ICD-10 Updates
Laura L. Little, RHIT, CCS, CPC, CASCC
AHIMA Approved ICD10 Trainer
HES, Sr. Coding Educator
OBJECTIVES

- Review Coding Changes during 2016
- Review *Proposed* ICD-10-CM FY2017 changes
- Review FY2017 ICD-10-PCS Changes
Reminders

- **ICD-10-CM**
  
  *International Classification of Diseases, Tenth Revision, Clinical Modification*; consists of diagnosis codes
  
  - Applies to Everyone

- **ICD-10-PCS**
  
  *International Classification of Diseases, Tenth Revision, Procedure Coding System*; consists of procedure codes
  
  - Only for Hospital Inpatients

- CPT still owns the world! 😊
Coding Hierarchy

I. Index
II. Tabular
III. Coding Guidelines
IV. Coding Clinic
V. Coding Handbook
“Other Diagnoses”

UHDDS #11 B defines “Other Diagnoses” as “all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.”

**General Rule**

For reporting purposes the definition for “other diagnoses” is interpreted as additional conditions that affect patient care in terms of requiring the following:

- Clinical evaluation; or
- Therapeutic treatment; or
- Diagnostic procedures; or
- Extended length of hospital stay; or
- Increased nursing care and/or monitoring; or
- Has implications for future health care needs.
Coding Clinic Surprises
First Quarter ICD-10 2016
Ask the Editor

They won’t publish your name... 😊
The Central Office on ICD-10-CM and ICD-10-PCS has received numerous requests to advise users how past issues of AHA Coding Clinic for ICD-9-CM are to be utilized in the ICD-10 environment.

In general, clinical information and information on documentation best practices published in Coding Clinic were not unique to ICD-9-CM, and remain applicable for ICD-10-CM with some caveats. For example, Coding Clinic may still be useful to understand clinical clues when applying the guideline regarding not coding separately signs or symptoms that are integral to a condition. Users may continue to use that information, as clues—not clinical criteria.

As far as previously published advice on documentation is concerned, documentation issues would generally not be unique to ICD-9-CM, and so long as there is nothing new published in Coding Clinic for ICD-10-CM and ICD-10-PCS to replace it, the advice would stand.

Previously published ICD-9-CM advice that is still relevant and applicable to ICD-10 will continue to be re-published in Coding Clinic for ICD-10-CM/PCS. As with the application of any of the coding advice published in Coding Clinic, the information needs to be reviewed carefully for similarities and differences on a case by case basis. Care must be exercised as the codes may have changed. Such change could be related to new codes, new combination codes, code revisions, a change in nonessential modifiers, or any other instructional note. This is particularly true as ICD-10-CM has many new combination codes that were not available in ICD-9-CM. For example, previous Coding Clinic for ICD-9-CM advice has indicated that hypoxia is not inherent in chronic obstructive pulmonary disease (COPD) and it could be separately coded. Coders should not assume this advice inevitably applies to ICD-10-CM. The correct approach when coding with ICD-10-CM is to review the index entries for COPD, and determine whether or not there is a combination code for COPD with hypoxia, verify the code in the Tabular List, and review any instructional notes. The coder should then determine whether to code the hypoxia separately—and not automatically assume that a separate code should be assigned.

In order to simplify the learning process, when the Cooperating Parties developed the ICD-10-CM guidelines, every attempt was made to remain as consistent with the ICD-9-CM guidelines as possible, unless there was a change inherent to the ICD-10-CM classification. If a particular guideline has remained exactly the same in both coding systems, and Coding Clinic for ICD-9-CM has published an example of the application of that guideline, it’s more than likely that the interpretation would be similar.
Heart Failure with Preserved Ejection Fraction and Heart Failure with Reduced Ejection Fraction
Coding Clinic, First Quarter ICD-10 2016
Pages: 10-11 Effective with discharges: March 18, 2016

Question:

Please reconsider the advice previously published in Coding Clinic, First Quarter 2014, page 25, stating that the coder cannot assume either diastolic or systolic failure or a combination of both, based on documentation of heart failure with preserved ejection fraction (HFpEF) or heart failure with reduced ejection fraction (HFrEF). Would it be appropriate to code diastolic or systolic heart failure when the provider documents HFpEF or HFrEF?

Answer:

Based on additional information received from the American College of Cardiology (ACC), the Editorial Advisory Board for Coding Clinic for ICD-10-CM/PCS has reconsidered previously published advice about coding heart failure with preserved ejection fraction (HFpEF), and heart failure with reduced ejection fraction (HFrEF). HFpEF may also be referred to as heart failure with preserved systolic function, and this condition may also be referred to as diastolic heart failure. HFrEF may also be called heart failure with low ejection fraction, or heart failure with reduced systolic function, or other similar terms meaning systolic heart failure. These terms HFpEF and HFrEF are more contemporary terms that are being more frequently used, and can be further described as acute or chronic.

Therefore, when the provider has documented HFpEF, HFrEF, or other similar terms noted above, the coder may interpret these as “diastolic heart failure” or “systolic heart failure,” respectively, or a combination of both if indicated, and assign the appropriate ICD-10-CM codes.
Diabetes Mellitus with Associated Conditions
Coding Clinic, First Quarter ICD-10 2016 Pages: 11-12
Effective with discharges: March 18, 2016

Question:

- The ICD-10-CM Alphabetic Index entry for 'Diabetes with' includes listings for conditions associated with diabetes, which was not the case in ICD-9-CM. Does the provider need to document a relationship between the two conditions or should the coder assume a causal relationship?

Answer:

- According to the ICD-10-CM Official Guidelines for Coding and Reporting, the term "with" means "associated with" or "due to," when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List, and this is how it's meant to be interpreted when assigning codes for diabetes with associated manifestations and/or conditions. The classification assumes a cause-and-effect relationship between diabetes and certain diseases of the kidneys, nerves, and circulatory system. Assumed cause-and-effect relationships in the classification are not necessarily the same in ICD-9-CM and ICD-10-CM.

- However, if the physician documentation specifies diabetes mellitus is not the underlying cause of the other condition, the condition should not be coded as a diabetic complication. When the coder is unable to determine whether a condition is related to diabetes mellitus, or the ICD-10-CM classification does not provide coding instruction, it is appropriate to query the physician for clarification so that the appropriate codes may be reported. (See ICD-10-CM Official Guidelines for Coding and Reporting, Section I.A.15.)

- In addition, the following advice published in Coding Clinic, Third Quarter 2012, page 3, also applies to ICD-10-CM:

  - "It is not required that two conditions be listed together in the health record. However, the provider needs to document the linkage, except for situations where the classification assumes an association (e.g., hypertension with chronic kidney involvement). When the provider establishes a linkage or relationship between the two conditions, they should be coded as such. However, the entire record should be reviewed to determine whether a relationship between the two conditions exists. The fact that a patient has two conditions that commonly occur together does not necessarily mean they are related. A different cause may be documented by the provider. If it is not clear whether or not two conditions are related, query the provider."
Diabetic with Foot Ulcer
Coding Clinic, First Quarter ICD-10 2016 Pages: 12-13
Effective with discharges: March 18, 2016

Question:

A patient, who is a type 2 diabetic, is admitted with a chronically infected ulcer of the left mid-foot. The provider documented, "Diabetic foot ulcer with skin breakdown, positive for Methicillin resistant Staphylococcus aureus (MRSA) infection." She also had been diagnosed with polyneuropathy, end-stage renal disease (ESRD), on hemodialysis maintenance. Does the ICD-10-CM assume a cause-and-effect relationship between the diabetes mellitus, the foot ulcer, polyneuropathy and ESRD? How should this case be coded?

Answer:

ICD-10-CM assumes a causal relationship between the diabetes mellitus and the foot ulcer, the polyneuropathy, as well as the chronic kidney disease. Assign code E11.621, Type 2 diabetes mellitus with foot ulcer, as the principal diagnosis. Codes L97.421, Non-pressure chronic ulcer of left heel and midfoot limited to breakdown of skin; E11.42, Type 2 diabetes mellitus with diabetic polyneuropathy; B95.62, Methicillin resistant Staphylococcus aureus infection as the cause of disease classified elsewhere; E11.22, Type 2 diabetes mellitus with diabetic chronic kidney disease; N18.6, End stage renal disease; and Z99.2, Dependence on renal dialysis, should be assigned as additional diagnoses.
ICD-10-CM DKA Coding

Question:

What is the correct code assignment for type 2 diabetes mellitus with diabetic ketoacidosis?

Answer:

Assign code E13.10, Other specified diabetes mellitus with ketoacidosis without coma, for a patient with type 2 diabetes with ketoacidosis. Given the less than perfect limited choices, it was felt that it would be clinically important to identify the fact that the patient has ketoacidosis. The National Center for Health Statistics (NCHS), who has oversight for volumes I and II of ICD-10-CM, has agreed to consider a future ICD-10-CM Coordination and Maintenance Committee meeting proposal.
A patient with anemia and melena underwent esophagogastroduodenoscopy (EGD) with brush biopsy. An area of white plaque in the midesophagus was brushed to rule out candida. Extraction appears to be the appropriate root operation, and describes the brush biopsy procedure because tissue was not cut out. What is the procedure code assignment for endoscopic brush biopsy of the esophagus?

The ICD-10-PCS does not provide the "Extraction" root operation value for biopsies except for biopsy of bone marrow. The root operation "Excision" is the closest available equivalent. Assign the following ICD-10-PCS code:

- **0DB28ZX**  Excision of middle esophagus, via natural or artificial opening endoscopic, diagnostic, for the endoscopic brush biopsy of the mid-esophagus

A brush biopsy is obtained by manipulating tiny brushes against a lesion or tissue to gain a sample of cells. Although excision, the cutting out/off without replacement a portion of a body part, is not clearly described during brush biopsy, the codes for excision report the fact that tissue from the esophagus was obtained for examination.
ICD-10 Coordination and Maintenance Committee Updates
ICD Coordination and Maintenance Committee

- Forum for proposals to update ICD
  - National Center for Health Statistics (NCHS)
  - Centers for Medicare and Medicaid Services (CMS)
  - Committee meets bi-yearly

- Responsibility for maintenance divided:
  - ICD (Diagnoses): NCHS
  - ICD (Procedures): CMS
ICD-10 Coordination and Maintenance Committee Meeting March 9-10, 2016

To see the complete documentation on the code proposals discussed at the meeting use the following links under the Coordination and Maintenance committee:

For the ICD-10-PCS proposals go to the CMS website:

For the ICD-10-CM proposals go to the CDC website:
http://www.cdc.gov/nchs/icd/icd9cm_maintenance.htm
Proposed ICD-10-CM Codes

Effective 10.1.16

“Your blood sugar is high, but your salt, pepper, ketchup, mustard and grated cheese levels are fine.”
Where are my new Codes?

1. Table 1A-1E: This excel spreadsheet contains the proposed FY 2017 Operating and Capital National Standardized Amounts.

2. FY 2017 Proposed Rule Tables 2 and 3 (Wage Index Tables): Table 2- Proposed Case-Mix Index and Wage Index Table by CMS Certification Number (CCN); Table 3- Proposed Wage Index Table by CBSA.

3. Table 5: List of Proposed MS-DRGs, Relative Weighting Factors and Geometric and Arithmetic Mean Length of Stay

4. 6A-6M.1 and Tables 6P.1a-6P.4K: Table 6A-New Diagnosis Codes; Table 6B-New Procedure Codes; Table 6C-Invalid Diagnosis Codes; Table 6G.1- Proposed Secondary Diagnosis Order Additions to the CC Exclusions List; Table 6G.2- Proposed Principal Diagnosis Order Additions to the CC Exclusions List; Table 6H.1- Proposed Secondary Diagnosis Order Deletions to the CC Exclusions List; Table 6H.2- Proposed Principal Diagnosis Order Deletions to the CC Exclusions List; Table 6I- Proposed Complete Major CC List; Table 6J- Proposed Complete Major CC List; Table 6J.1- Proposed Additions to Major CC List; Table 6J.2- Proposed Deletions to Major CC List; Table 6L-Proposed Principal Diagnosis Is Its Own MCC LIST; Table 6M-Proposed Principal Diagnosis Is Its Own CC LIST; Table 6M.1-Proposed Additions to the Principal Diagnosis Is Its Own CC LIST; Tables 6P.1a-6P.4k (ICD-10-PCS Code Translations for MS-DRG Changes): See summary tab in excel spreadsheet called "CMS-1655-P TABLE 6P ICD-10-CM and ICD-10-PCS Codes for MCE and MS-DRG Changes.xlsx" for complete description of all tables.

5. Tables 7A and 7B: Tables 7A and 7B contain the number of discharges, and selected percentile lengths of stay for both MS-DRGs, version 33 and MS-DRGs, version 34

6. Tables 8A, 8B, and 8C: Tables 8A and 8B contain the proposed FY 2017 IPPS operating and capital statewide average cost-to-charge-ratios. Table 8C contains the proposed FY 2017 LTCH statewide average cost-to-charge-ratios.

7. Table 10: Contains the proposed cost thresholds by MS-DRG for the cost criteria for new technology add on payment applications for applications for FY 2018.

8. Table 14: List of Hospitals with Fewer than 1,600 Medicare Discharges Based on the December 2015 Update of the FY 2015 MedPAR File and Potentially Eligible Hospitals’ Proposed FY 2017 Low-Volume Hospital Payment Adjustment. (Eligibility for the low-volume hospital payment adjustment is also dependent upon meeting the mileage criteria specified at § 412.101(b)(2)(ii) of the regulations.)

9. Table 15: Proposed FY 2017 Proxy Readmissions Adjustment Factors

10. Table 16: Proposed Proxy Hospital Inpatient Value-Based Purchasing (VBP) Program Adjustment Factors for FY 2017

11. Table 18: Proposed FY 2017 Medicare DSH Uncompensated Care Payment Factor 3 and Projected DSH Eligibility

Just how many are we talking about?
by Chapter...

1. Infection - None
2. Neoplasms - 11
4. Endocrine - 264
5. Mental - 13
6. Nervous - 20
7. Eye - 92
8. Ear - 12
9. Circulatory - 78
10. Respiratory - 4
11. Digestive - 83
12. Skin - 4
13. Musculoskeletal - 152
14. Genitourinary - 60
15. OB - 67
16. Perinatal - 2
17. Congenital Malformations - 20
18. Symptoms - 79
19. Injuries - 879
20. External Causes - 22
21. Z-Codes - 36

1900 TOTAL CODES
Chapter 2 - Neoplasms (C00-D49)

11 New Codes, 1 Deleted code
Neoplasms

NEW

- **C49.A0** Gastrointestinal stromal tumor, unspecified site (CC)
- **C49.A1** Gastrointestinal stromal tumor of esophagus (CC)
- **C49.A2** Gastrointestinal stromal tumor of stomach (CC)
- **C49.A3** Gastrointestinal stromal tumor of small intestine (CC)
- **C49.A4** Gastrointestinal stromal tumor of large intestine (CC)
- **C49.A5** Gastrointestinal stromal tumor of rectum (CC)
- **C49.A9** Gastrointestinal stromal tumor of other sites (CC)
- **D49.511** Neoplasm of unspecified behavior of right kidney
- **D49.512** Neoplasm of unspecified behavior of left kidney
- **D49.519** Neoplasm of unspecified behavior of unspecified kidney
- **D49.59** Neoplasm unspecified behavior of other genitourinary organ

DELETED

- **D49.5** Neoplasm of unspecified behavior of other genitourinary organ
Chapter 3 - Diseases of the Blood & Blood Forming Organs & Certain Disorders Involving the Immune Mechanism (D50-D89)

13 New Codes, 0 Deleted codes
Spleen Complications

- D78.31 Postprocedural hematoma of the spleen following a procedure on the spleen (cc)
- D78.32 Postprocedural hematoma of the spleen following other procedure (CC)

- No Deleted Codes
Chapter 4 - Endocrine, Nutritional and Metabolic Diseases (E00-E89)

264 New Codes, 41 Deleted codes
SEE CMS SPREADSHEET
Chapter 5 - Mental, Behavioral and Developmental Disorders (F01-F99)

13 New Codes, 15 Deleted codes
Mental Menstruation?

- F32.81 Premenstrual dysphoric disorder
- F32.89 Other specified depressive episodes
- F34.81 Disruptive mood dysregulation disorder (CC)
- F34.89 Other specified persistent mood disorders (CC)
- F42.2 Mixed obsessional thoughts and acts
- F42.3 Hoarding disorder
- F42.4 Excoriation (skin-picking) disorder
- F42.8 Other obsessive compulsive disorder
- F42.9 Obsessive-compulsive disorder, unspecified
- F50.81 Binge eating disorder
- F50.89 Other specified eating disorder
- F64.0 Transsexualism
- F80.82 Social pragmatic communication disorder
DELETED CODES

- F32.8 Other depressive episodes
- F34.8 Other persistent mood [affective] disorders
- F42 Obsessive-compulsive disorder
- F50.8 Other eating disorders
Chapter 6 - Diseases of the Nervous System (G00-G99)

20 New Codes, 0 Deleted codes
Neuro procedural complications

- G97.61 Postprocedural hematoma of a nervous system organ or structure following a nervous system procedure (CC)
- G97.62 Postprocedural hematoma of a nervous system organ or structure following other procedure (CC)
G56.03  Carpal tunnel syndrome, bilateral upper limbs
G56.13  Other lesions of median nerve, bilateral upper limbs
G56.23  Lesion of ulnar nerve, bilateral upper limbs
G56.33  Lesion of radial nerve, bilateral upper limbs
G56.43  Causalgia of bilateral upper limbs
G56.83  Other specified mononeuropathies of bilateral upper limbs
G56.93  Unspecified mononeuropathy of bilateral upper limbs
- G57.03  Lesion of sciatic nerve, bilateral lower limbs
- G57.13  Meralgia paresthetica, bilateral lower limbs
- G57.23  Lesion of femoral nerve, bilateral lower limbs
- G57.33  Lesion of lateral popliteal nerve, bilateral lower limbs
- G57.43  Lesion of medial popliteal nerve, bilateral lower limbs
- G57.53  Tarsal tunnel syndrome, bilateral lower limbs
- G57.63  Lesion of plantar nerve, bilateral lower limbs
- G57.73  Causalgia of bilateral lower limbs
- G57.83  Other specified mononeuropathies of bilateral lower limbs
- G57.93  Unspecified mononeuropathy of bilateral lower limbs
- G61.82  Multifocal motor neuropathy
Chapter 7 - Diseases of the Eye & Adnexa (H00-H59)

92 New Codes, 15 Deleted codes
SEE CMS SPREADSHEET
Chapter 8 - Diseases of the Ear & Mastoid Process (H60-H95)

12 New Codes, 0 Deleted codes
Do you hear what I hear?

- **H90.A11**  Conductive hearing loss, unilateral, right ear with restricted hearing on the contralateral side
- **H90.A12**  Conductive hearing loss, unilateral, left ear with restricted hearing on the contralateral side
- **H90.A21**  Sensorineural hearing loss, unilateral, right ear, with restricted hearing on the contralateral side
- **H90.A22**  Sensorineural hearing loss, unilateral, left ear, with restricted hearing on the contralateral side
- **H90.A31**  Mixed conductive and sensorineural hearing loss, unilateral, right ear with restricted hearing on the contralateral side
- **H90.A32**  Mixed conductive and sensorineural hearing, unilateral, left ear with restricted hearing on the contralateral side
- **H93.A1**  Pulsatile tinnitus, right ear
- **H93.A2**  Pulsatile tinnitus, left ear
- **H93.A3**  Pulsatile tinnitus, bilateral
- **H93.A9**  Pulsatile tinnitus, unspecified ear
- **H95.51**  Postprocedural hematoma of ear & mastoid process following a procedure on the ear & mastoid process
- **H95.52**  Postprocedural hematoma of ear and mastoid process following other procedure
Chapter 9 - Diseases of the Circulatory System (I00-I99)

78 New Codes, 10 Deleted codes
Chapter 10 - Diseases of the Respiratory System (J00-J99)

4 New Codes, 1 Deleted code
Respiratory Changes

New Codes

- J95.860  Postprocedural hematoma of a respiratory system organ or structure following a respiratory system procedure
- J95.861  Postprocedural hematoma of a respiratory system organ or structure following other procedure
- J98.51   Mediastinitis
- J98.59   Other diseases of mediastinum, not elsewhere classified

Deleted Code

- J98.5D  Diseases of mediastinum, not elsewhere classified
Asthma...
SEE CMS SPREADSHEET
Chapter 11 - Diseases of the Digestive System (K00-K95)

83 New Codes, 17 Deleted codes
SEE CMS SPREADSHEET
Chapter 12 - Diseases of the Skin & Subcutaneous Tissue (L00-L99)

4 New Codes, 0 Deleted codes
Skin & SubQ

- L03.213 Periorbital cellulitis
- L76.31 Postprocedural hematoma of skin and subcutaneous tissue following a dermatologic procedure
- L76.32 Postprocedural hematoma of skin and subcutaneous tissue following other procedure
- L98.7 Excessive and redundant skin and subcutaneous tissue

- No Deleted Codes
Chapter 13 - Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)

152 New Codes, 10 Deleted codes
SEE CMS SPREADSHEET
Chapter 14 - Diseases of the Genitourinary System (N00-N99)

60 New Codes, 15 Deleted codes
Chapter 15 - Pregnancy, Childbirth, and the Puerperium (O00-O9A)

67 New Codes, 8 Deleted codes
SEE CMS SPREADSHEET
Chapter 16 - Certain Conditions Originating in the Perinatal Period (P00-P96)

2 New Codes, 0 Deleted codes
Newborn Codes

- P05.09   Newborn light for gestational age, 2500 grams and over
- P05.19   Newborn small for gestational age, other
- None Deleted 😊
Chapter 17 - Congenital Malformations, Deformations & Chromosomal Abnormalities (Q00-Q99)

20 New Codes, 4 Deleted codes
SEE CMS SPREADSHEET
Chapter 18 - Symptoms, Signs and Abnormal Clinical and Laboratory Findings, NEC (R00-R99)

79 New Codes, 9 Deleted codes
SEE CMS SPREADSHEET
Chapter 19 - Injury, Poisoning and Certain Other Consequences of External Causes (S00-T88)

879 New Codes, 123 Deleted codes
SEE CMS SPREADSHEET
Chapter 20 - External Causes of Morbidity (V00-Y99)

22 New Codes, 42 Deleted codes
SEE CMS SPREADSHEET
Chapter 21 - Factors Influencing Health Status and Contact with Health Services (Z00-Z99)

36 New Codes, 5 Deleted codes
FY 2017 ICD-10-PCS
Effective 10.1.2016
ICD-10-PCS FY 2017
Update Summary

Change Summary Table

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ICD-10-PCS Code FY 2017 Totals, By Section

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ICD-10-PCS Changes Highlights

- In the Medical and Surgical section, root operation definitions for the root operations Control and Creation revised
- In the Extracorporeal Therapies section, new root operation Perfusion created
- ICD-10-PCS guidelines revised in response to public comment and internal review
- Code conversion table, new file available for ICD-10-PCS
Annual File Updates - No more

The following files provided in preparation for ICD-10 implementation will no longer be updated annually. The last updated versions of these files are posted with the FY 2016 update.

- ICD-10-PCS Reference Manual PDF
- Development of the ICD-10 Procedure Coding System (ICD-10-PCS) PDF
- ICD-10 Procedure Coding System PowerPoint slides
2017 Official ICD-10-PCS Guidelines

- Guidelines B2.1a, B3.2, B3.4a, B3.6b, B3.6c, B3.7, B3.9, B4.2 and B4.4 revised in response to public comment and Cooperative Parties review.
PCS Guideline B2.1a Body System

**FY2016 General Guidelines**
- The procedure codes in the general anatomical regions body systems should only be used when the procedure is performed on an anatomical region rather than a specific body part (e.g., root operations Control and Detachment, Drainage of a body cavity) or on the rare occasion when no information is available to support assignment of a code to a specific body part.
- *Example:* Control of postoperative hemorrhage is coded to the root operation Control found in the general anatomical regions body systems.

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- *Examples:* Control of postoperative hemorrhage is coded to the root operation Control found in the general anatomical regions body systems. Chest tube drainage of the pleural cavity is coded to the root operation Drainage found in the general anatomical regions body systems. Suture repair of the abdominal wall is coded to the root operation Repair in the general anatomical regions body systems.
PCS Guideline B3.2 Root Operation

FY2016 Multiple Procedures

During the same operative episode, multiple procedures are coded if:

a. The same root operation is performed on different body parts as defined by distinct values of the body part character.

   Examples: Diagnostic excision of liver and pancreas are coded separately.

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

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

c. Multiple root operations with distinct objectives are performed on the same body part.

   Example: Destruction of sigmoid lesion and bypass of sigmoid colon are coded separately.

d. The intended root operation is attempted using one approach, but is converted to a different approach.

   Example: Laparoscopic cholecystectomy converted to an open cholecystectomy is coded as percutaneous endoscopic inspection and open Resection.

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   Examples: Diagnostic excision of liver and pancreas are coded separately.

   Excision of lesion in the ascending colon and excision of lesion in the transverse colon are coded separately.

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

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

   Extraction of multiple toenails are coded separately.

c. Multiple root operations with distinct objectives are performed on the same body part.

   Example: Destruction of sigmoid lesion and bypass of sigmoid colon are coded separately.

d. The intended root operation is attempted using one approach, but is converted to a different approach.

   Example: Laparoscopic cholecystectomy converted to an open cholecystectomy is coded as percutaneous endoscopic inspection and open Resection.
PCS Guideline B3.4a Root Operation

FY2016 Biopsy procedures
- Biopsy procedures are coded using the root operations Excision, Extraction, or Drainage and the qualifier Diagnostic.
- *Examples:* Fine needle aspiration biopsy of lung is coded to the root operation Drainage with the qualifier Diagnostic.
- Biopsy of bone marrow is coded to the root operation Extraction with the qualifier Diagnostic.
- Lymph node sampling for biopsy is coded to the root operation Excision with the qualifier Diagnostic.

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- Biopsy of bone marrow is coded to the root operation Extraction with the qualifier Diagnostic.
- Lymph node sampling for biopsy is coded to the root operation Excision with the qualifier Diagnostic.
Coronary arteries are classified by number of distinct sites treated, rather than number of coronary arteries or anatomic name of a coronary artery (e.g., left anterior descending). Coronary artery bypass procedures are coded differently than other bypass procedures as described in the previous guideline. Rather than identifying the body part bypassed from, the body part identifies the number of coronary artery sites bypassed to, and the qualifier specifies the vessel bypassed from.

Example: Aortocoronary artery bypass of one site on the left anterior descending coronary artery and one site on the obtuse marginal coronary artery is classified in the body part axis of classification as two coronary artery sites and the qualifier specifies the aorta as the body part bypassed from.

Coronary artery bypass procedures are coded differently than other bypass procedures as described in the previous guideline. Rather than identifying the body part bypassed from, the body part identifies the number of coronary arteries bypassed to, and the qualifier specifies the vessel bypassed from.

Example: Aortocoronary artery bypass of the left anterior descending coronary artery and the obtuse marginal coronary artery is classified in the body part axis of classification as two coronary arteries, and the qualifier specifies the aorta as the body part bypassed from.
PCS Guideline B3.6c Root Operation

FY2016 Bypass procedures

- If multiple coronary artery sites are bypassed, a separate procedure is coded for each coronary artery site that uses a different device and/or qualifier.

  Example: Aortocoronary artery bypass and internal mammary coronary artery bypass are coded separately.

FY2017 Bypass procedures

- If multiple coronary arteries are bypassed, a separate procedure is coded for each coronary artery that uses a different device and/or qualifier.

  Example: Aortocoronary artery bypass and internal mammary coronary artery bypass are coded separately.
PCS Guideline B3.7 Root Operation

FY2016 Control vs. more definitive root operations

- The root operation Control is defined as, “Stopping, or attempting to stop, postprocedural bleeding.” If an attempt to stop postprocedural bleeding is initially unsuccessful, and to stop the bleeding requires performing any of the definitive root operations Bypass, Detachment, Excision, Extraction, Reposition, Replacement, or Resection, then that root operation is coded instead of Control.

- Example: Resection of spleen to stop postprocedural bleeding is coded to Resection instead of Control.

FY2017 Control vs. more definitive root operations

- The root operation Control is defined as, “Stopping, or attempting to stop, postprocedural or other acute bleeding.” If an attempt to stop postprocedural or other acute bleeding is initially unsuccessful, and to stop the bleeding requires performing any of the definitive root operations Bypass, Detachment, Excision, Extraction, Reposition, Replacement, or Resection, then that root operation is coded instead of Control.

- Example: Resection of spleen to stop bleeding is coded to Resection instead of Control.
PCS Guideline B3.9 Root Operation

FY2016 Excision for graft

- If an autograft is obtained from a different body part in order to complete the objective of the procedure, a separate procedure is coded.

- *Example:* Coronary bypass with excision of saphenous vein graft, excision of saphenous vein is coded separately.

FY2017 Excision for graft

- If an autograft is obtained from a different procedure site in order to complete the objective of the procedure, a separate procedure is coded.

- *Example:* Coronary bypass with excision of saphenous vein graft, excision of saphenous vein is coded separately.
PCS Guideline B4.2  Body Part

FY2016 Branches of body parts

- Where a specific branch of a body part does not have its own body part value in PCS, the body part is coded to the closest proximal branch that has a specific body part value.

- Example: A procedure performed on the mandibular branch of the trigeminal nerve is coded to the trigeminal nerve body part value.

FY2017 Branches of body parts

- Where a specific branch of a body part does not have its own body part value in PCS, the body part is typically coded to the closest proximal branch that has a specific body part value. In the cardiovascular body systems, if a general body part is available in the correct root operation table, and coding to a proximal branch would require assigning a code in a different body system, the procedure is coded using the general body part value.

- Examples: A procedure performed on the mandibular branch of the trigeminal nerve is coded to the trigeminal nerve body part value.

- Occlusion of the bronchial artery is coded to the body part value Upper Artery in the body system Upper Arteries, and not to the body part value Thoracic Aorta, Descending in the body system Heart and Great Vessels.
PCS Guideline B4.4 Body Part

FY2016  *Coronary arteries*

- The coronary arteries are classified as a single body part that is further *specified by number of sites treated and not by name or number of arteries*. Separate body part values are used to specify the number of sites treated when the same procedure is performed on multiple sites in the coronary arteries.

- *Examples*: Angioplasty of two distinct sites in the left anterior descending coronary artery with placement of two stents is coded as *Dilation of Coronary Arteries, Two Sites, with Intraluminal Device*.

- Angioplasty of two distinct sites in the left anterior descending coronary artery, one with stent placed and one without, is coded separately as *Dilation of Coronary Artery, One Site with Intraluminal Device*, and *Dilation of Coronary Artery, One Site with no device*.

FY2017  *Coronary arteries*

- The coronary arteries are classified as a single body part that is further *specified by number of arteries treated*. One procedure code specifying multiple arteries is used when the same procedure is performed, including the same device and qualifier values.

- *Examples*: Angioplasty of two distinct coronary arteries with placement of two stents is coded as *Dilation of Coronary Artery, Two Arteries with Two Intraluminal Devices*.

- Angioplasty of two distinct coronary arteries, one with stent placed and one without, is coded separately as *Dilation of Coronary Artery, One Artery with Intraluminal Device*, and *Dilation of Coronary Artery, One Artery with no device*. 


Laura L. Little, RHIT, CCS, CPC, CASCC
AHIMA Approved ICD-10-CM/PCS Trainer
Sr. Coding Educator
Healthcare Education Strategies, Inc.
Lauralittle.codingeducator@gmail.com