



ICD-10 for Urology

UConn Health



Just himagine what we can accomplish together.

Introduction

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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**
 - Discuss **the importance behind the query writing process and Physician response.**

ICD-10 Resources: USA.GOV

ICD-10 Resources: CMS.GOV

<http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html>



- **About ICD-10**
- The transition to ICD-10 is required for everyone covered by the [Health Insurance Portability Accountability Act \(HIPAA\)](#). Please note, the change to ICD-10 does not affect CPT coding for outpatient procedures and physician services.
- **Road to 10: CMS Online Tool for Small Practices**
- **Jumpstart your ICD-10 transition with [Road to 10](#), an online resource built with input from providers in small practices.**
- **“Road to 10” includes specialty references and helps providers build ICD-10 action plans tailored for their practice needs.**
- **CMS Resources**
- Check out the updated [CMS ICD-10 Resources Flyer](#).
- Access three new **Medscape Education resources** that **provide guidance around the transition to ICD-10**. [Continuing medical education \(CME\)](#) and [nursing continuing education \(CE\)](#) credits are available to health care professionals who complete the learning modules. Anyone can earn a certificate of completion. If you are a first-time visitor to Medscape, you will need to create a free account to access these resources.
 - Video: [ICD-10: Getting From Here to There -- Navigating the Road Ahead](#)
 - Video: [ICD-10 and Clinical Documentation](#)
 - Expert Column: [Preparing for ICD-10: Now Is the Time](#)
- View the [ICD-10 Introduction](#) fact sheet.
- Find official resources designed to help [providers](#), [payers](#), [vendors](#), and [non-covered entities](#) with the transition to ICD-10.



Road to ICD-10

- ICD (International Classification of Diseases) System created by WHO in 1893 as worldwide standard for classifying deaths.
- Implemented worldwide with modifications by country to fit their needs.
- ICD-9 in use in the United States since 1979. ICD-10 published in 1992.
- Most recent country to implement ICD-10, Canada from 2001-2005.
- Difference in U.S., ICD used for multiple purposes besides classification.



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

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**



Consequences of Inadequate Documentation

Inappropriate
Payment for
Submitted
Claims

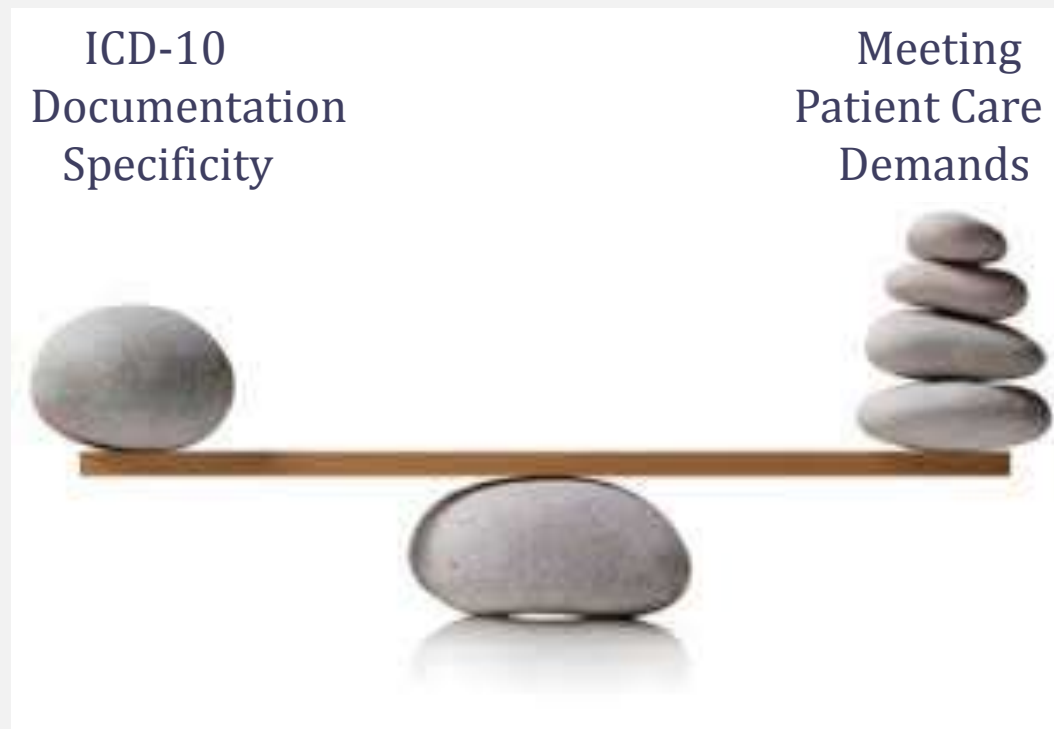
Claim Denials

Increased Risk
of Government
Audit,
Repayment
and Fines

Structural Differences in ICD-9 and ICD-10

- **ICD-10 has 2 parts compared to 3 volumes of ICD-9:**
 - ICD-10-CM (Clinical Modification) - Diagnoses
 - ICD-10-PCS (Procedure Coding System) – Inpatient Procedures ONLY
- **ICD-10-CM is 7 alphanumeric characters vs 5 for ICD-9:**
 - Allows better description of acuity, complexity and location of medical conditions markedly increasing specificity, but similar premise to ICD-9-CM Volumes 1 and 2
- **ICD-10-PCS developed by CMS to replace Volume 3 of ICD-9-CM:**
 - Markedly different structure and approach compared to ICD-9

IT'S A DELICATE BALANCE!



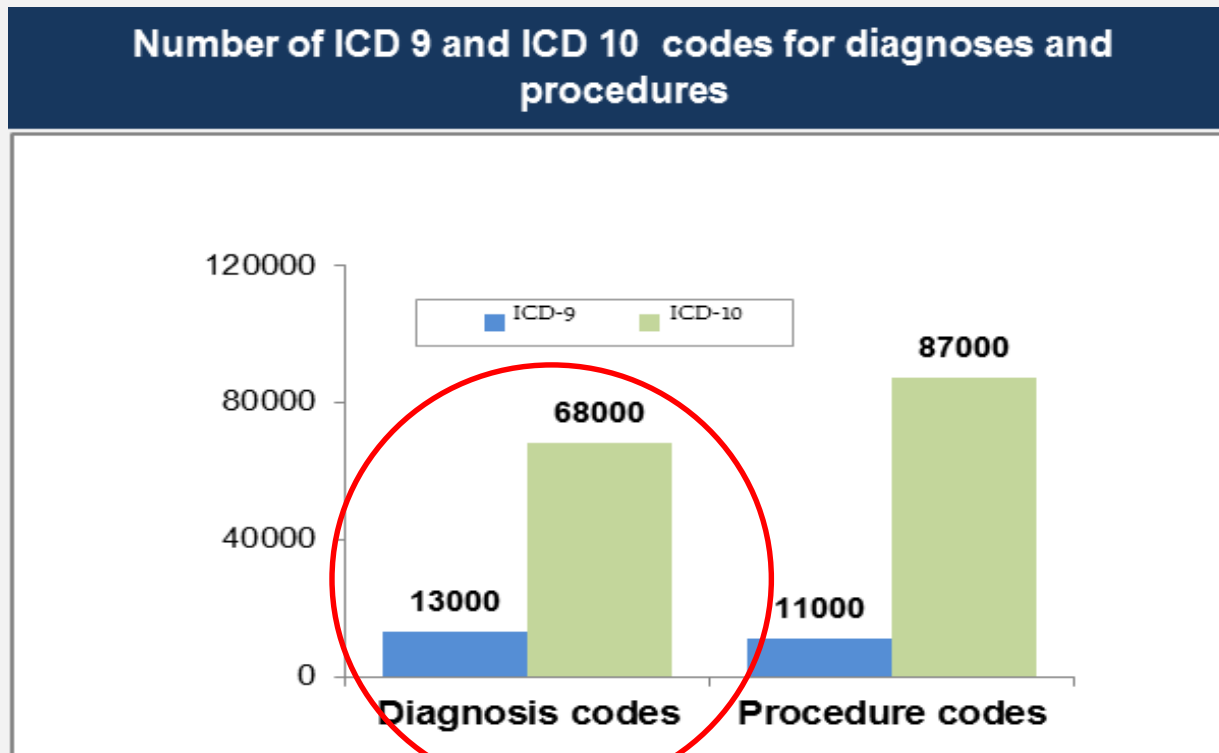


The ICD-10 and CPT Connection

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



Increased Number of Codes



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



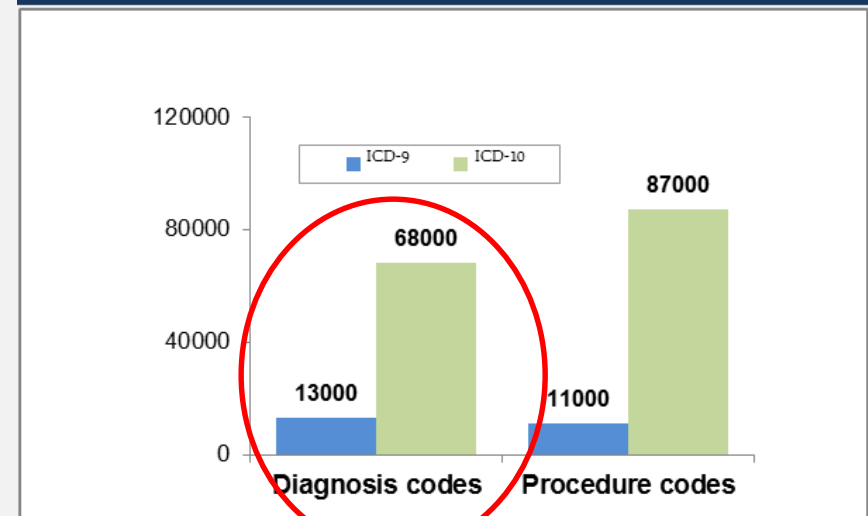
Changes to Diagnosis Codes

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

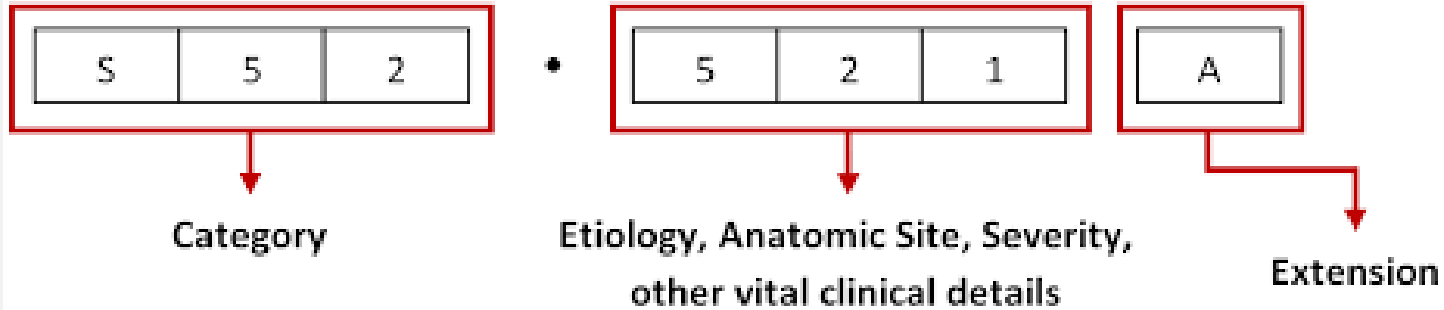
Number of ICD 9 and ICD 10 codes for diagnoses and procedures



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



Structure of ICD-10 codes



Think “Dummy Code”
Problem List diagnosis:

“Migraine”= G43

Adds detail as clinical picture
becomes clearer.

“Headache”= C34.090

For Injuries and Fractures:

- Initial, Subsequent, Sequela
- Open, Closed, Nonunion, etc. for fractures

-Pregnancies



Code Breakdown by ICD-10 Chapter

# of Codes	Description	# of Codes	Description	# of Codes	Description
1,056	Infectious and Parasitic Diseases	642	Diseases of Ear and Mastoid Process	2,155	Pregnancy, Childbirth & the Puerperium
1,620	Neoplasms	1,254	Diseases of Circulatory System	417	Certain Perinatal Conditions
238	Blood and Immune System Diseases	336	Diseases of Respiratory System	790	Congenital malform., Chromosomal Abnl.
675	Endocrine, Nutritional, Metabolic Diseases	706	Diseases of Digestive System	639	Symptoms, Signs, Abnl Clinical & Lab Findings
724	Mental, Neurodevel., Behavioral Disorders	769	Diseases of Skin and Subcutaneous Tissue	39,869	Injury, Poisonings, Other External Causes
591	Disease of the Nervous System	6,339	Musculoskeletal and Connective Tissue Dz	6,812	External Causes of Morbidity
2,452	Diseases of the Eye and Adnexa	591	Diseases of Genitourinary System	1,178	Factors influencing health and care

Documentation for Diagnoses

Requirements for Detailed Documentation for Diagnoses	
Acuity	Acute, chronic or both
Specific site	Left Ureter
Laterality	Right, left, bilateral
Specific type of condition	Acute blood loss anemia, type 2 diabetes with hyperglycemia
Etiology of diagnosis	Chest pain due to gastroesophageal reflux, anxiety due to alcohol abuse
Link must be established between manifestations and underlying diseases	Hypertension due to cardiovascular disease, vascular insufficiency secondary to diabetic PVD
Complications of care	Intraoperative, postoperative, mechanical malfunctions, infections
Degree of severity	Mild, moderate, severe, e.g., malnutrition: mild, moderate, severe

Documentation for Diagnoses

Requirements for Detailed Documentation for Diagnoses

Stages (I, II, III, IV)	Stage IV decubitus ulcer
Injury details	Place of occurrence, activity causing the injury
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)
Cerebral and myocardial infarctions	Site and artery specificity
Non-pressure skin ulcers	Site, laterality and depth of tissue involvement



Reimagine Healthcare.

Diagnosis Documentation Examples



Clinical Example: 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.



Documentation Requirements

To properly classify **urethral stricture** in ICD-10-CM, physicians must specify the type.

- **Post-traumatic urethral stricture**
- Male
- Meatal
- Bulbous urethral stricture
- Membranous urethral stricture
- Anterior urethral stricture
- Unspecified
- Female
- Due to childbirth
- Other
- **Postinfective/postprocedural urethral stricture, NEC**

Combination codes

- Combination codes exist to identify the presence of an infection without without hematuria
 - N30.00 Acute cystitis without hematuria
 - N30.01 Acute cystitis with hematuria
 - N30.20 Other Chronic cystitis without hematuria
 - N30.21 Other Chronic cystitis with hematuria
- Identify infectious agent with cystitis

Urinary Tract Infection ICD-9

- 599 Other disorders of urethra and urinary tract
 - 599.0 Urinary tract infection, site not specified
 - Use additional code to identify organism, such as E. coli

Urinary Tract Infection ICD-10

Other diseases of the urinary system (N30-N39)

- N30 Cystitis
 - N30.0 Acute cystitis
 - N30.1 Interstitial cystitis (chronic)
 - N30.2 Other chronic cystitis
 - N30.3 Trigonitis
 - N30.4 Irradiation cystitis
 - N30.8 Other cystitis
 - N30.9 Cystitis, unspecified
 - N30.90 without hematuria
 - N30.91 with hematuria
- N39 Other disorders of urinary system
 - **N39.0 Urinary tract infection, site not specified**
 - Use additional codes (B95-B97), to identify infectious agent

Dysuria ICD-9

- 788 Symptoms involving urinary system
 - 788.0 Renal colic
 - **788.1 Dysuria**
 - 788.2 Retention of urine
 - 788.3 Urinary incontinence
 - 788.4 Frequency of urination and polyuria
 - 788.5 Oliguria and anuria
 - 788.6 Other abnormality of urination
 - 788.7 Urethral discharge
 - 788.8 Extravasation of urine
 - 788.9 Other symptoms involving urinary system

Dysuria ICD-10

- R30 Pain associated with micturition
 - **R30.0 Dysuria**
 - R30.1 Vesical tenesmus (feeling of incomplete emptying after unination)
 - R30.2 Painful micturition, unspecified
- **[Painful micturition (dysuria, oliguria)].**
- [Article in German]
- [Hochreiter W.](#)
- **Source**
- Urologische Universitätsklinik, Inselspital, Bern.
- **Abstract**
- Painful micturition is one of the most common symptoms of urological diseases. The term "dysuria" is descriptive for micturition which the patient perceives as unpleasant.



Cushing Syndrome

Diagnosis Code Comparisons

ICD-9-CM Diagnosis

2550	Cushing's syndrome
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ICD-10-CM Translation Options

E240	Pituitary-dependent Cushing's disease
E242	Drug-induced Cushing's syndrome
E243	Ectopic ACTH syndrome
E244	Alcohol-induced pseudo-Cushing's syndrome
E248	Other Cushing's syndrome
E249	Cushing's syndrome, unspecified

ICD-9 Malignant neoplasm of prostate

- **2015 ICD-9-CM Diagnosis Code 185**
- **Clinical Information**
- A primary or metastatic malignant tumor involving the prostate gland. The vast majority are carcinomas
- The prostate is the gland below a man's bladder that produces fluid for semen. Prostate cancer is common among older men. It is rare in men younger than 40. Risk factors for developing prostate cancer include being over 65 years of age, family history, being african-american, and some genetic changes. symptoms of prostate cancer may include
- Problems passing urine, such as pain, difficulty starting or stopping the stream, or dribbling
- Low back pain

ICD-10 Malignant neoplasm of prostate

- ICD-9-CM 185 converts directly to:2015 [ICD-10-CM C61](#) Malignant neoplasm of prostate.
- **C61** is a billable ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes.

ICD-10 Malignant neoplasm of prostate

- **Documentation Improvement**
- **ICD-10-CM C61** Malignant neoplasm of prostate
- Acuity, Specific site, Specific details of condition, Etiology of diagnosis, Injury details, Severity, Link must be established between manifestations and underlying diseases, Degree of Severity.
- **Clinical Information**
- A primary or metastatic malignant tumor involving the prostate gland. The vast majority are carcinomas.
- The prostate is the gland below a man's bladder that produces fluid for semen. Prostate cancer is common among older men.
- It is rare in men younger than 40. Risk factors for developing prostate cancer include being over 65 years of age, family history, being african-american, and some genetic changes. Symptoms of prostate cancer may include
 - problems passing urine, such as pain, difficulty starting or stopping the stream, or dribbling
 - low back pain



ICD-9 Elevated prostate specific antigen [PSA]

- 2015 ICD-9-CM Diagnosis Code **790.93**
- ICD-9-CM **790.93** is a billable medical code that can be used to specify a diagnosis on a reimbursement claim.



ICD-10 Elevated prostate specific antigen [PSA]

- ICD-9-CM 790.93 converts directly to:2015 [ICD-10-CM R97.2](#) Elevated prostate specific antigen [PSA].

ICD-10 Elevated prostate specific antigen [PSA]

- Documentation Improvement
- ICD-10-CM R97.2 Elevated prostate specific antigen [PSA]
- Acuity, Specific site, Specific details of condition, Etiology of diagnosis, Injury details, Severity, Link must be established between manifestations and underlying diseases, Degree of Severity.
- Adult Only Dx (15-124 years), Male Only Dx
Questionable As Admission Dx.

ICD-9 Urinary frequency

- 2015 ICD-9-CM Diagnosis Code **788.41**
- ICD-9-CM **788.41** is a billable medical code that can be used to specify a diagnosis on a reimbursement claim.

ICD-10 Frequency of micturition

- ICD-9-CM **788.41** converts directly to:2015 [ICD-10-CM R35.0](#) Frequency of micturition.
- **R35.0** is a billable ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes.

ICD-10 Frequency of micturition

- **Documentation Improvement**
- **ICD-10-CM R35.0** Frequency of micturition.
- Acuity, Specific site, Specific details of condition, Etiology of diagnosis, Link must be established between manifestations and underlying diseases, Degree of Severity.
- **Clinical Information**
- A disorder characterized by urination at short intervals.
- Urination at short intervals; it may result from increased urine formation, decreased bladder capacity, or lower urinary tract irritation.

ICD-9 Urge incontinence

- 2015 ICD-9-CM Diagnosis Code **788.31**
- ICD-9-CM **788.31** is a billable medical code that can be used to specify a diagnosis on a reimbursement claim.

ICD-10 Urge incontinence

- ICD-9-CM 788.31 converts directly to:2015 [ICD-10-CM N39.41](#) Urge incontinence.
- **N39.41** is a billable ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes.
-

ICD-10 Urge incontinence

- **Documentation Improvement**
- [ICD-10-CM N39.41](#) Urge incontinence.
- Acuity, Specific site, Specific details of condition, Etiology of diagnosis, Link must be established between manifestations and underlying diseases, Degree of Severity.

- **Clinical Information**
- Involuntary discharge of urine that is associated with an abrupt and strong desire to void. It is usually related to the involuntary contractions of the detrusor muscle of the bladder (detrusor hyperreflexia or detrusor instability).
- Involuntary passage of urine following a sense of urgency to void.
- Involuntary passage of urine occurring soon after a strong sense of urgency to void.

Long-term Use of Medications ICD-9

- V58.6 Long-term (current) drug use
 - V58.61 anticoagulants
 - V58.62 antibiotics
 - V58.63 antiplatelets/antithrombotics
 - V58.64 NSAID
 - V58.65 steroids
 - V58.66 aspirin
 - V58.67 insulin
 - V58.69 other medications

Long-term Use of Medications ICD-10

Z79 Long-term (L/T) (current) drug therapy

Z79.0 Long term use of anticoagulants and antithrombotics/antiplatelets

Z79.01 – Anticoagulants

Z79.02 – Antithrombotics/antiplatelets

Z79.1 – non-steroidal anti-inflammatories

Z79.2 – antibiotics

Z79.3 – hormonal contraceptives

Z79.4 – insulin

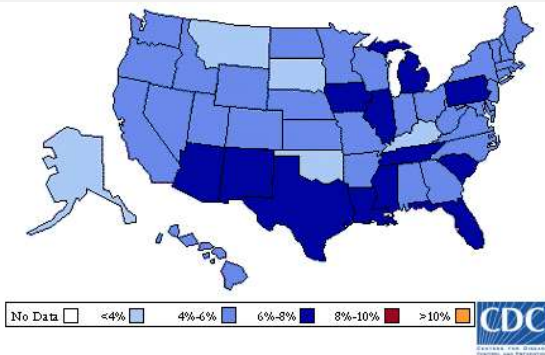
Z79.5 – steroids

Z79.51 – inhaled steroids

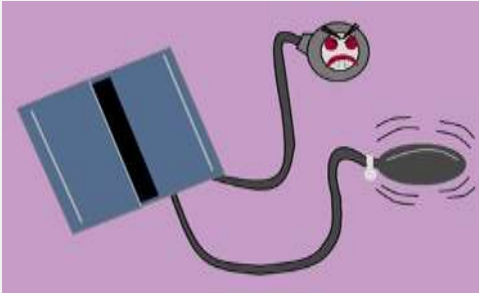
Z79.52 – systemic steroids



Diabetes Mellitus



- **New in ICD-10-CM**
- The diabetes mellitus codes are combination codes that include the type of diabetes mellitus, the body system affected, and the complications affecting that body system.
- When documenting diabetes, include the following:
 - **Type:** e.g. Type 1 or Type 2 disease, drug or chemical induced, due to underlying condition, gestational
 - **Control:** out of control, inadequately controlled and controlled are no longer used in ICD-10-CM
 - **Complications:** What (if any) other body systems are affected by the diabetes condition? e.g. Foot ulcer related to diabetes mellitus
 - **Treatment:** Is the patient on insulin?



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

- Documentation has been simplified to Essential (Primary) Hypertension
 - No longer use malignant, systolic, accelerated, etc.
 - As with diabetes, document associated heart or kidney disease
- Examples:
 - I10 Essential hypertension
 - I12 Hypertensive heart disease
 - I12 Hypertensive chronic kidney disease
 - I13 Hypertensive heart and kidney diseaseAdditional specificity by indicating with or without heart failure and stage of kidney disease
- If Secondary Hypertension, document cause

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

- New concept in ICD-10 that can be used to document patient compliance with medications
- Identify condition being treated, medication, and why they are not taking it as prescribed
- May be Intentional OR Unintentional
 - Financial hardship
 - Other reasons
 - Age-related debility
 - Other reasons

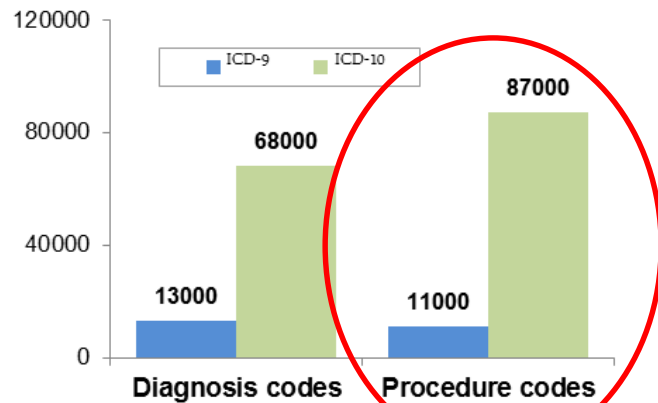
Procedure Documentation Examples





Changes to Procedure Codes

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

Overview of ICD-10-PCS

- PCS stands for ***Procedure Classification System***
- Only used for **Inpatient Procedures**
- 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

- Procedures require documentation of:
 - Specific anatomical location
 - Right or left kidney
 - Right or left ureter
 - Approach
 - Open
 - Percutaneous
 - Percutaneous endoscopic
 - External (Cystoscopy)
 - Type of device
 - Intraluminal (stent)

ICD-10-PCS Resection

Patient presents for resection of right kidney pelvis

ICD-10-PCS

0TT38ZZ

- Resection of Right Kidney Pelvis, Via Natural or Artificial Opening, Endoscopic



ICD-10-PCS Table

<i>Section</i>	0 Medical and Surgical		
<i>Body System</i>	T Urinary System		
<i>Operation</i>	T Resection: Cutting out or off, without replacement, all of a body part		
<i>Body Part</i>	<i>Approach</i>	<i>Device</i>	<i>Qualifier</i>
0 Kidney, Right 1 Kidney, Left 2 Kidneys, Bilateral	0 Open 4 Percutaneous Endoscopic	Z No Device	Z No Qualifier
3 Kidney Pelvis, Right 4 Kidney Pelvis, Left 6 Ureter, Right 7 Ureter, Left B Bladder C Bladder Neck D Urethra	0 Open 4 Percutaneous Endoscopic 7 Via Natural or Artificial Opening 8 Via Natural or Artificial Opening Endoscopic	Z No Device	Z No Qualifier

ICD-10-PCS Resection

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	T	T	3	8	Z	Z

The ICD-10-PCS code structure tells a story

ICD-10-PCS Destruction

Patient presents for destruction of left ureter
ICD-10-PCS
0T578ZZ

- Destruction of Left Ureter, Via Natural or Artificial Opening Endoscopic



ICD-10-PCS Table

Section 0 Medical and Surgical Body System T Urinary System Operation 5 Destruction: Physical eradication of all or a portion of a body part by the direct use of energy, force, or a destructive agent			
Body Part	Approach	Device	Qualifier
0 Kidney, Right 1 Kidney, Left 3 Kidney Pelvis, Right 4 Kidney Pelvis, Left 6 Ureter, Right 7 Ureter, Left B Bladder C Bladder Neck	0 Open 3 Percutaneous 4 Percutaneous Endoscopic 7 Via Natural or Artificial Opening 8 Via Natural or Artificial Opening Endoscopic	Z No Device	Z No Qualifier
D Urethra	0 Open 3 Percutaneous 4 Percutaneous Endoscopic 7 Via Natural or Artificial Opening 8 Via Natural or Artificial Opening Endoscopic X External	Z No Device	Z No Qualifier

ICD-10-PCS Destruction

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	T	5	7	8	Z	Z

The ICD-10-PCS code structure tells a story

ICD-10-PCS Dilation

Patient presents for Dilation of ureter's and stent placement

ICD-10-PCS
0T788DZ

- Dilation of Bilateral Ureters with Intraluminal Device, Via Natural or Artificial Opening Endoscopic



ICD-10-PCS Table

Section	0 Medical and Surgical		
Body System	T Urinary System		
Operation	7 Dilation: Expanding an orifice or the lumen of a tubular body part		
Body Part	Approach	Device	Qualifier
3 Kidney Pelvis, Right 4 Kidney Pelvis, Left 6 Ureter, Right 7 Ureter, Left 8 Ureters, Bilateral B Bladder C Bladder Neck D Urethra	0 Open 3 Percutaneous 4 Percutaneous Endoscopic 7 Via Natural or Artificial Opening 8 Via Natural or Artificial Opening Endoscopic	D Intraluminal Device Z No Device	Z No Qualifier

ICD-10-PCS Dilation

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	T	7	7	8	D	Z

The ICD-10-PCS code structure tells a story



Ureteroneocystostomy

ICD-9 CM

- Type of procedure performed

ICD-10 PCS

- Type of procedure performed
- Approach used
 - Open
 - Percutaneous
 - Percutaneous endoscopic
- Side of the body on which procedure is performed
 - Left
 - Right
 - Bilateral
- Type of device used
 - Autologous
 - Synthetic
 - Non-autologous
- Bypass organ destination



Ureteroneocystostomy

<i>Section</i>	0	Medical and Surgical
<i>Body System</i>	T	Urinary System
<i>Operation</i>	1	Bypass: Altering the route of passage of the contents of a tubular body part

<i>Body Part</i>	<i>Approach</i>	<i>Device</i>	<i>Qualifier</i>
3 Kidney Pelvis, Right 4 Kidney Pelvis, Left	0 Open 4 Percutaneous Endoscopic	7 Autologous Tissue Substitute J Synthetic Substitute K Nonautologous Tissue Substitute Z No Device	3 Kidney Pelvis, Right 4 Kidney Pelvis, Left 6 Ureter, Right 7 Ureter, Left 8 Colon 9 Colocutaneous A Ileum B Bladder C Ileocutaneous D Cutaneous
3 Kidney Pelvis, Right 4 Kidney Pelvis, Left	3 Percutaneous	J Synthetic Substitute	D Cutaneous
6 Ureter, Right 7 Ureter, Left 8 Ureters, Bilateral	0 Open 4 Percutaneous Endoscopic	7 Autologous Tissue Substitute J Synthetic Substitute K Nonautologous Tissue Substitute Z No Device	6 Ureter, Right 7 Ureter, Left 8 Colon 9 Colocutaneous A Ileum B Bladder

Ureterneocystostomy of the left ureter to bladder via open incision with no device is 0T170ZB.



Ureteroneocystostomy

<i>Section</i>	0 Medical and Surgical		
<i>Body System</i>	T Urinary System		
<i>Operation</i>	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>
0 Kidney, Right 1 Kidney, Left 2 Kidneys, Bilateral 3 Kidney Pelvis, Right 4 Kidney Pelvis, Left 6 Ureter, Right 7 Ureter, Left 8 Ureters, Bilateral B Bladder C Bladder Neck D Urethra	0 Open 4 Percutaneous Endoscopic	Z No Device	Z No Qualifier

If the reflux is caused by a congenital malposition of the ureter to the bladder and it is repositioned in the same bladder to the correct position, the classification for this procedure would be 0TS70ZZ.



Cystoscopy

Section	0 Medical and Surgical		
Body System	T Urinary System		
Operation	J Inspection: Visually and/or manually exploring a body part		
Body Part	Approach	Device	Qualifier
5 Kidney	0 Open	Z No Device	Z No Qualifier
9 Ureter	3 Percutaneous		
B Bladder	4 Percutaneous Endoscopic		
D Urethra	7 Via Natural or Artificial Opening		
	8 Via Natural or Artificial Opening Endoscopic		
	X External		

Cystoscopy of bladder is 0TJB8ZZ. If the procedure is expanded further to the ureters, then ureter would be delineated as the correct body part as the distal most organ examined is the body part used in these procedures.



Section	0 Medical and Surgical
Body System	T Urinary System
Operation	B Excision: Cutting out or off, without replacement, a portion of a body part

Body Part	Approach	Device	Qualifier
0 Kidney, Right 1 Kidney, Left 3 Kidney Pelvis, Right 4 Kidney Pelvis, Left 6 Ureter, Right 7 Ureter, Left B Bladder C Bladder Neck	0 Open 3 Percutaneous 4 Percutaneous Endoscopic 7 Via Natural or Artificial Opening 8 Via Natural or Artificial Opening Endoscopic	Z No Device	Biopsy = Diagnostic X Diagnostic Z No Qualifier
D Urethra	0 Open 3 Percutaneous 4 Percutaneous Endoscopic 7 Via Natural or Artificial Opening 8 Via Natural or Artificial Opening Endoscopic X External	Z No Device	Excision for therapeutic purpose = Z - No qualifier X Diagnostic Z No Qualifier

If a biopsy or excision of lesion is performed during the cystoscopy, the procedure is classified as an excision. The code for biopsy of bladder via cystoscopy is 0TBB8ZX; if lesion is excised, code is 0TBB8ZZ

Calculus Removal: ICD-9 vs. ICD-10

ICD-9 CM

- Type of procedure performed

ICD-10 PCS

- Type of procedure performed
- Side of the urinary system on which procedure is performed
 - Left
 - Right
- Approach
 - Open
 - Percutaneous
 - Percutaneous endoscopic
 - Via natural or artificial opening
 - Via natural or artificial opening endoscopic



<i>Section</i>	0 Medical and Surgical		
<i>Body System</i>	T Urinary System		
<i>Operation</i>	C Extirpation: Taking or cutting out solid matter from a body part		
<i>Body Part</i>	<i>Approach</i>	<i>Device</i>	<i>Qualifier</i>
0 Kidney, Right 1 Kidney, Left 3 Kidney Pelvis, Right 4 Kidney Pelvis, Left 6 Ureter, Right 7 Ureter, Left B Bladder C Bladder Neck	0 Open 3 Percutaneous 4 Percutaneous Endoscopic 7 Via Natural or Artificial Opening 8 Via Natural or Artificial Opening Endoscopic	Z No Device	Z No Qualifier
D Urethra	0 Open 3 Percutaneous 4 Percutaneous Endoscopic 7 Via Natural or Artificial Opening 8 Via Natural or Artificial Opening Endoscopic X External	Z No Device	Z No Qualifier

Code for calculus removal from right ureter via endoscopic basket approach is 0TC68ZZ.



Fragmentation: ICD-9 vs. ICD-10

ICD-9 CM

- Method of fragmentation
 - ESWL
 - Ultrasound or other lithotripsy

ICD-10 PCS

- Type of procedure performed
 - Calculus Fragmentation?
 - Calculus Removal?
- Method of fragmentation or removal
- Side of urinary system on which procedure is performed
- Approach
 - Open
 - Percutaneous
 - Percutaneous endoscopic
 - Via natural or artificial opening
 - Via natural or artificial opening endoscopic
 - External



Fragmentation of Urinary Stone

Section	0 Medical and Surgical
Body System	T Urinary System
Operation	F Fragmentation: Breaking solid matter in a body part into pieces

Body Part	Approach	Device	Qualifier
3 Kidney Pelvis, Right	0 Open	Z No Device	Z No Qualifier
4 Kidney Pelvis, Left	3 Percutaneous		
6 Ureter, Right	4 Percutaneous Endoscopic		
7 Ureter, Left	7 Via Natural or Artificial Opening		
B Bladder	8 Via Natural or Artificial Opening Endoscopic		
C Bladder Neck	X External		
D Urethra			

Fragmentation of a urinary stone involves only fragmentation without removal

- Endoscopic fragmentation of urinary stone via lithotripsy in the right ureter is coded **0TF68ZZ**.
- If procedure is done via extracorporeal shockwave lithotripsy (ESWL) it is coded **0TF6XZZ** for the external approach.
- If the stone or its fragments are removed, procedure is coded extirpation so documentation of fragmentation vs. removal will be important for the accurate classification of the procedure

Kidney Transplant: ICD-9 vs. ICD-10

ICD-9 CM

- Type of procedure performed

ICD-10 PCS

- Type of procedure performed
- Approach
 - Open
- Laterality of kidney transplanted
- Type of transplant
 - Allogeneic (another person)
 - Synogeneic (genetically identical persons)
 - Zooplastic (animal organ transplant)



Kidney Transplant Documentation Requirement Example

<i>Section</i>	0 Medical and Surgical		
<i>Body System</i>	T Urinary System		
<i>Operation</i>	Y Transplantation: Putting in or on all or a portion of a living body part taken from another individual or animal to physically take the place and/or function of all or a portion of a similar body part		
<i>Body Part</i>	<i>Approach</i>	<i>Device</i>	<i>Qualifier</i>
0 Kidney, Right 1 Kidney, Left	0 Open	Z No Device	0 Allogeneic 1 Syngeneic 2 Zooplastic



Orchiopexy

<i>Section</i>	0 Medical and Surgical		
<i>Body System</i>	V Male Reproductive System		
<i>Operation</i>	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>
9 Testis, Right B Testis, Left C Testes, Bilateral F Spermatic Cord, Right G Spermatic Cord, Left H Spermatic Cords, Bilateral	0 Open 3 Percutaneous 4 Percutaneous Endoscopic	Z No Device	Z No Qualifier

- In ICD-10-PCS, Orchiopexy is classified to a repositioning – moving testis from current (abnormal) location to correct location.
- Requires documentation of laterality (right/left/bilateral) and Approach (open, percutaneous or percutaneous endoscopic)



Prostatectomy Documentation Requirement

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

Body Part	Approach	Device	Qualifier
0 Prostate	0 Open 3 Percutaneous 4 Percutaneous Endoscopic 7 Via Natural or Artificial Opening 8 Via Natural or Artificial Opening Endoscopic	Z No Device	X Diagnostic Z No Qualifier

Excision=Partial Removal

Biopsy = Diagnostic

Excision for therapeutic purpose = Z - No qualifier

Section **0** Medical and Surgical
Body System **V** Male Reproductive System
Operation **T** Resection: Cutting out or off, without replacement, all of a body part

Body Part	Approach	Device	Qualifier
0 Prostate	4 Percutaneous Endoscopic 7 Via Natural or Artificial Opening 8 Via Natural or Artificial Opening Endoscopic	Z No Device	Z No Qualifier

Resection=Total Removal



<i>Section</i>	0 Medical and Surgical		
<i>Body System</i>	T Urinary System		
<i>Operation</i>	7 Dilation: Expanding an orifice or the lumen of a tubular body part		
<i>Body Part</i>	<i>Approach</i>	<i>Device</i>	<i>Qualifier</i>
3 Kidney Pelvis, Right 4 Kidney Pelvis, Left 6 Ureter, Right 7 Ureter, Left 8 Ureters, Bilateral B Bladder C Bladder Neck D Urethra	0 Open 3 Percutaneous 4 Percutaneous Endoscopic 7 Via Natural or Artificial Opening 8 Via Natural or Artificial Opening Endoscopic	D Intraluminal Device Z No Device	Z No Qualifier

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...when?

A query is written when the Health record Documentation:

- **Is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent**
- Describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis
- Includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure
- Provides a diagnosis without underlying clinical validation
- Is unclear for present on admission indicator assignment

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

Query...when?

“A proper query process ensures that appropriate documentation appears in the health record”



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?

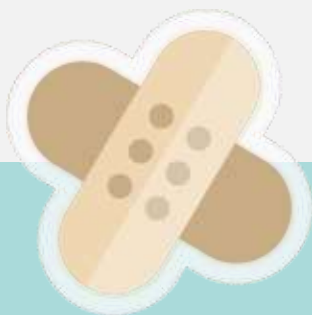
A Physician response, 'see notes' does not fulfill the request generated by the query.

- The coder has already reviewed the notes and Medical Record Documentation
- *Although the response may seem 'obvious' coders are only '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
- The classification systems allow for greater specificity, resulting in:
 - Comprehensive data for research
 - Development of standards for evidence-based medicine
 - Public health programs
 - Reimbursement for services rendered
 - Identification of accurate severity of illness



Questions?

