



ICD-10 for Orthopedics

UConn Health



Just himagine what we can accomplish together.

Introductions

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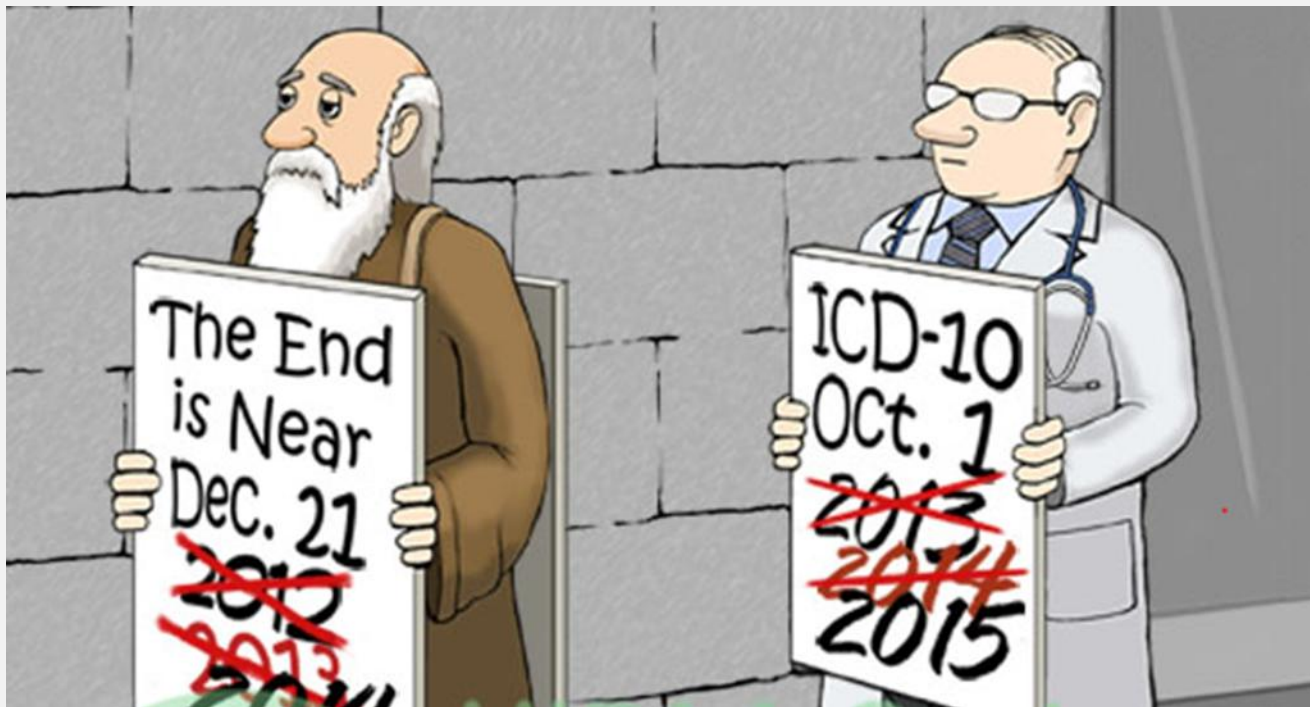
Agenda

- Describe the challenges associated with ICD-10 implementation
- Identify the importance of physician documentation and coding
- Review examples of the impact of the changes in ICD-10



Final Rule Issued

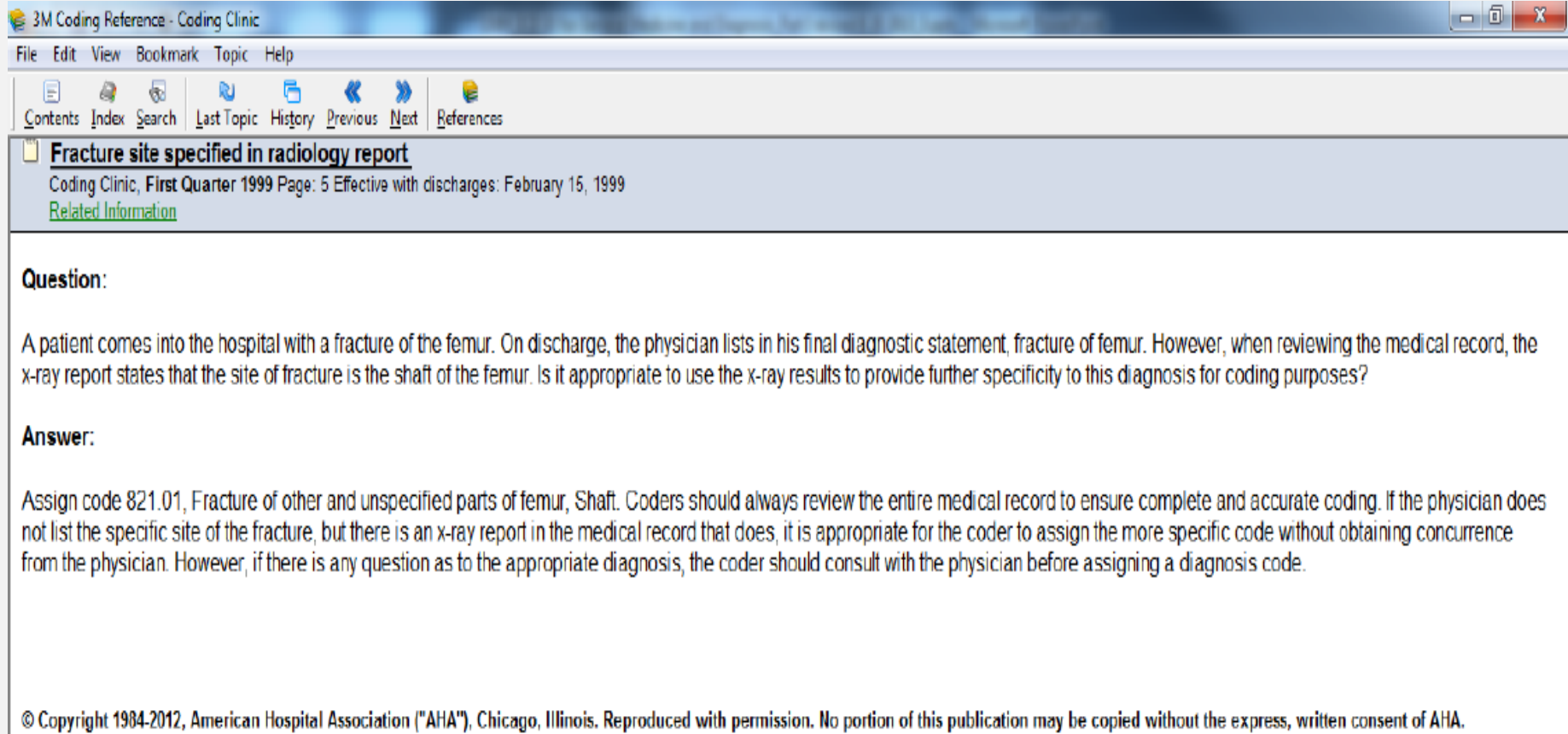
- ▶ On July 31st, 2014, The U.S. Department of Health and Human Services (HHS) issued a rule finalizing October 1, 2015 as the new compliance date



Challenges

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

Challenges: Coding Specificity



3M Coding Reference - Coding Clinic

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Fracture site specified in radiology report

Coding Clinic, First Quarter 1999 Page: 5 Effective with discharges: February 15, 1999
[Related Information](#)

Question:

A patient comes into the hospital with a fracture of the femur. On discharge, the physician lists in his final diagnostic statement, fracture of femur. However, when reviewing the medical record, the x-ray report states that the site of fracture is the shaft of the femur. Is it appropriate to use the x-ray results to provide further specificity to this diagnosis for coding purposes?

Answer:

Assign code 821.01, Fracture of other and unspecified parts of femur, Shaft. Coders should always review the entire medical record to ensure complete and accurate coding. If the physician does not list the specific site of the fracture, but there is an x-ray report in the medical record that does, it is appropriate for the coder to assign the more specific code without obtaining concurrence from the physician. However, if there is any question as to the appropriate diagnosis, the coder should consult with the physician before assigning a diagnosis code.

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Considerations

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

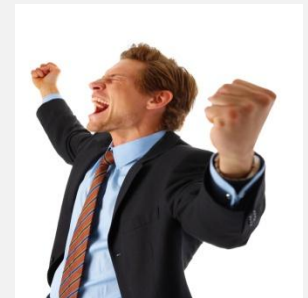


Uses of Enhanced Specificity of ICD-10

- Data will be collected over the next 2 years – as well as 2 years following implementation to 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
 - Justification of medical necessity

The ICD-10 and CPT Connection

- CPT codes **do not** change!
- ICD-10 diagnoses correlate with CPT procedures
- Potential reimbursement implications



Differences in ICD-9 and ICD-10

- ICD 9 is five digits where ICD 10 is 7 alphanumeric characters
- ICD 10 better describes acuity, complexity and laterality of the medical conditions
- ICD-10-CM- Diagnoses
- ICD-10-PCS- Procedures (**Hospital only**)

It's Not As Bad As It Seems

- Almost 40,000 codes apply to Injury, Poisoning, and External Causes
 - Over 6,300 codes apply to Musculoskeletal System and Connective Tissue
 - 336 codes related to the Respiratory System
- ❖ **Remember:** Many of the new codes are based on laterality (over 5000 codes) and location



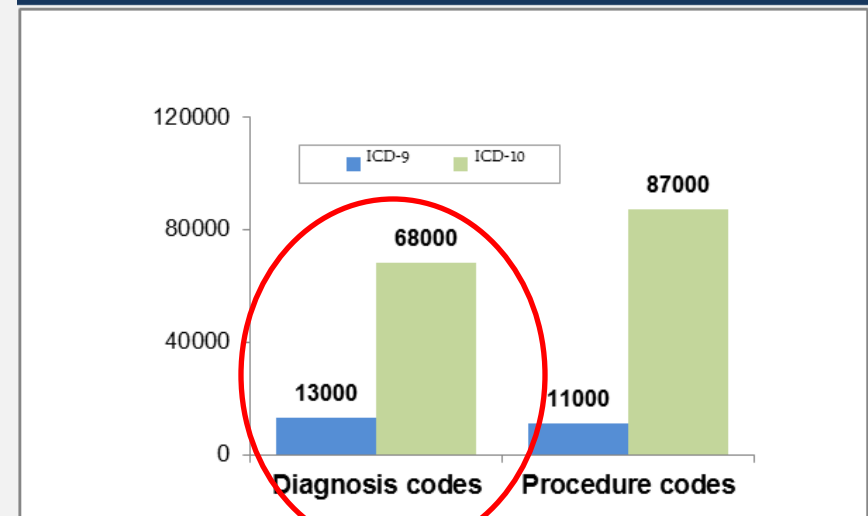
Changes to Diagnosis Codes

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)

Documentation for Diagnosis

Requirements for Detailed Documentation for Diagnoses	
Acuity	Acute, chronic or both
Specific site	Femur trochanteric – apophyseal, greater trochanter, intertrochanteric, lesser trochanter
Laterality	Right, left, bilateral
Specific type of fractures	Displaced/non-displaced fractures, transverse, oblique, spiral, comminuted, segmental
Etiology of diagnosis	Fracture/dislocation due to – pathological, recurrent, fatigue, age-related, osteoporosis
Link must be established between manifestations and underlying diseases	Osteomalacia – puerperal, senile, due to malabsorption or malnutrition, aluminum bone disease, drug induced
Non-pressure skin ulcers	Site, laterality and depth of tissue involvement



Documentation for Diagnosis (cont.)

Requirements for Detailed Documentation for Diagnoses	
Complications of care	Intraoperative, postoperative, mechanical malfunctions, Infections (device vs. wound)
Injury details	Place of occurrence, activity causing the injury; accident details
Episode of care	Initial treatment, subsequent treatment (for routine or delayed healing), sequela
Drug reactions/interactions/adverse reactions	Poisoning (accidental/intentional/assault/undetermined), adverse effect, underdosing (due to financial hardship, age-related)
Degree of severity	Mild, moderate, severe, e.g., Malnutrition: mild, moderate, severe

Orthopedics Diagnosis Documentation Examples



Top Orthopedics Diagnosis Codes

719.46 - JOINT PAIN-L/LEG
836.0 - TEAR MED MENISC KNEE-CUR
717.83 - OLD DISRUPT ANT CRUCIATE
717.3 - DERANG MED MENISCUS NEC
836.3 - DISLOCAT PATELLA-CLOSED
723.1 - CERVICALGIA
780.4 - DIZZINESS AND GIDDINESS
844.1 - SPRAIN MEDIAL COLLAT LIG
914.0 - ABRASION HAND
850.9 - CONCUSSION NOS
726.2 - SHOULDER REGION DIS NEC
V45.89 - POSTSURGICAL STATES NEC
727.09 - SYNOVITIS NEC
844.2 - SPRAIN CRUCIATE LIG KNEE
380.4 - IMPACTED CERUMEN
910.0 - ABRASION HEAD
717.7 - CHONDROMALACIA PATELLAE
996.78 - OTH COMP DUE TO INTERNAL ORTHO DEV,
IMPLANT, GRAFT
716.96 - ARTHROPATHY NOS-L/LEG
726.12 - BICIPITAL TENOSYNOVITIS
840.7 - SUPERIOR GLENOID LABRUM LESIONS (SLAP)



Clinical Examples – Documentation Improvement

Laterality

- ICD-10-CM introduces laterality to the diagnosis classification system. Many providers already document which side of the body the disease or injury occurred, but it is now a required data element with ICD-10-CM.
- **Over 5,000 diagnoses have a right and left distinction, such as:**
 - Joint pain/effusion
 - Injuries/fractures/sprains/dislocations
 - Arthritis
 - Cancer
- The following are classification examples of when documentation of laterality is required:
 - M25.561 Pain in right knee
 - S52.521A Torus fracture of lower end of right radius
 - L89.011 Pressure ulcer of the right elbow, stage 1

Fractures

- Classification also includes episodes of care (EOC):
 - Initial
 - Subsequent
 - Sequela
- Gustilo-Anderson grade is required for some open fractures utilizing a 7th character in the code. There are 10 EOC codes relating to this grading system which specify grade 1/2 or 3A/3B/3C for initial visit, routine healing, delayed healing, nonunion, and malunion.
- 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”

Documentation Requirements

I	Open fracture, clean wound, wound <1 cm in length
II	Open fracture, wound > 1 cm in length without extensive soft-tissue damage, flaps, avulsions
III	Open fracture with extensive soft-tissue laceration, damage, or loss or an open segmental fracture. This type also includes open fractures caused by farm injuries, fractures requiring vascular repair, or fractures that have been open for 8 hr prior to treatment
IIIA	Type III fracture with adequate periosteal coverage of the fracture bone despite the extensive soft-tissue laceration or damage
IIIB	Type III fracture with extensive soft-tissue loss and periosteal stripping and bone damage. Usually associated with massive contamination. Will often need further soft-tissue coverage procedure (i.e. free or rotational flap)
IIIC	Type III fracture associated with an arterial injury requiring repair, irrespective of degree of soft-tissue injury.

Classifications of the Gustilo-Anderson scale must be documented by the Physician...coders cannot select the classification based on documentation.

Episode of Care

- Sequela
 - **Complications or conditions that arise as a direct result of an injury,** such as scar formation after a burn. The scars are sequela of the burn.

***Sequela is the new terminology in ICD-10-CM
for late effects***





Episodes of Care – up to 15 EOC encounter codes (characters)

Fractures in ICD-10-CM:

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

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

NOTE: Documentation requirements for the initial injury is the same throughout the continuum of care, including hospital, skilled nursing or rehab, physician office/clinic with appropriate 7th character representing episode of care.

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 use “subsequent” code.



Fractures– Documentation Improvement

Throughout Continuum of Care...

Requirements for Detailed Documentation for Fractures/Injuries	
Initial hospital stay	Unstable burst fracture of 1 st cervical vertebra, initial encounter for closed fracture – S12.02xA
SNF/rehab facility	Unstable burst fracture of 1 st cervical vertebra, subsequent encounter for routine healing – S12.02xD
Physician office/clinic visit	Unstable burst fracture of 1 st cervical vertebra, subsequent encounter for delayed healing – S12.02xG
Subsequent office/clinic visit	Unstable burst fracture of 1 st cervical vertebra, subsequent encounter for nonunion – S12.02xK
2 nd hospital stay for surgical treatment	Unstable burst fracture of 1 st cervical vertebra, subsequent encounter for nonunion – S12.02xK

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



Documentation Requirements (cont'd)

- Classification also includes episode of care, and timeframe (days, weeks, etc.):
 - Initial
 - Subsequent
 - Sequela
- Initial encounters
 - *patient is receiving active treatment for the injury*
 - surgical treatment, emergency department encounter, and evaluation and treatment by a new physician.
- Subsequent encounters
 - the *patient has received active treatment of the injury and is receiving routine care for the injury during the healing or recovery phase*
 - cast change or removal, removal of external or internal fixation device, medication adjustment, other aftercare and follow-up visits following injury treatment).



Code Example

Coding example: F/U for Nonunion of right humeral greenstick fracture

ICD-9-CM format:

Ø-V,E 2 3 . 4 5 (5 possible characters)

Current ICD-9-CM code: *Nonunion of fracture*

7 3 3 . 8 2

ICD-10-CM format:

A-Z 2 3 . 4 5 6 7 (7 possible)

Proposed ICD-10-CM code: *Greenstick fracture, humerus, right, subsequent visit for fracture with nonunion*

S 4 2 . 3 1 1 K



Clinical Examples – Documentation Improvement

- The key differences between ICD-9-CM and ICD-10-CM for documenting disorders of bone density and structure are listed below:
- **ICD-9-CM**
 - 733 Other disorders of bone and cartilage
- **ICD-10-CM**
 - M80 Osteoporosis with current pathological fracture
 - M81 Osteoporosis without current pathological fracture
 - M83 Adult osteomalacia
 - M84 Disorder of continuity of bone
 - M85 Other disorders of bone density and structure

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.**

Backache ICD-9

- 724 Other and unspecified disorders of back
 - 724.0 Spinal stenosis, other than cervical
 - 724.1 Pain in thoracic spine
 - 724.2 Lumbago
 - 724.3 Sciatica
 - 724.4 Thoracic or lumbosacral neuritis or radiculitis
 - **724.5 Backache unspecified**
 - 724.6 Disorders of sacrum
 - 724.7 Disorders of coccyx
 - 724.8 Other symptoms referable to back
 - 724.9 Other unspecified back disorders

Backache

- M54 Dorsalgia
 - M54.0 Panniculitis affecting regions of neck and back
 - M54.1 Radiculopathy
 - M54.2 Cervicalgia
 - M54.3 Sciatica
 - M54.4 Lumbago with sciatica
 - M54.5 Low back pain
 - Includes Loin pain, Lumbago NOS
 - M54.6 Pain in thoracic spine
 - M54.8 Other dorsalgia
 - **M54.9 Dorsalgia, unspecified**



Clinical Examples – Documentation Improvement

Gout Classifications include:

- Acute
 - Idiopathic
 - Lead-induced
 - Drug-induced
 - Due to renal impairment
 - Other or unspecified
 - 6th character for site
- Chronic
 - Idiopathic
 - Lead-induced
 - Drug-induced
 - Due to renal impairment
 - Other or unspecified
 - 6th character for site; 7th character for with or without tophus

Osteoarthritis

- ICD-10-CM classifies osteoarthritis by the following:
 - Generalized
 - Post-traumatic
 - Primary
 - Secondary
 - Site
- Documentation must state the specific type or code will be for unspecified

Osteoarthritis

Patient presents with osteoarthritis of the left knee. History and physical states that patient is admitted for a total knee replacement for osteoarthritis of the knee.



Osteoarthritis – Documentation Improvement

- Without specification of the type of osteoarthritis, the scenario codes to:
 - M17.9 – Osteoarthritis of knee, unspecified
- If the documentation stated “post-traumatic osteoarthritis of the left knee”, scenario codes to:
 - M17.32 – Unilateral post-traumatic osteoarthritis, left knee

Sprains– Documentation Improvement

- If documentation specified that the metatarsophalangeal joint of the left great toe was sprained, scenario would code as:
 - S93.522A – Sprain of metatarsophalangeal joint of left great toe, initial episode of care

Sprain Diagnoses

- In ICD-10, as in ICD-9, when coding strains and sprains the specified type of muscle, ligament or tendon injured should be documented for coding to the highest level of specificity.



Sprains and Strains

- Ankle
 - Calcaneofibular
 - Deltoid
 - Tibiofibular
 - Other/unspecified
- Toe
 - Interphalangeal joint
 - Metatarsophalangeal joint
 - Unspecified
- Foot
 - Tarsal ligament
 - Tarsometatarsal ligament



Clinical Examples – Documentation Improvement

Osteoporosis M80

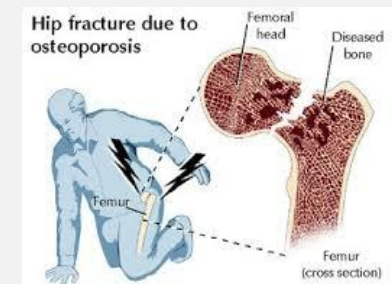
- In ICD10, osteoporosis is further delineated as:

Osteoporosis *without* pathological fracture -

Patients with osteoporosis who do not currently have a pathologic fracture due to the osteoporosis, even if they have had a fracture in the past.

Osteoporosis *with* current pathological fracture -

Patients who have a current pathologic fracture at the time of the encounter. The codes under M80 identify the site of the fracture.



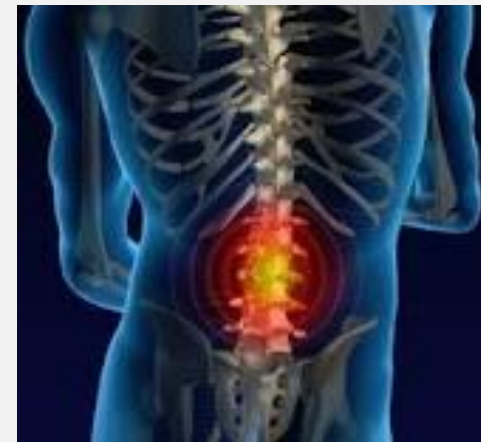
M81.0	Age related osteoporosis without current pathological fracture
M80.052	Age related osteoporosis without current pathological fracture, left femur
M80.032	Age related osteoporosis without current pathological fracture, left forearm



Clinical Examples – Documentation Improvement

Other osteopathies

- To properly classify other osteopathies in ICD-10-CM, physicians must specify the following about the condition:
 - Osteomyelitis
 - Acute hematogenous
 - Other acute
 - Subacute
 - Chronic multifocal
 - Chronic with draining sinus
 - Other chronic hematogenous





Clinical Examples – Documentation Improvement

Biomechanical lesions

To properly classify biomechanical lesions in ICD-10-CM, *physicians must specify the site and laterality, as well as:*

- Segmental and somatic dysfunction
- Subluxation complex (vertebral)
- Subluxation stenosis neural canal
- Connective tissue and disc stenosis of intervertebral foramina
- Other/unspecified biomechanical lesions

Biomechanical lesions, NEC is a new classification for ICD-10-CM with no corresponding ICD-9-CM classifications.



Pain in Limb ICD-10

- Pain in limb, hand, foot, fingers and toes
 - Pain in limb, unspecified
 - Pain in upper arm
 - Pain in forearm
 - Pain in hand and fingers
 - Pain in thigh
 - Pain in lower leg
 - Pain in foot and toes

Pain in Limb ICD-10

- Pain in limb, hand, foot, fingers and toes
 - Pain in hand and fingers
 - right hand
 - left hand
 - unspecified hand
 - right finger(s)
 - left finger(s)
 - unspecified finger(s)

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

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.

ICD-10 Orthopedic Procedure Documentation Examples





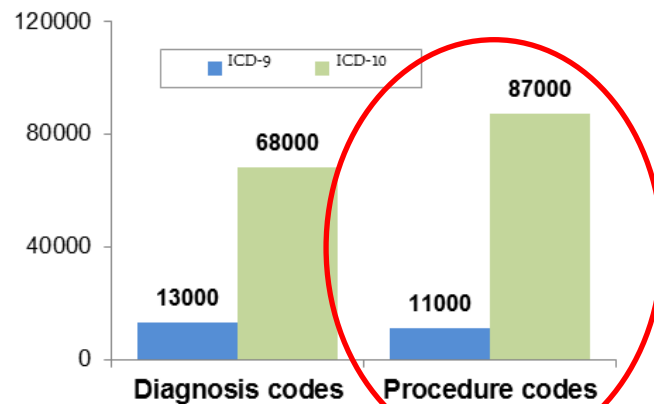
Overview of ICD-10-PCS

- PCS stands for **Procedure Classification System**.
- It is a multi-axial 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**.



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



Overview of ICD-10-PCS Classification System

Section	0 Medical and Surgical		
Body System	Q Lower Bones		
Operation	S Reposition: Moving to its normal location, or other suitable location, all or a portion of a body part		
<i>Body Part</i>	<i>Approach</i>	<i>Device</i>	<i>Qualifier</i>
6 Upper Femur, Right 7 Upper Femur, Left 8 Femoral Shaft, Right 9 Femoral Shaft, Left B Lower Femur, Right C Lower Femur, Left G Tibia, Right H Tibia, Left J Fibula, Right K Fibula, Left	0 Open 3 Percutaneous 4 Percutaneous Endoscopic	4 Internal Fixation Device 5 External Fixation Device 6 Internal Fixation Device, Intramedullary B External Fixation Device, Monoplanar C External Fixation Device, Ring D External Fixation Device, Hybrid Z No Device	Z No Qualifier

EXAMPLE - ORIF RT femur; fracture reduction = "repositioning"; procedure code is 0QS606Z



Overview of ICD-10-PCS Classification System

Section	O Medical and Surgical		
Body System	S Lower Joints		
Operation	R Replacement: Putting in or on biological or synthetic material that physically takes the place and/or function of all or a portion of a body part		
Body Part	Approach	Device	Qualifier
9 Hip Joint, Right B Hip Joint, Left	0 Open	1 Synthetic Substitute, Metal 2 Synthetic Substitute, Metal on Polyethylene 3 Synthetic Substitute, Ceramic 4 Synthetic Substitute, Ceramic on Polyethylene J Synthetic Substitute	9 Cemented A Uncemented Z No Qualifier
9 Hip Joint, Right B Hip Joint, Left	0 Open	7 Autologous Tissue Substitute K Nonautologous Tissue Substitute	Z No Qualifier
A Hip Joint, Acetabular Surface, Right E Hip Joint, Acetabular Surface, Left	0 Open	0 Synthetic Substitute, Polyethylene 1 Synthetic Substitute, Metal 3 Synthetic Substitute, Ceramic J Synthetic Substitute	9 Cemented A Uncemented Z No Qualifier
A Hip Joint, Acetabular Surface, Right E Hip Joint, Acetabular Surface, Left	0 Open	7 Autologous Tissue Substitute K Nonautologous Tissue Substitute	Z No Qualifier

EXAMPLE – Rt. THR with metal on polyethylene cemented – code is OSR9029

Joint Replacements

- Procedures require documentation of:
 - Specific joint
 - Right or left
 - Material used
 - Metal
 - Metal on polyethylene
 - Ceramic
 - Ceramic on polyethylene

Joint Replacements

- Cemented or uncemented
- Surface in some cases
 - Acetabular
 - Femoral or tibial
- Code examples
 - ICD-9 – 81.51 – total hip replacement, 00.76 – ceramic on ceramic
 - ICD-10-PCS – 0SR9039 – replacement, hip joint right, open, synthetic substitute, ceramic, cemented

ICD-10-PCS Joint Replacement

Patient presents for replacement of right shoulder

ICD-10-PCS

0RRJ0J6

- Replacement of Right Shoulder Joint with Synthetic Substitute, Humeral Surface, Open Approach



ICD-10-PCS Table

Section	Medical and Surgical	Approach	Device	Qualifier
Body System	Upper Joints			
Operation	Replacement: Putting in or on biological or synthetic material that physically takes the place and/or function of all or a portion of a body part			
0 Occipital-cervical Joint 1 Cervical Vertebral Joint 3 Cervical Vertebral Disc 4 Cervicothoracic Vertebral Joint 5 Cervicothoracic Vertebral Disc 6 Thoracic Vertebral Joint 9 Thoracic Vertebral Disc A Thoracolumbar Vertebral Joint B Thoracolumbar Vertebral Disc C Temporomandibular Joint, Right D Temporomandibular Joint, Left E Sternoclavicular Joint, Right F Sternoclavicular Joint, Left G Acromioclavicular Joint, Right H Acromioclavicular Joint, Left L Elbow Joint, Right M Elbow Joint, Left N Wrist Joint, Right P Wrist Joint, Left Q Carpal Joint, Right R Carpal Joint, Left S Metacarpocarpal Joint, Right T Metacarpocarpal Joint, Left U Metacarpophalangeal Joint, Right V Metacarpophalangeal Joint, Left W Finger Phalangeal Joint, Right X Finger Phalangeal Joint, Left	0 Open	7 Autologous Tissue Substitute J Synthetic Substitute K Nonautologous Tissue Substitute	Z No Qualifier	
J Shoulder Joint, Right K Shoulder Joint, Left	0 Open	0 Synthetic Substitute, Reverse Ball and Socket 7 Autologous Tissue Substitute K Nonautologous Tissue Substitute	Z No Qualifier	
J Shoulder Joint, Right K Shoulder Joint, Left	0 Open	J Synthetic Substitute	6 Humeral Surface 7 Glenoid Surface Z No Qualifier	

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

ICD-10-PCS Amputation

Patient presents for amputation of toe

ICD-10-PCS

0Y6U0Z1

- Detachment at Left 3rd Toe, High, Open Approach



ICD-10-PCS Table

Section	0 Medical and Surgical	Y Anatomical Regions, Lower Extremities	6 Detachment: Cutting off all or a portion of the upper or lower extremities
Body System			
Operation			
Body Part	Approach	Device	Qualifier
2 Hindquarter, Right 3 Hindquarter, Left 4 Hindquarter, Bilateral 7 Femoral Region, Right 8 Femoral Region, Left F Knee Region, Right G Knee Region, Left	0 Open	Z No Device	Z No Qualifier
C Upper Leg, Right D Upper Leg, Left H Lower Leg, Right J Lower Leg, Left	0 Open	Z No Device	1 High 2 Mid 3 Low
M Foot, Right N Foot, Left	0 Open	Z No Device	0 Complete 4 Complete 1st Ray 5 Complete 2nd Ray 6 Complete 3rd Ray 7 Complete 4th Ray 8 Complete 5th Ray 9 Partial 1st Ray B Partial 2nd Ray C Partial 3rd Ray D Partial 4th Ray F Partial 5th Ray
P 1st Toe, Right Q 1st Toe, Left R 2nd Toe, Right S 2nd Toe, Left T 3rd Toe, Right U 3rd Toe, Left V 4th Toe, Right W 4th Toe, Left X 5th Toe, Right Y 5th Toe, Left	0 Open	Z No Device	0 Complete 1 High 2 Mid 3 Low

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.

ICD-10-PCS Drainage

Patient presents for diagnostic arthrocentesis of right elbow joint

ICD-10-PCS

0R9L3ZX

- Drainage of Right Elbow Joint, Percutaneous Approach, Diagnostic



ICD-10-PCS Table

Section	0 Medical and Surgical			
Body System	R Upper Joints			
Operation	9 Drainage: Taking or letting out fluids and/or gases from a body part			
	Body Part	Approach	Device	Qualifier
0 Occipital-cervical Joint				
1 Cervical Vertebral Joint				
3 Cervical Vertebral Disc				
4 Cervicothoracic Vertebral Joint				
5 Cervicothoracic Vertebral Disc				
6 Thoracic Vertebral Joint				
9 Thoracic Vertebral Disc				
A Thoracolumbar Vertebral Joint				
B Thoracolumbar Vertebral Disc				
C Temporomandibular Joint, Right				
D Temporomandibular Joint, Left				
E Sternoclavicular Joint, Right				
F Sternoclavicular Joint, Left				
G Acromioclavicular Joint, Right				
H Acromioclavicular Joint, Left				
J Shoulder Joint, Right				
K Shoulder Joint, Left				
L Elbow Joint, Right				
M Elbow Joint, Left				
N Wrist Joint, Right				
P Wrist Joint, Left				
Q Carpal Joint, Right				
R Carpal Joint, Left				
S Metacarpocarpal Joint, Right				
T Metacarpocarpal Joint, Left				
U Metacarpophalangeal Joint, Right				
V Metacarpophalangeal Joint, Left				
W Finger Phalangeal Joint, Right				
X Finger Phalangeal Joint, Left				

<p>0 Open</p> <p>3 Percutaneous</p> <p>4 Percutaneous Endoscopic</p>	<p>Z No Device</p>	<p>X Diagnostic</p> <p>Z No Qualifier</p>
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Debridements

- Procedures require documentation of:
 - Excisional vs. Nonexcisional
 - Level of tissue debrided:
 - Skin
 - Subcutaneous tissue and fascia
 - Soft tissue
 - Muscle
 - Exact body part
 - Laterality of the procedure

Excisional Debridement of Skin Example

Section **0** Medical and Surgical
Body System **H** Skin and Breast
Operation **B** Excision: Cutting out or off, without replacement, a portion of a body part

Body Part	Approach	Device	Qualifier
0 Skin, Scalp 1 Skin, Face 2 Skin, Right Ear 3 Skin, Left Ear 4 Skin, Neck 5 Skin, Chest 6 Skin, Back 7 Skin, Abdomen 8 Skin, Buttock 9 Skin, Perineum A Skin, Genitalia B Skin, Right Upper Arm C Skin, Left Upper Arm D Skin, Right Lower Arm E Skin, Left Lower Arm F Skin, Right Hand G Skin, Left Hand H Skin, Right Upper Leg J Skin, Left Upper Leg K Skin, Right Lower Leg L Skin, Left Lower Leg	<p style="text-align: center;"> Debridements: Excisional = Excision Non-excisional = Extraction </p> <p style="text-align: center;"> Qualifier: Diagnostic = Biopsy No Qualifier = Therapeutic </p>	<p style="text-align: center;">Z No Device</p>	<p style="text-align: center;"> X Diagnostic Z No Qualifier </p>

X External

Biopsy = Diagnostic

Excisional debridement of an ulcer of the skin of the right hip (upper leg) is classified to procedure code 0HBHXZZ (procedure performed for therapeutic reasons).

Lumbar Vertebral Fusion Practice Exercise Answer

Section **0** Medical and Surgical
Body System **S** Lower Joints
Operation **G** 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>
0 Lumbar Vertebral Joint 1 Lumbar Vertebral Joints, 2 or more 3 Lumbosacral Joint	0 Open 3 Percutaneous 4 Percutaneous Endoscopic	7 Autologous Tissue Substitute A Interbody Fusion Device J Synthetic Substitute K Nonautologous Tissue Substitute Z No Device	0 Anterior Approach, Anterior Column 1 Posterior Approach, Posterior Column J Posterior Approach, Anterior Column
5 Sacrococcygeal Joint 6 Coccygeal Joint 7 Sacroiliac Joint, Right 8 Sacroiliac Joint, Left	0 Open 3 Percutaneous 4 Percutaneous Endoscopic	4 Internal Fixation Device 7 Autologous Tissue Substitute J Synthetic Substitute K Nonautologous Tissue Substitute Z No Device	Z No Qualifier

Posterior Column lumbar fusion of multiple joints with an interbody fusion device, posterior approach is classified to code OSG10A1.

Vertebral Fusions

- Fusions are classified to fusion;
 - lower joints=below diaphragm;
 - upper joints=above diaphragm.
- Internal devices utilized to accomplish fusion can be found in the body of the operative report along with the posterior/anterior approach for correct qualifier.

Knee Arthroscopy Example

Section **0** Medical and Surgical
Body System **S** Lower Joints
Operation **J** Inspection: Visually and/or manually exploring a body part

Body Part	Approach	Device	Qualifier
0 Lumbar Vertebral Joint 2 Lumbar Vertebral Disc 3 Lumbosacral Joint 4 Lumbosacral Disc 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 F Ankle Joint, Right G Ankle Joint, Left	0 Open 3 Percutaneous 4 Percutaneous Endoscopic X External	Z No Device	Z No Qualifier

0SJC4ZZ is a right knee arthroscopy code as it is assumed in this case to be a percutaneous endoscopic procedure.



Reimagine Healthcare.

Physician Queries



Query...why?

A query is a communication tool used to clarify documentation in the health record for accurate code assignment.



The desired outcome from a query is an update of a health record to better reflect a practitioner's intent and clinical thought processes, documented in a manner that supports accurate code assignment.

Article citation: AHIMA. "Guidelines for Achieving a Compliant Query Practice." Journal of AHIMA 84

Query... answer how?

Queries are generated to elicit more information from the Provider.

- A response is ***necessary*** from the provider to fulfill this process.



- ***A signature alone on a generated query does not fulfill this requirement.***

Query... answer how?

Queries are generated in various formats depending on the information being requested:

- *Written response* format
 - Requesting provider to freehand a response
- *Multiple Choice* format
 - Requesting provider select one of the offered responses



Please sign, date and time Queries!

Query... answer how?

- A Physician response, “**see notes**” does not fulfill the request generated by the query.
- The coder has already reviewed the notes and Medical Record Documentation
- ***Although the response may seem “obvious,” coders are “reporters” of the medical record and cannot code a diagnosis that is not documented by the Provider.***



Summary

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



Questions?

