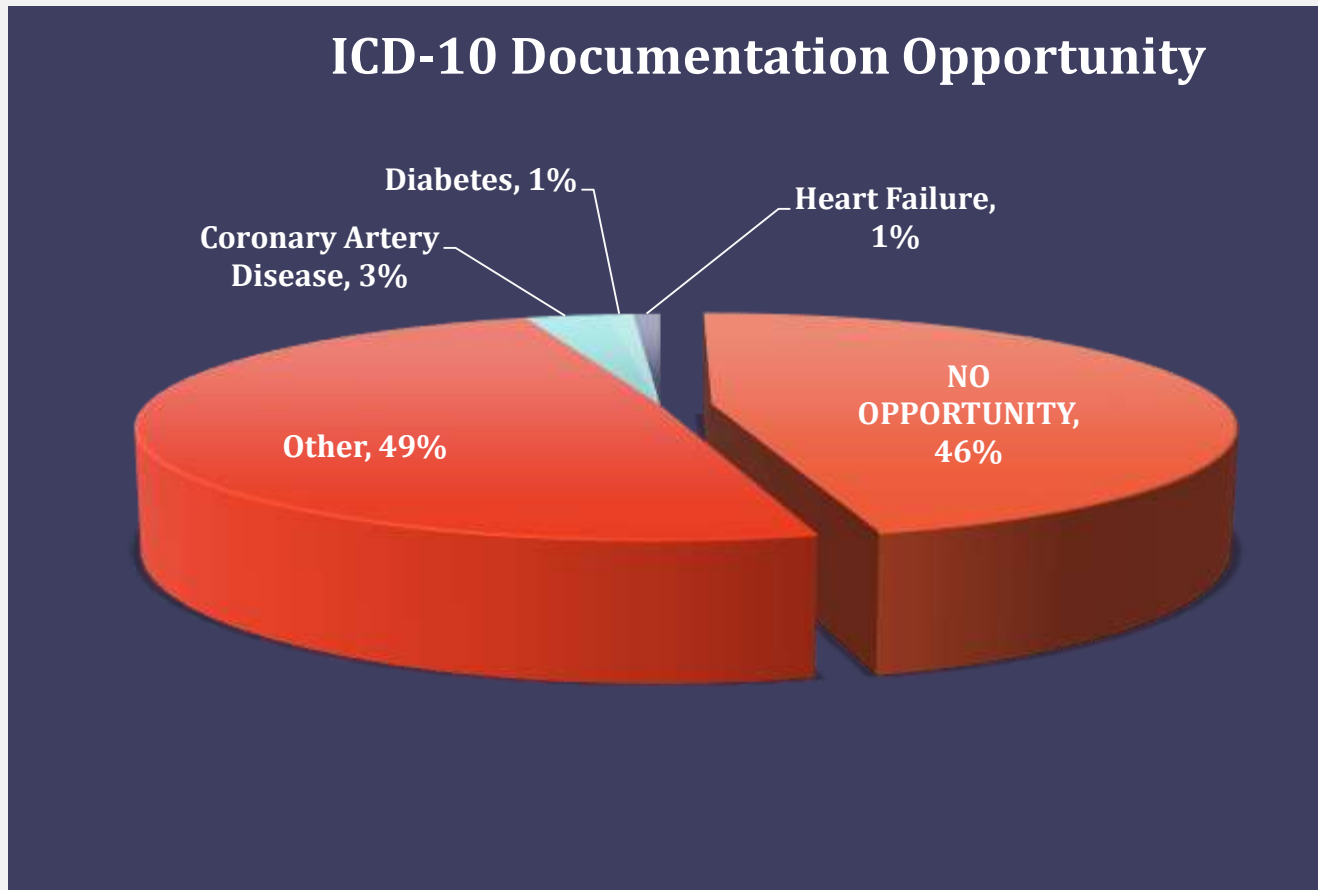
Opportunities Identified

Diagnosis or Procedure Category	Number of Diagnoses/Procedures Reviewed	Number of Documentation Opportunities Identified
Excision of intervertebral disc (80.51) (Other*)	3	1
Central venous catheter placement with guidance (38.97) (Other*)	3	3
Lumbar/lumbosacral fusion of the posterior column, posterior technique (81.07) (Other*)	3	0
Continuous invasive mechanical ventilation for less than 96 consecutive hours (96.71)	3	0
EGD w/bx (45.16)	4	0
Colonoscopy (45.23) (Other*)	4	0
Colonoscopy w/polypectomy (45.42)(Other*)	5	1
Closure of skin and subcutaneous tissue of other sites (86.59) (Other*)	5	2
Injection of therapeutic substance into joint/ligament (81.92) (Other*)	2	0
Colonoscopy w/bx (45.25) (Other*)	4	3
Injection or infusion of therapeutic or prophylactic substance (99.29) (Other*)	2	2
Diagnostic procedure on breast (85.19) (Other*)	2	0
Repair of knee (81.47) (Other*)	2	0
Endoscopy of small intestine (45.13) (Other*)	3	0
Total	100	54

Overall Record Accuracy



Opportunities Identified



**Note: Multiple documentation opportunities may exist on single medical record account.*

ICD-10-CM Opportunities

Atrial Fibrillation

- Type specificity
 - Chronic
 - Paroxysmal
 - Persistent
- Typical vs. atypical

Pain in Limb

- Acuity
- Laterality
- Site specificity

Diabetes Mellitus

- Linkage of manifestation to disease
- Type
- Control status
 - Hyper/hypoglycemia
- See table on next slide for further detail on this diagnosis.

ICD-10-CM Changes for Diabetes

Condition	New in ICD-10-CM	Description of Change
Diabetes Mellitus (DM)	Poorly controlled, out of control, inadequately controlled and controlled are no longer used in ICD-10-CM	Diabetes must be described by type with hyperglycemia
Gestational Diabetes	Classified to insulin controlled, diet controlled, or puerperal in the OB chapter	If described as puerperal, the diet controlled or insulin controlled component must be described as well
Other specified complications of Diabetes	Expanded to include with neuropathic arthropathy, dermatitis and oral complication including periodontal disease	Documentation of complication relationships to diabetes continues to be an opportunity for improvement
Secondary Diabetes	Specify if due to underlying condition or drug or chemical induced	Documentation must reflect the underlying cause of the DM

ICD-10-CM Opportunities

Depression

- Type
- Episode
- w/wo psychotic features
 - 311 (Depression), maps to F32.9 (Major depressive disorder, single episode, unspecified)

Anxiety

- Type specificity
 - Panic D/O w/o agoraphobia
 - Generalized
 - Other
 - Unspecified
 - w/wo stress reaction

CHF

- Type
 - Diastolic
 - Systolic
 - Diastolic and Systolic
- Acuity
- See next slide for further detail on this diagnosis.

Heart Failure

To properly classify heart failure in ICD-10-CM, physicians must specify the ***acuity and type of coronary heart failure***:

- systolic/diastolic or a combination of both
- acute, chronic or acute on chronic
- Cardiac arrest is further delineated as:
 - *Due to underlying cardiac condition*
 - *Other underlying condition*
 - *Cause unspecified*



Acute Myocardial Infarction

- Acute phase changed from 8 to 4 weeks
- STEMI:
 - Specific site involvement:
 - Anterior
 - Inferior
 - Other/unspecified
 - Specific artery involvement:
 - Left main coronary artery
 - Left anterior descending coronary artery
 - Other coronary artery of anterior wall
 - Right coronary artery
 - Other coronary artery of inferior wall
 - Left circumflex coronary artery
- NSTEMI – No change



ICD-10-CM Opportunities

Tobacco Use

- Type of nicotine
 - Cigarette
 - Chewing tobacco
 - Pipe
 - Cigar
- Remission
- Dependence

Urinary Tract Infection

No classification for Urosepsis

Query will always be required if “urosepsis” is documented by providers

Anemia

- Type
- Acuity
- Underlying cause

ICD-10-CM Opportunities

CKD

- Linkage of manifestation to disease
 - E.g. diabetic chronic kidney disease
- Stage

CAD

- Site Specificity
 - native or bypassed vessels
- w/wo angina combination codes are utilized in the CAD categories to eliminate necessity for additional code identifying angina (type).

Asthma

- Type
 - mild, moderate, severe
- w/wo status asthmaticus
- w/wo exacerbation
- Episode
 - intermittent
 - persistent
- See following slides for further information on this diagnosis

Asthma

	Intermittent	Mild Persistent	Moderate Persistent	Severe Persistent
Symptoms	2 or less days per week	More than 2 days per week	Daily	Throughout the day
Nighttime Awakenings	2 X's per month or less	3-4 X's per month	More than once per week but not nightly	Nightly
Rescue Inhaler Use	2 or less days per week	More than 2 days per week, but not daily	Daily	Several times per day
Interference With Normal Activity	None	Minor limitation	Some limitation	Extremely limited
Lung Function	FEV1 >80% predicted and normal between exacerbations	FEV1 >80% predicted	FEV1 60-80% predicted	FEV1 less than 60% predicted

Asthma

Asthma Scenario

- Patient presents with a history of extrinsic asthma. She is complaining of waking up a couple of nights per week coughing and uses her rescue inhaler on a daily basis. She is sent for a PFT to evaluate her lung volume.

Asthma

Asthma Documentation Requirements

- Physician (provider) must document if asthma is moderate persistent or some other level. Clinical findings from lung function tests are insufficient to appropriately classify a disease without physician (provider) documentation of the specific classification

ICD-10-PCS Opportunities

Venous Catheterization

S

- Site specificity
 - Peripheral artery/vein
 - Central artery /vein
- Laterality
- Fluoroscopy
 - Contrast material

Injection and Infusion

- Site Specificity
- Peripheral artery/vein
- Central artery/vein
- Intramuscular
- Subcutaneous
- Laterality
- Specific substance infused/injected

Colonoscopy w/polypectomy

- Site specificity
Documentation of the specific body part is necessary for classification of these procedures. Each location of biopsy requires a separate code.

ICD-10-PCS Opportunities

PTCA

- Site specificity
 - number of sites, not arteries as in ICD-9
- w/wo intraluminal devices
 - type of device

OB Laceration

- Site Specificity
 - specific to structures repaired - not “degree” of laceration as 1st, 2nd, 3rd and 4th in ICD-9.

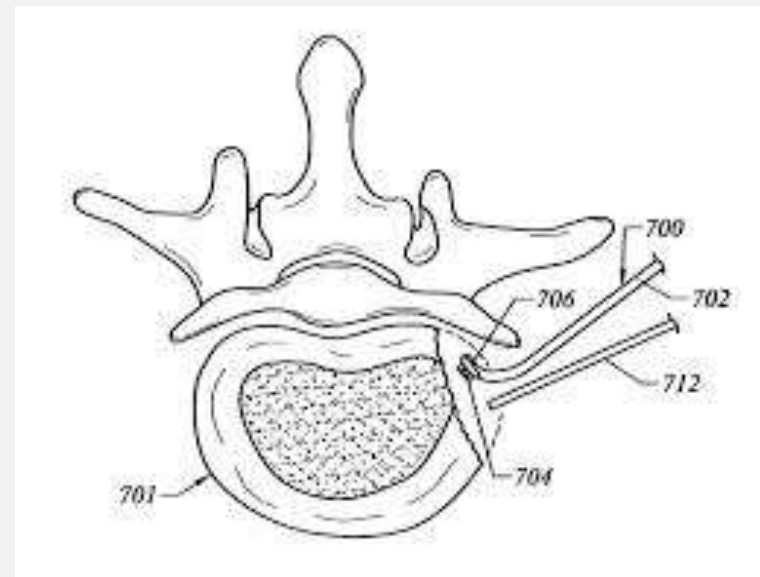
Closure Skin/sub tissue

- Site specificity
- Laterality
- Depth of closure
 - Skin
 - Subcutaneous tissue
 - Fascia
 - Muscle

ICD-10-PCS Opportunities

Excision of Disc

- Site specificity
- Extent of removal
 - Excision vs. resection
 - Discectomies can either be resections (removal of all disc material) or excisions (removal of part of the disc material).



ICD-10 CM



Hypertension

- There is only **one** code for hypertension **without manifestations** (benign, malignant, essential, etc...) in ICD-10.
 - The code is I10
- Documentation is required for any relationship between hypertension and other diseases.
 - Hypertensive heart disease- I11
 - Hypertensive chronic kidney disease- I12

Hypertension ICD-9

- 401 Essential hypertension
 - 401.0 Malignant
 - 401.1 Benign
 - 401.9 Unspecified

Hypertension ICD-10

- **I10 Essential (primary) hypertension**
 - Includes high blood pressure, hypertension (arterial) (benign) (essential) (malignant) (primary) (systemic)
 - Excludes hypertension complicating pregnancy and associated with end organ disease

Pressure Ulcers

A patient is admitted with a chronic non-pressure ulcer of the leg.

- In ICD-9-CM Diagnosis, seven (7) codes specify the site of the lower limb.
- **In ICD-10-CM, more than 100 codes are used to delineate:**
 - Site of the chronic non-pressure ulcer
 - Laterality
 - Depth of ulcer of the lower limb (e.g., limited to breakdown of skin, with fat layer exposed, with necrosis of muscle, with necrosis of bone and unspecified severity)



Pressure Ulcers ICD-10 Code Examples

Pressure Ulcers

L97.10 – Non-pressure chronic ulcer of unspecified thigh

L97.101 – Non-pressure chronic ulcer of unspecific thigh, limited to skin breakdown

L97.102 – Non-pressure chronic ulcer of unspecified thigh, with fat layer exposed

L97.103 – Non-pressure chronic ulcer of unspecified thigh, with necrosis of muscle

L97.104 – Non-pressure chronic ulcer of unspecified thigh, with necrosis of bone

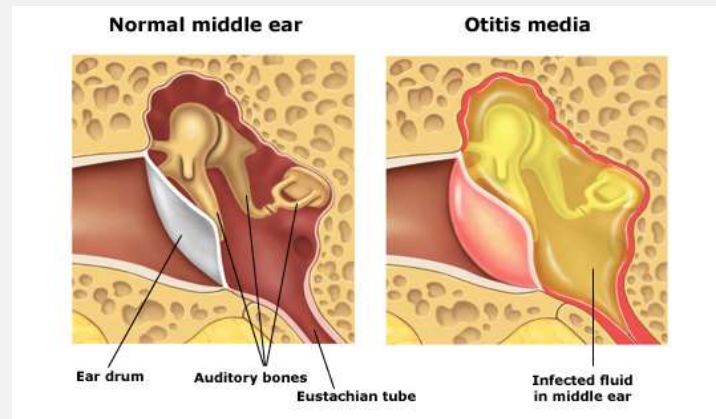
L97.109 – Non-pressure chronic ulcer of unspecified thigh, with unspecified severity



Right, left, unspecified lower limbs with all the above complications are specified in ICD-10-CM

Otitis Media

- In ICD-10-CM for Otitis Media conditions, the physician should specify laterality and type: with effusion or nonpurulent, allergic, catarrhal, exudative, post measles, purulent, secretory, suppurative, etc. as well as acuity (acute or chronic).



Episodes of Care

- ***ICD-10-CM relies more heavily on categorizing the episodes of care*** for injuries and illnesses. ***Detailed documentation is required***, for example, for fractures:
 - ***Fracture codes in ICD-10 include greater specificity:***
 - Type of fracture
 - Anatomical site
 - Displaced or not
 - Laterality

Fractures

- Classification also includes episodes of care:
 - Initial
 - Subsequent
 - Sequela
- Gustilo-Anderson is required for some open fractures utilizing a 7th character in the code
- ***Fractures not indicated as open or closed will be classified as a closed fracture***
- ***Fracture modifiers are “displaced” (default if not further specified) and “non-displaced”***
- **Fracture cause must be documented**
 - Traumatic or nontraumatic?

Episodes of Care w/Fractures

Fractures in ICD-10-CM:

- Open Fracture of the Right Wrist, Initial Encounter – S62.101**B**

Character	
A	Initial Encounter/Closed Fracture
B	Initial Encounter/Open Fracture
D	Subsequent Encounter/Fracture Routine Healing
E	Subsequent Encounter for Open Fracture, Type I or II Routine Healing
G	Subsequent Encounter/Fracture Delayed Healing
K	Subsequent Encounter/Fracture Nonunion
P	Subsequent Encounter/Fracture Malunion
S	Sequela

Fractures/Injuries – General Rule

- Documentation of the initial injury must be consistent for each visit with episode of care information:
 - Each record must stand on its own.
 - Documentation from previous records will not be used / must be re-iterated in current note.
 - No aftercare or follow-up classification for fractures or injuries (V codes in ICD-9-CM Diagnosis) – in ICD-10-CM use “subsequent” code.

Pathological Fractures

- ICD-10-CM introduces more specificity in the classification of pathological fractures due to osteoporosis.
 - Age related, includes
 - Senile
 - Post menopausal
 - Other, includes
 - Drug induced
 - Idiopathic
 - Post oophorectomy
 - Postsurgical malabsorption
 - Post traumatic

Open Wounds/Lacerations

Below is an example of the classification differences between ICD-9-CM Diagnosis and ICD-10-CM for an open wound or laceration of the thumb with a foreign body.

ICD-9-CM Diagnosis

- 883.1 Complicated open wound of the finger.

ICD-10-CM

- S61.021A Laceration with foreign body of right thumb without damage to nail, initial encounter.
- **Much more descriptive of the injury allowing for reflection of patient acuity, outcome/prognosis, evaluation as well as follow up expectations.**

Documentation Improvement

- Coders/CDI staff are not permitted to classify diseases from lung function tests only
- For inpatients: possible, probable and suspected conditions are coded as though they exist
- For outpatients: code only to the highest level of certainty

Pregnancy Complications

ICD-9-CM and ICD-10-CM differences for pregnancy complication:

ICD-9-CM

- 648.03– Diabetes Mellitus in mother complicating pregnancy, antepartum

ICD-10-CM

- 024.912– Unspecified diabetes mellitus in pregnancy, second trimester
- The trimester or number of weeks in which the condition occurred should be coded from physician documentation.
- It's also important to know whether the condition is pre-existing or not.

Underdosing

Underdosing – new concept in ICD-10

- Taking less of a medication than prescribed by physician or manufacturer's instruction
 - Noncompliance
 - Complication of care

Underdosing – *Documentation Needed:*

- If a patient is purposely stopping or altering their medication regimen this needs to be documented to provided accurate coding

Underdosing

These codes also require a 7th digit to identify whether this is:

- Initial encounter
- Subsequent encounter
- Sequela (takes priority for code – if no sequela, code initial or subsequent)

Underdosing

- Underdosing of drugs specifies documentation of intentional or unintentional underdosing:
 - Intentional underdosing
 - Due to financial hardship
 - Other reasons
 - Unintentional underdosing
 - Age-related debility
 - Other reasons

Separate “Z” code that is submitted alongside the code for underdosing.



Underdosing/Poisoning ICD-10 Code Examples

Underdosing/Poisoning Coding Examples

T45.511 – Poisoning by anticoagulants, accidental (unintentional)

T45.512 – Poisoning by anticoagulants, intentional self-harm

T45.513 – Poisoning by anticoagulants, assault

T45.514 – Poisoning by anticoagulants, undetermined

T45.515 – Adverse effect of anticoagulants

T45.516 – Underdosing of anticoagulants

Crohn's Disease

- Classifications now include
 - Without complications
 - With complications
 - Rectal bleeding
 - Intestinal obstruction
 - Fistula
 - Abscess
 - Other or unspecified

Crohn's Disease Scenario

- Patient presents with a known history of Crohn's disease. He is experiencing abdominal pain and some bloating. A CT scan and colonoscopy are performed to evaluate for obstruction.

Crohn's Disease

Documentation Requirements

- Physician (provider) must document if obstruction is associated with or caused by the Crohn's disease. Clinical findings from colonoscopy or CT studies are insufficient to appropriately classify a disease without physician (provider) documentation of specific cause and effect relationship.

Crohn's Disease ICD-10 Code Examples

Crohn's Disease (sm. Intestine, large intestine, both, unspecified)

K50.0 – Crohn's disease of small intestine

K50.00 – Crohn's disease of small intestine **without complications**

K50.01 – Crohn's disease of small intestine **with complications**

K50.011 – Crohn's disease of small intestine with **rectal bleeding**

K50.012 – Crohn's disease of small intestine with **intestinal obstruction**

K50.013 – Crohn's disease of small intestine with **fistula**

K50.014 – Crohn's disease of small intestine with **abscess**

K50.018 – Crohn's disease of small intestine with **other complication**

K50.019 – Crohn's disease of small intestine with **unspecified complication**

Gout

Physician (provider) must document the type and site of the gout in order to get the most specific classification.

Gout

- Classifications include:

- Acute, flare, attack, NOS – M10 (coded M10 if ‘chronic gout’ not specified)
- Chronic – M1A
 - Idiopathic – M1A.0
 - Lead-induced
 - Drug-induced
 - Due to renal impairment
 - Other secondary gout
 - Unspecified – M1A.9
 - 6th character for site; 7th character for with or without tophus



Gout ICD-10 Code Examples

Gout

M10.0 – Idiopathic gout

M10.00 – Idiopathic gout, unspecified site

M10.01 – Idiopathic gout, shoulder

M10.011 – idiopathic gout, right shoulder

M10.012 – idiopathic gout, left shoulder

M10.019 – idiopathic gout, unspecified shoulder

M10.1 – Lead-induced gout

M10.2 – Drug-induced gout

M10.3 – Gout due to renal impairment

M10.4 – Other secondary gout

M10.9 – Gout, unspecified

Alcohol Abuse/Use

- Classifications include
 - Uncomplicated
 - Complications
 - With intoxication
 - Delirium
 - Delusions
 - Hallucinations
 - Anxiety disorder
 - Sexual dysfunction
 - Sleep disorder
 - Unspecified



Alcohol Abuse/Use

- Physician (provider) must document whether the complication is associated with/due to the alcohol abuse.
 - For example:
 - F10.18 Alcohol abuse with other alcohol-induced disorders
 - F10.180 Alcohol abuse with alcohol-induced anxiety disorder
 - F10.181 Alcohol abuse with alcohol-induced sexual dysfunction
 - F10.182 Alcohol abuse with alcohol-induced sleep disorder
 - F10.188 Alcohol abuse with other alcohol-induced disorder

Blood Alcohol Level

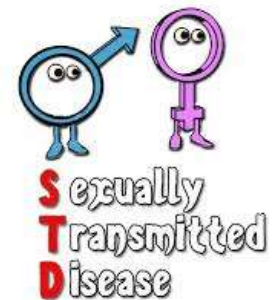
An additional code from category Y90, Evidence of alcohol involvement determined by blood alcohol level, should be used with a code from F10, Alcohol-related disorders, if the patient's blood alcohol level is recorded.

- Y90 Evidence of alcohol involvement determined by blood alcohol level.
 - Y90.0 Blood alcohol level of less than 20 mg/100ml
 - Y90.1 Blood alcohol level of 20-39 mg/100ml
 - Y90.2 Blood alcohol level of 40-59 mg/100ml
 - Y90.3 Blood alcohol level of 60-79 mg/100ml
 - Y90.4 Blood alcohol level of 80-99 mg/100ml
 - Y90.5 Blood alcohol level of 100-119 mg/100ml
 - Y90.6 Blood alcohol level of 120-199 mg/100ml
 - Y90.7 Blood alcohol level of 200-239 mg/100ml
 - Y90.8 Blood alcohol level of 240 mg/100ml or more
 - Y90.9 Presence of alcohol in blood, level not specified

STDs

ICD-10-CM has created a range of codes to identify infections with a predominantly Sexual mode of transmission (A50-A64).

- Physician (provider) must document the type of STD and infection.
- It is important to note that human immunodeficiency virus infection and acquired immunodeficiency syndrome **(HIV) disease is excluded from this range of codes**
 - A56.11 Disease, sexually transmitted, chlamydial



Domestic Violence Coding

- ICD-10-CM has multiple codes each describing type of assault instrument as well as type of encounter such as:

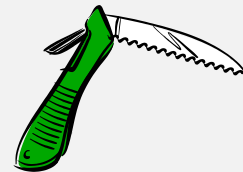
Example:

ICD-9-CM

- E code=E966=Assault by cutting and piercing instrument

ICD-10-CM

- X99.0xxA = Assault by sharp glass, initial encounter;
- X99.0xxD = Assault by sharp glass, subsequent encounter;
- X99.1xxA = Assault by knife, initial encounter;
- X99.1xxD = Assault by knife, subsequent encounter



Domestic Violence Coding

ICD-10-CM includes whether the maltreatment was ***suspected or confirmed*** and also details if the encounter was ***initial or subsequent***:

- T74.91xA Unspecified adult maltreatment, confirmed, initial encounter;
 - T74.91xD Unspecified adult maltreatment, confirmed, subsequent encounter
 - T76.91xA Unspecified adult maltreatment, suspected, initial encounter
 - T76.91xD Unspecified adult maltreatment, suspected, subsequent encounter
-
- ICD-10-CM also includes the terminology of ***“abandonment”***

Top 5 New Codes Signs and Symptoms

- Projectile Vomiting
 - Previously vomiting alone (787.03)
 - ICD-10-CM: R11.12
- Anterior chest wall pain
 - Previously chest pain, other (786.59)
 - ICD-10-CM: R07.89
- Somnolence
 - Previously other alteration of consciousness (780.09)
 - ICD-10-CM: R40.0

Top 5 New Codes Signs and Symptoms

- Repeated falls
 - Previously other symptoms involving nervous and musculoskeletal systems (781.99)
 - ICD-10-CM: R29.6
- Mouth breathing
 - Previously other symptoms involving head and neck (784.99)
 - ICD-10-CM: R06.5

Infections resistant to antibiotics

- Many bacterial infections are resistant to current antibiotics. ***It is necessary to identify all infections documented as antibiotic resistant.*** The infection must also be identified.
- Code Category Z16 - Resistance to antimicrobial drugs



Infections resistant to antibiotics

This 78 year old patient is seen for continued follow-up for C.diff colitis. Cultures of the organism have found this infection to be resistant to flagyl. A new drug regimen will be started at this time.

ICD-10-CM

A04.7 Colitis (acute)(catarrhal)(chronic)(noninfective)(hemorrhagic),
Clostridium difficile

Z16.39 Resistance, resistant (to), organism(s), to, drug, antimicrobial
(single), specified NEC

Combination Codes for MRSA Infection

Methicillin Resistant Staphylococcus Aureus (MRSA) infections have been revised to include combination codes that *specify the causal organism*.

- A41.02 Sepsis due to Methicillin Resistant Staphylococcus Aureus
- J15.212 Pneumonia due to Methicillin Resistant Staphylococcus Aureus

Providers must specify the causal relationship!

MSSA and MRSA colonization

- A positive MRSA colonization test might be documented by the provider as ***“MRSA screen positive”*** or ***“MRSA nasal swab positive”***.
 - Z22.322, Carrier or suspected carrier of Methicillin resistant Staphylococcus aureus
 - Z22.321, Carrier or suspected carrier of Methicillin susceptible Staphylococcus aureus

Obesity

- The following are important documentation tips and strategies for this disease/condition as required by the specificity needed in ICD-10:
 - Include descriptions such as overweight, obesity or morbid obesity due to excess calories, drug-induced obesity, and morbid obesity with alveolar hypoventilation.
 - List the specific drug(s) associated with drug-induced obesity.
 - Detail body mass index (BMI), especially if greater than 40.

Obesity ICD-9

- 278 Overweight, obesity, and other hyperalimentation
 - 278.0 Overweight and obesity
 - 278.00 Obesity, unspecified (Obesity NOS)
 - 278.01 Morbid obesity
 - 278.02 Overweight

Obesity ICD-10

- E66 Overweight and obesity
 - E66.0 **Obesity due to excess calories**
 - E66.01 Morbid (severe) obesity due to excess calories, excludes E66.2
 - **E66.09 Other obesity due to excess calories**
 - **E66.1 Drug-induced obesity**
 - E66.2 Morbid (severe) obesity with alveolar hypoventilation
 - E66.3 Overweight
 - **E66.8 Other obesity**
 - **E66.9 Obesity, unspecified (Obesity NOS)**

ICD-10 PCS



Overview of ICD-10-PCS

- PCS stands for ***Procedure Classification System***
- It is a *multiaxial system with a 7 character alphanumeric code* classification providing a **unique code** for all substantially different procedures and with **easy expandability**, *incorporating new procedures, technologies and devices utilized in medical/surgical procedures*
- The *classification for the general surgery procedures has undergone significant revision focusing primarily on section, body system, root operation, body part, approach, device and qualifier*

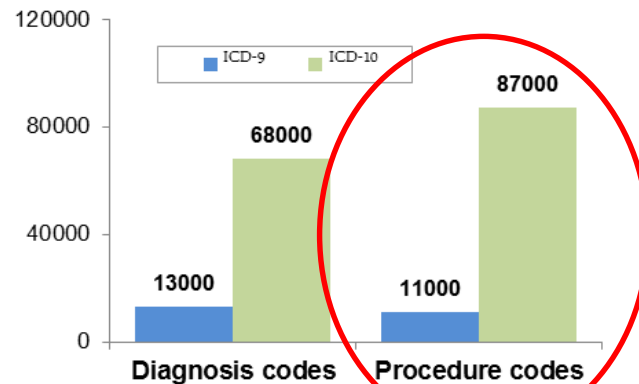
Overview of ICD-10-PCS

- The ICD-9-PCS procedure classification system does not allow for adequate expansion to accommodate new technologies and the advancement of procedures performed or devices utilized in procedures
- Basic principles used when developing the system were that **no diagnostic information is included** in the procedure description (i.e., no codes for procedures exclusive to aneurysms, cleft lip, strictures or neoplasms, etc.)
- This procedure classification system is only utilized in the **inpatient hospital setting**



ICD-10 PCS

Number of ICD 9 and ICD 10 codes for diagnoses and procedures



(Source: ICD-10-CM and ICD-10-PCS Update, Thirteenth National HIPAA Summit, 9/26/2006; Rand Study, March 2004)

ICD 10 procedure codes will require additional and significant detail in surgical reporting

- Key ICD 10 characteristics
 - ICD 10 is a “dramatic departure” from current practice
 - Surgical codes lack decimals
 - The new code set will allow for incorporation of new procedures and technologies
 - Terminology is precisely defined and used consistently across all codes

ICD-10-PCS: Overall Structure and Components

1 st	2 nd	3 rd	4 th	5 th	6 th	7 th
Section	Body System	Root Operation	Body Part	Approach	Device	Qualifier

The ICD-10-PCS code structure tells a story

ICD-10-PCS Example

- Open biopsy of ileocecal valve, (i.e. laparotomy with excision of the ileocecal valve for diagnostic reasons)

ICD-10-PCS Table

Section	0	Medical and Surgical	
Body System	D	Gastrointestinal System	
Operation	B	Excision: Cutting out or off, without replacement, a portion of a body part	
Body Part	Approach	Device	Qualifier
1 Esophagus, Upper			
2 Esophagus, Middle			
3 Esophagus, Lower			
4 Esophagogastric Junction			
5 Esophagus			
7 Stomach, Pylorus			
8 Small Intestine			
9 Duodenum			
A Jejunum	0 Open		
B Ileum	3 Percutaneous		
C Ileocecal Valve	4 Percutaneous Endoscopic	Z No Device	X Diagnostic
E Large Intestine	7 Via Natural or Artificial Opening		Z No Qualifier
F Large Intestine, Right	8 Via Natural or Artificial Opening Endoscopic		
G Large Intestine, Left			

ODBC0ZX = Open biopsy,
ileocecal valve

Open Biopsy, Ileocecal Valve

1 st	2 nd	3 rd	4 th	5 th	6 th	7 th
Section	Body System	Root Operation	Body Part	Approach	Device	Qualifier
0	D	B	C	0	Z	X

The ICD-10-PCS code structure tells a story

ICD-10-PCS Example

- Open ileostomy (i.e. laparotomy with bypass ileum to skin)



ICD-10-PCS Table

Section	0 Medical and Surgical		
Body System	D Gastrointestinal System		
Operative	1 Bypass: Altering the route of passage of the contents of a tubular body part		
Body Part	Approach	Device	Qualifier
B Ileum	0 Open 4 Percutaneous Endoscopic 8 Via Natural or Artificial Opening Endoscopic	7 Autologous Tissue Substitute J Synthetic Substitute K Nonautologous Tissue Substitute Z No Device	4 Cutaneous B Ileum H Cecum K Ascending Colon L Transverse Colon M Descending Colon N Sigmoid Colon P Rectum Q Anus

0D1B0Z4 = Ileostomy (bypass)

Ileostomy

1 st	2 nd	3 rd	4 th	5 th	6 th	7 th
Section	Body System	Root Operation	Body Part	Approach	Device	Qualifier
0	D	1	B	0	Z	4

The ICD-10-PCS code structure tells a story

Incision and Drainage

- Require documentation of:
 - Level of tissue incised
 - Skin
 - Subcutaneous tissue and fascia
 - Was a drainage device left in?
 - Code example
 - ICD-9-CM Procedures – 86.04 Incision with drainage of skin and subcutaneous tissue
 - ICD-10-PCS – 0J9700Z – Drainage, subcutaneous tissue and fascia, back, open approach, with drainage device

Incision and Drainage

<i>Section</i>	0	Medical and Surgical		
<i>Body System</i>	J	Subcutaneous Tissue and Fascia		
<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	Subcutaneous Tissue and Fascia, Scalp			
1	Subcutaneous Tissue and Fascia, Face			
4	Subcutaneous Tissue and Fascia, Anterior Neck			
5	Subcutaneous Tissue and Fascia, Posterior Neck			
6	Subcutaneous Tissue and Fascia, Chest			
7	Subcutaneous Tissue and Fascia, Back			
8	Subcutaneous Tissue and Fascia, Abdomen			
9	Subcutaneous Tissue and Fascia, Buttock			
B	Subcutaneous Tissue and Fascia, Perineum			
C	Subcutaneous Tissue and Fascia, Pelvic Region			
D	Subcutaneous Tissue and Fascia, Right Upper Arm	0 Open	0 Drainage Device	Z No Qualifier
F	Subcutaneous Tissue and Fascia, Left Upper Arm	3 Percutaneous		

Catheter Insertion into Vein

- Procedures require documentation of:
 - Specific vein where insertion performed
 - Right or left internal jugular vein
 - Right or left external jugular vein
 - Approach
 - Open
 - Percutaneous
 - Percutaneous endoscopic
 - Type of device
 - Infusion
 - intraluminal
 - Code examples
 - ICD-9 – – venous catheterization.
 - ICD-10-PCS – 05HM33Z – Insertion, internal jugular vein right, percutaneous, infusion device.

Catheter Insertion

S 0 Medical and Surgical			
Body System 2 Heart and Great Vessels			
Operation H Insertion: Putting in a nonbiological appliance that monitors, assists, performs, or prevents a physiological function but does not physically take the place of a body part			
Body Part	Approach	Device	Qualifier
4 Coronary Vein 6 Atrium, Right 7 Atrium, Left K Ventricle, Right L Ventricle, Left	0 Open 3 Percutaneous 4 Percutaneous Endoscopic	0 Monitoring Device, Pressure Sensor 2 Monitoring Device 3 Infusion Device D Intraluminal Device J Cardiac Lead, Pacemaker K Cardiac Lead, Defibrillator M Cardiac Lead	Z No Qualifier
P Pulmonary Trunk Q Pulmonary Artery, Right R Pulmonary Artery, Left S Pulmonary Vein, Right T Pulmonary Vein, Left V Superior Vena Cava W Thoracic Aorta	0 Open 3 Percutaneous 4 Percutaneous Endoscopic	0 Monitoring Device, Pressure Sensor 2 Monitoring Device 3 Infusion Device D Intraluminal Device	Z No Qualifier

Debridement

- Some providers may refer to a debridement procedure using scissors as selective debridement. **This is not the same as excisional debridement.**
- Documenting **debridement with a sharp instrument does not qualify as excisional debridement.**
- Physicians must document whether debridement is excisional or nonexcisional along with specifying the deepest layer debrided.

ICD-10-PCS Debridement

Patient present for non-excisional debridement of subcutaneous tissue, open wound, right foot

ICD-10-PCS

0JDQ0ZZ

- Extraction of Right Foot Subcutaneous Tissue and Fascia, Open Approach

ICD-10-PCS Table – Debridement

Section	0	Medical and Surgical	
Body System	J	Subcutaneous Tissue and Fascia	
Operation	D	Extraction: Pulling or stripping out or off all or a portion of a body part by the use of force	
Body Part	Approach	Device	Qualifier
0 Subcutaneous Tissue and Fascia, Scalp			
1 Subcutaneous Tissue and Fascia, Face			
4 Subcutaneous Tissue and Fascia, Anterior Neck			
5 Subcutaneous Tissue and Fascia, Posterior Neck			
6 Subcutaneous Tissue and Fascia, Chest			
7 Subcutaneous Tissue and Fascia, Back			
8 Subcutaneous Tissue and Fascia, Abdomen			
9 Subcutaneous Tissue and Fascia, Buttock			
B Subcutaneous Tissue and Fascia, Perineum			
C Subcutaneous Tissue and Fascia, Pelvic Region			
D Subcutaneous Tissue and Fascia, Right Upper Arm	0 Open	Z No Device	Z No Qualifier
F Subcutaneous Tissue and Fascia, Left Upper Arm	3 Percutaneous		
G Subcutaneous Tissue and Fascia, Right Lower Arm			
H Subcutaneous Tissue and Fascia, Left Lower Arm			
J Subcutaneous Tissue and Fascia, Right Hand			
K Subcutaneous Tissue and Fascia, Left Hand			
L Subcutaneous Tissue and Fascia, Right Upper Leg			
M Subcutaneous Tissue and Fascia, Left Upper Leg			
N Subcutaneous Tissue and Fascia, Right Lower Leg			
P Subcutaneous Tissue and Fascia, Left Lower Leg			
Q Subcutaneous Tissue and Fascia, Right Foot			
R Subcutaneous Tissue and Fascia, Left Foot			

ICD-10-PCS Debridement

1 st	2 nd	3 rd	4 th	5 th	6 th	7 th
Section	Body System	Root Operation	Body Part	Approach	Device	Qualifier
0	J	D	Q	0	Z	Z

The ICD-10-PCS code structure tells a story

Amputation

- Procedures require documentation of:
 - Level of amputation for arm, leg, thumb, finger or toe
 - High
 - Mid
 - low
 - Complete or partial ray for hand and foot
 - Also identify which ray (1 through 5)
 - Code examples
 - ICD -9 – 84.11 – amputation of toe
 - ICD-10- PCS – 0Y6P0Z1 – detachment, 1st toe right, open, high

Bowel Resection

- Procedures require documentation of:
 - ALL sections of the bowel removed, including any part of the small and large intestine origination and termination points
 - Example: Transverse colectomy may involve resection up to the ileocecal valve down to the descending colon requiring clear documentation of beginning point of resection to termination point of resection
 - Any lymph node removal (chain, single, sampling)
 - Mesenteric or other tissue removal
 - Path reports cannot be used to determine entirety of the procedure
 - physicians (surgeons) must document every aspect of procedures performed

Summary

- The transition to ICD-10 classification systems on October 1, 2015 will have a significant impact on physician documentation requirements.
- Please let us know areas or items that you would like to see further addressed in more detail.

Questions???

