Transition to ICD 10 PCS – Preparing for October 1, 2015

Irene Mueller, EdD, RHIA

August 14, 2014
10am – 12 Noon Mtn

© 2014 by Irene L. E. Mueller

By attending this workshop, participants will

• Identify the
  • Settings that will require ICD-10-PCS
  • Knowledge that coders will need to apply ICD-10-PCS
  • Key components required for “building” ICD-10-PCS Codes

• Receive
  • ICD-10-PCS Coding Examples and Cases
  • ICD-10-PCS Resources Listing for future use
Book for 2014 Sessions

- Basic 1CD-10-CM/PCS Coding
  - Schraffenberger, Lou Ann
  - AHIMA AC200512
- 3rd Session Readings
  - Chapter 2, pp. 29-50
  - Chapter 13, pp. 238-239
  - Chapters 14, pp. 251-254
  - Chapter 22A, pp. 392-393
  - Chapter 22B, pp. 412-413

ICD-10-PCS Development

- WHO permitted creation of ICD-10-PCS as successor to Vol. 3, ICD-9-CM
- ICD-10-CM does NOT have procedure codes
- CMS issued contract
  - 3M Health Information Systems in 1993
  - Design & develop procedure classification system to replace Volume 3 of ICD-9-CM,
- ONLY used in United States
Development Goals

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completeness</td>
<td>A unique code for each substantially different procedure</td>
</tr>
<tr>
<td>Expandability</td>
<td>Structure should allow easy expansion</td>
</tr>
<tr>
<td>Multiaxial</td>
<td>Should contain independent characters, &amp; an individual axis that maintains its meaning across ranges of codes</td>
</tr>
<tr>
<td>Standardized Terminology</td>
<td>Definitions are well defined, with no multiple meanings, and each term assigned a specific meaning</td>
</tr>
</tbody>
</table>

Other Development Guidelines

- Diagnostic Information NOT Included in Procedure Description
- Explicit Not Otherwise Specified (NOS) Options are NOT Provided
- Limited Use of Not Elsewhere Classified (NEC) Option
- Level of Specificity = Granularity
  - Greater granularity = Deeper level of detail
Control of ICD-10-PCS

- Developed & Maintained by CMS

- Cooperating Parties
  - Same as for ICD-10-CM
  - AHA
  - AHIMA
  - CMS
  - NCHS

ICD-10-PCS

- Replaces Volume 3 of ICD-9-CM
  - INPATIENT Procedures ONLY

- Code structure
  - Multi-axial 7-character
  - Alphanumeric code structure
  - Unique codes for procedures
  - New codes for new procedures
    - Easy to incorporate into system
Components of ICD-10-PCS

- Index (Do NOT have to start here)
  - Used to access Root Operations Tables
    - Detachment, Ring finger 0X6----
- Tables (1st 3 characters at top) 0X6
  - Provide valid values available for code construction
  - 4 columns
  - Varying number of rows
  - Each row gives valid choices for characters 4-7
- List of Codes

ICD-10-PCS Guidelines

- A. Conventions……………………………………1
- B. Medical & Surgical Section
  Guidelines ………………………………4
  - 2. Body System……………………………4
  - 3. Root Operation…………………………5
  - 4. Body Part ………………………………9
  - 5. Approach………………………………12
  - 6. Device…………………………………13
- C. Obstetrics Section Guidelines...14

**Code descriptions**

- Standardized
  - Provide precise and stable definitions
- Do **NOT** include (Smaller Index)
  - Eponyms
  - Common procedure names
  - Acronyms
- Very few codes for multiple procedures

**Coders and Attributes**

- ICD-10-PCS should allow coders to **construct** accurate codes with minimal effort
- Logical, consistent coding process
- Codes are CONSTRUCTED/BUILT
- **Values** (individual letters & numbers) selected in **sequence**
- Placed in 7 spaces (**Characters**) of code

Values in Table become Characters in Code
Standardized Terminology

• Example:
  • Excision = documentation of wide variety of surgical procedures

• In ICD-10-PCS
  • Excision = cutting out or off, without replacement, a portion of a body part
  • ONLY definition for this word in ICD-10-PCS

ICD-10-PCS Definitions

• Character – One of 7 components that comprise an ICD-10-PCS procedure code

• Procedure – Complete specification of seven characters

• Section (1st character) – Defines general type of procedure

• Value – Individual units defined for each character & represented by number OR letter
Possible Values

- 34 values
  - Numbers 0 thru 9
  - Letters A-Z, BUT NOT I and O

- Definition of each character of code
  - Function of its physical position in code

- Same value in different position = Different meaning
  - Ex: Value 0 in 1st character means something different than Value 0 in 2nd character

- Characters 2-7 in each section always same meaning, but maybe NOT same in another

Do NOT try to Memorize!

ICD-10-PCS Sections

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
<th>Sections B-D, F-H are Ancillary Sections</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Medical &amp; Surgical</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Obstetrics</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Placement</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Administration</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Measuring &amp; Monitoring</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Extracorporeal Assistance &amp; Performance</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Extracorporeal Therapies</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Osteopathic</td>
<td></td>
</tr>
</tbody>
</table>

Sections 1-9 are Med/Surg-Related sections

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Other Procedures</td>
</tr>
<tr>
<td>9</td>
<td>Chiropractic</td>
</tr>
<tr>
<td>B</td>
<td>Imaging</td>
</tr>
<tr>
<td>C</td>
<td>Nuclear Medicine</td>
</tr>
<tr>
<td>D</td>
<td>Radiation Oncology</td>
</tr>
<tr>
<td>F</td>
<td>Physical Rehabilitation and Diagnostic Audiology</td>
</tr>
<tr>
<td>G</td>
<td>Mental Health</td>
</tr>
<tr>
<td>H</td>
<td>Substance</td>
</tr>
</tbody>
</table>
Largest section in ICD-10-PCS
About 86% of all codes
Majority of codes used for Inpatient coding
2-7 Characters in this section
Specific to this section
Consistent meanings throughout this section

MED/SURG SECTION

ICD-10-PCS Definitions (Med/Surg)

- **Body System (2nd character)**
  - Defines
    - General physiological system on which procedure performed OR
    - Anatomic region where procedure performed

- **Root Operation/Type (3rd character)**
  - Defines **objective** of procedure

- **Body Part or Region (4th character)**
  - Defines specific anatomical site where procedure performed
ICD-10-PCS Definitions (Med/Surg)

- **Approach (5th character)**
  - Technique used to reach procedure site
- **Device (6th character)**
  - Material or appliance that remains in/on body at end of procedure
- **Qualifier (7th character)**
  - Additional attribute of procedure performed, IF applicable

---

Code Structure in Medical-Surgical Section

<table>
<thead>
<tr>
<th>Character 1 Section</th>
<th>Character 2 Body System</th>
<th>Character 3 Root Operation</th>
<th>Character 4 Body Part</th>
<th>Character 5 Approach</th>
<th>Character 6 Device</th>
<th>Character 7 Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ALL ICD-10-PCS codes are 7 characters long**
Body System Subdivisions
Character 2

- Body Parts
  - Branches or portions of body part that don’t have more specific designation

- Each Section’s Tables include all body parts values for that designated body system

General vs Specific Body Part - Character 3

- General Body part assigned ONLY when documentation does not support more specific code
  - Ex: Liver - Right Lobe, Left Lobe

- When specified Portion of Body Part NOT designated in ICD-10-PCS, use whole body part
  - Ex: Alveolar process of mandible
  - Assign value for Mandible (R or L)
**Peri- Body Part**

- IF a body part with prefix PERI- does not have an assigned value, use value for body part
- Some do, such as pericardium

---

**Body Part Key (Table)**
Arteries, Bones, Glands, Muscles, Veins, etc.

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abductor hallucis muscle</td>
<td>Foot Muscle, Right</td>
</tr>
<tr>
<td></td>
<td>Foot Muscle, Left</td>
</tr>
<tr>
<td>Adductor brevis muscle</td>
<td>Upper Leg Muscle, Right</td>
</tr>
<tr>
<td></td>
<td>Upper Leg Muscle, Left</td>
</tr>
<tr>
<td>Anatomical snuffbox</td>
<td>Lower Arm and Wrist Muscle, Right</td>
</tr>
<tr>
<td></td>
<td>Lower Arm and Wrist Muscle, Left</td>
</tr>
<tr>
<td>Arytenoid muscle</td>
<td>Neck Muscle, Right</td>
</tr>
<tr>
<td></td>
<td>Neck Muscle, Left</td>
</tr>
</tbody>
</table>
Root Operation Character 4

- KEY to identifying correct ICD-10-PCS code
- Main Term for procedure is most often a Root Operation
- Many fewer Main Terms in Index
  - Only Objective of Procedure
  - Components of procedures NOT indexed
  - Ex:
    - Reduction (see), Anastomosis (no entry)

Index and Root Operations

- Common Procedure terms may refer
  - Amputation – see Detachment
  - Arthrectomy – see Excision, Resection
  - Arthrocentesis – see Drainage
  - Arthrodesis – see Fusion
  - Arthrolysis – see Release
  - Biopsy – see Drainage, see Excision
  - Debridement – see Excision or Extraction
  - Suture – see Repair
**Root Operation**

- Accurately identifies **objective** of procedure
- Familiarity with these definitions is **critical** to success in ICD-10-PCS coding
- Constructing **correct** codes relies on correct interpretation & understanding of these definitions

**Med Surg Root Operations**

- 31 root operations
- Select root operation matching specific **objective** of documented procedure
- Divided into 9 groups that share similar attributes

- Coders MUST understand definitions before starting coding process
9 Root Operation Groups

• Taking out some/all of body part
  • Destruction
  • Detachment
  • Excision
  • Extraction
  • Resection
• Taking out solids/fluids/gases from body part
  • Drainage
  • Extirpation
  • Fragmentation

9 Root Operation Groups

• Involving cutting or separation only
  • Division
  • Release
• Putting in/back or moving some/all of body part
  • Reattachment
  • Reposition
  • Transfer
  • Transplantation
• Altering diameter/route of tubular body part
  • Bypass
  • Dilation
  • Occlusion
  • Restriction
9 Root Operation Groups

• Always involving a device
  • Change
  • Insertion
  • Removal
  • Replacement
  • Revision
  • Supplement

• For other objectives
  • Alteration
  • Creation
  • Fusion

• Involving examination only
  • Inspection
  • Map

• Involving other repairs
  • Control
  • Repair

Approach – Character 5

• Technique used to reach site of procedure

• 0 Open - Cutting through skin or mucous membrane & any other body layers necessary to expose site of procedure

• 3 Percutaneous - Entry, by puncture or minor incision, of instrumentation through skin or mucous membrane and any other body layers necessary to reach site of procedure
Approach – Character 5

4 Percutaneous **Endoscopic** - Entry, by puncture or minor incision, of instrumentation through skin or mucous membrane and any other body layers necessary to reach and visualize site of procedure.

7 Via Natural or Artificial Opening - Entry of instrumentation through a natural or artificial external opening to reach site of procedure.

---

Approach – Character 5

- 8 Via Natural or Artificial Opening Endoscopic - Entry of instrumentation through a natural or artificial external opening to reach and visualize site of procedure.

- F Via Natural or Artificial Opening with Percutaneous Endoscopic Assistance - Entry of instrumentation through natural or artificial external opening and entry, by puncture or minor incision, of instrumentation through skin or mucous membrane and any other body layers necessary to aid in performance of procedure.

- X External - Procedures performed directly on skin or mucous membrane and procedures performed indirectly by application of external force through skin or mucous membrane.
Device – Character 6

- Device values fall into 4 basic categories
  - Grafts and Prostheses
  - Implants
  - Simple or Mechanical Appliances
  - Electronic Appliances

Devices* – Character 6

- 0 Drainage Device
- 2 Monitoring Device
- 3 Infusion Device
- 7 Autologous Tissue Substitute
- C Extraluminal Device
- D Intraluminal Device
- J Synthetic Substitute
- K Nonautologous Tissue Substitute
- L Artificial Sphincter
- M Stimulator Lead
- Y Other Device
- Z No Device

* MUST Remain after procedure completed
**Types of Devices**

- Biological/Synthetic replacement
- Biological/Synthetic assists/prevents function
- Therapeutic, not absorbed, eliminated, incorporated into body part
- Mechanical/Electronic appliances
- Y = Other Device = NEW device NOT yet in ICD-10-PCS

**When to code Device**

- IF device means by which procedural **objective** accomplished, then specific device value coded as 6th character
- A coder should ask
  - Is this material **central** to achieving **objective** of procedure, or does it only support performance of procedure?
- Device stays in specific location
- Device is technically removable
### When to code
#### Device vs. Substance

- **Device** – intended to maintain fixed location at procedure site where put
  - Drainage Device
  - Radioactive Element
  - Extraluminal device
  - Intraluminal device

- **Substance** - intended to disperse or be absorbed in the body
  - therapeutic, diagnostic, nutritional, physiological, or prophylactic substance except blood or blood products

### Device Key Table

<table>
<thead>
<tr>
<th>Cultured epidermal cell autograft</th>
<th>Use: Autologous Tissue Substitute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delta frame external fixator</td>
<td>Use: External Fixation Device, Hybrid for Insertion in Upper Bones</td>
</tr>
<tr>
<td></td>
<td>External Fixation Device, Hybrid for Reposition in Upper Bones</td>
</tr>
<tr>
<td></td>
<td>External Fixation Device, Hybrid for Insertion in Lower Bones</td>
</tr>
<tr>
<td></td>
<td>External Fixation Device, Hybrid for Reposition in Lower Bones</td>
</tr>
</tbody>
</table>
### Device Aggregation Table

<table>
<thead>
<tr>
<th>Device Example</th>
<th>Value</th>
<th>Character Def</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Lead, Pacemaker</td>
<td>Insertion</td>
<td>Heart and Great Vessels</td>
<td>M Cardiac Lead</td>
</tr>
<tr>
<td>Cardiac Resynchronization Defibrillator Pulse Generator</td>
<td>Insertion</td>
<td>Subcutaneous Tissue and Fascia</td>
<td>P Cardiac Rhythm Related Device</td>
</tr>
<tr>
<td>Monitoring Device, Hemodynamic</td>
<td>Insertion</td>
<td>Subcutaneous Tissue and Fascia</td>
<td>2 Monitoring Device</td>
</tr>
<tr>
<td>Internal Fixation Device, Intramedullary</td>
<td>All applicable</td>
<td>Lower Bones Upper Bones</td>
<td>4 Internal Fixation Device</td>
</tr>
</tbody>
</table>

### Device Example

- Total L hip replacement w/metal on plastic (polyethylene) prosthesis

<table>
<thead>
<tr>
<th>Value</th>
<th>Character Def</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Section</td>
<td>Med/Surg</td>
</tr>
<tr>
<td>S</td>
<td>Body System</td>
<td>Lower Joints</td>
</tr>
<tr>
<td>R</td>
<td>Root Operation</td>
<td>Replacement</td>
</tr>
<tr>
<td>B</td>
<td>Body Part</td>
<td>L Hip Joint</td>
</tr>
<tr>
<td>0</td>
<td>Approach</td>
<td>Open</td>
</tr>
<tr>
<td>2</td>
<td>Device</td>
<td>Synthetic Substitute, Metal on Polyethylene</td>
</tr>
<tr>
<td>Z</td>
<td>Qualifier</td>
<td>No Qualifier</td>
</tr>
</tbody>
</table>

**Note:** Qualifier has 3 choices; check MR.
Device Example

Taking out or off a device from a body part and putting back an identical or similar device in or on the same body part without cutting or puncturing the skin or a mucous membrane.

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>P Skin</td>
<td>X External</td>
<td>0 Drainage Device</td>
<td>Z No Qualifier</td>
</tr>
<tr>
<td>T Breast, Right</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>U Breast, Left</td>
<td></td>
<td>Y Other Device</td>
<td></td>
</tr>
</tbody>
</table>

One-Row Table

NOT Devices

- Instruments used only during procedure
  - Forceps
  - Vacuum extractor
  - Drill
  - Burr

- Instruments to visualize site (Approach)
  - Arthroscope

- Incidental materials
  - Clips
  - Staples

- Sutures & suture alternatives (fibrin glue, dermabond, etc.)
Devices & Root Operations

- Root Operations that ALWAYS have device
  - Change
  - Insertion
  - Removal
  - Replacement
  - Revision

- Root Operations that MAY have device
  - Alteration
  - Bypass
  - Creation
  - Dilation
  - Drainage
  - Fusion
  - Occlusion
  - Reposition
  - Restriction


Qualifier

- 7th character
- Information on attributes NOT captured in 1st 6 characters

- Most root operations DO NOT have a specific qualifier value
  - Z is default
Qualifier* – Character 7

0 Allogeneic
1 Syngeneic
2 Zooplast
3 Kidney Pelvis, Right
3 Full Thickness
4 Kidney Pelvis, Left
4 Partial Thickness
6 Ureter, Right
7 Ureter, Left
8 Colon
9 Colocutaneous

A Ileum
B Bladder
C Ileocutaneous
D Cutaneous
X Diagnostic
Z No Qualifier

*Unique values for individual procedures

Qualifier – Character 7

Qualifier choices vary depending on previous values selected

When constructing code from a Table, MUST stay in the same row, once you have selected the 4th character
### Value Z – as Device & Qualifier Character

- Device and Qualifier characters
  - Do NOT have specific value for EVERY procedure
  - NOT every procedure has device/qualifier

- Z as 6\(^{th}\) character = NO device used/left in
- Z as 7\(^{th}\) character = NO add’l attributes

### Gastrointestinal 0D1-0DY

<table>
<thead>
<tr>
<th>Body Part Character 4</th>
<th>Approach Character 5</th>
<th>Device Character 6</th>
<th>Qualifier Character 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Esophagus, Upper</td>
<td>0 Open</td>
<td>Z No Device</td>
<td>Z No Qualifier</td>
</tr>
<tr>
<td>2 Esophagus, Middle</td>
<td>3 Percutaneous</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Esophagus, Lower</td>
<td>4 Percutaneous</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Esophagogastric</td>
<td>7 Via Natural or Artificial Opening Endoscopic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Junction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Esophagus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 …</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>W</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Taking or cutting out solid matter from a body part

**EGD for Removal of dime from esophagus**
31 Body Systems in ICD-10-PCS Med/Surg

- Body Parts for Digestive
  - Mouth and Throat 0C0-0CX
    - Lips to Vocal Cords
  - GI System 0D1-0DY
    - Esophagus to Anus

- Body Parts for Respiratory
  - Ear, Nose, Sinus 090-09W
    - Nasal Turbinate to Nasopharynx
  - Respiratory System 0B1-0BY
    - Trachea to Diaphragm

- Body parts for Injury
  - Skin and Breast 0H0-0HY
  - SQ Tissue and Fascia 0J0-0JX
  - Muscles 0K2-0KX
  - Bursae & Ligaments 0M2-0MX
  - Head & Facial Bones 0N2-0NW
  - Etc.

Injury Code Example

<table>
<thead>
<tr>
<th>Character 1 Section</th>
<th>Character 2 Body System</th>
<th>Character 3 Root Operation</th>
<th>Character 4 Body Part</th>
<th>Character 5 Approach</th>
<th>Character 6 Device</th>
<th>Character 7 Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Surgical</td>
<td>Skin &amp; Breast</td>
<td>Extirpation</td>
<td>Skin, Right Hand</td>
<td>External</td>
<td>No Device</td>
<td>No Qualifier</td>
</tr>
</tbody>
</table>

0 H C F X Z Z

ED Patient with large staple in finger. Accident while installing paneling at home.

Removal of FB, Skin of Left Ring finger
10 Top Documentation Issues in ICD-10-CM/PCS

- Diabetes mellitus
- Injuries
  - Size/depth
- Drug underdosing
  - Reason
- Cerebral infarctions
- AMI
- Neoplasms
- Musculoskeletal conditions
  - Ex: Pathological Fxs
    - 8 codes in ICD-9-CM
    - 150 in ICD-10-CM
- Pregnancy
- Respiratory/vents
- ICD-10-PCS
  - Everything!

Interpreting Documentation

- Coding Guideline A11
- Many of the terms used to construct PCS codes are defined within the system. It is the coder’s responsibility to determine what the documentation in the medical record equates to in the PCS definitions. The physician is not expected to use the terms used in PCS code descriptions, nor is the coder required to query the physician when the correlation between the documentation and the defined PCS terms is clear.
# Needed Documentation

Medical and Surgical Section – MusculoSkeletal Example

<table>
<thead>
<tr>
<th>ICD-10-PCS</th>
<th>Description</th>
<th>ICD-9-CM</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0MN14ZZ</td>
<td>Right shoulder arthroscopy with coracoacromial ligament release</td>
<td>80.41</td>
<td>Release of ligament, shoulder</td>
</tr>
</tbody>
</table>

**Specificity Laterality**

**Body Part Laterality**

- Separate body part values for R and L
- Few bilateral body part values
- IF no bilateral value, assign two codes
“Unspecified” Codes

• AVOID
  • Must have specificity in codes
  • Justification for better reimbursement

• Bad effect on Severity of Illness and Risk Scores

Other Specificity

• Time Frames
  • Some codes require
  • Number of hours
    • Ventilation

• Severity
  • Asthma – level required
  • Respiratory failure – required

• MS-DRGs
  • CMS will be making future changes
  • Require more in-depth documentation
Digestive
Respiratory
Injury

COMMON MEDICAL-SURGICAL ROOT OPERATIONS

Alteration (0)

- Modifying the anatomic structure of a body part without affecting the function of the body part
- *Explanation* - Principal purpose is to improve appearance
- *Examples* - Face lift, breast augmentation
- USED FOR COSMETIC PROCEDURES ONLY
Detachment (6)

- Cutting off all or part of the upper or lower extremities
- **Explanation** - The body part value is the site of the detachment, with a qualifier if applicable to further specify the level where the extremity was detached
- **Examples**
  - Below knee amputation, disarticulation of shoulder

**Detachment Qualifiers**

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Qualifier Value</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper arm and upper leg</td>
<td>1</td>
<td>High: Amputation at the proximal portion of the shaft of the humerus or femur</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Mid: Amputation at the middle portion of the shaft of the humerus or femur</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Low: Amputation at the distal portion of the shaft of the humerus or femur</td>
</tr>
<tr>
<td>Hand and foot</td>
<td>0</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Complete 1st Ray</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Complete 2nd Ray</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Complete 3rd Ray</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>Complete 4th Ray</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>Partial 1st Ray</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>Partial 2nd Ray</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>Partial 3rd Ray</td>
</tr>
<tr>
<td></td>
<td>D</td>
<td>Partial 4th Ray</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>Partial 5th Ray</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Complete: Amputation through the carpometacarpal joint of the hand, or through the tarsal-metatarsal joint of the foot</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Partial: Amputation anywhere along the shaft or head of the metacarpal bone of the hand, or of the metatarsal bone of the foot</td>
</tr>
</tbody>
</table>
Detachment Qualifiers

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Qualifier Value</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thumb, finger, or toe</td>
<td>0</td>
<td>Complete: Amputation at the metacarpophalangeal/metatarsal-phalangeal joint</td>
</tr>
<tr>
<td>empty</td>
<td>1</td>
<td>High: Amputation anywhere along the proximal phalanx</td>
</tr>
<tr>
<td>empty</td>
<td>2</td>
<td>Mid: Amputation through the proximal interphalangeal joint or anywhere along the middle phalanx</td>
</tr>
<tr>
<td>empty</td>
<td>3</td>
<td>Low: Amputation through the distal interphalangeal joint or anywhere along the distal phalanx</td>
</tr>
</tbody>
</table>

Division (8)

- Cutting into a body part without draining fluids and/or gases from the body part in order to separate or transect a body part

- **Explanation**
  - All or a portion of body part is separated into two or more portions

- **Examples**
  - Osteotomy, Spinal cordotomy
  - Sacral rhizotomy for pain control, percutaneous
Drainage (9)

- Taking or letting out fluids and/or gases from a body part
- **Explanation**
  - Qualifier DIAGNOSTIC used to identify drainage procedures that are biopsies

**Examples**
- Arthrocentesis
- Open R hip arthrotomy with drain placement
- Breast cyst aspiration bx
- Thoracentesis
- Incision and drainage
- Aspiration
- Lumbar puncture

**Coding Tip:**
Focus on WHAT is TAKEN OUT

Drainage

- Procedure that involves only a catheter and indicates removal of gases or liquids, not specific body parts
- Use/Insertion of catheter distinguishes drainage from other similar procedures

Drainage Examples

- I&D External Perianal Abscess 0D9QXZZ
- Diagnostic percutaneous paracentesis for ascites 0W9G3ZX
- Lumbar puncture, diagnostic 009U3ZX
- Thoracentesis for Pleural effusion

I&D External Perianal Abscess

Drainage
Abdominal Wall 0W9F
Acetabulum Left 0Q9S
Right 0Q94
Adenoids 0C9Q
Ampulla of Vater 0F9C
Anal Sphincter 0D9R
Ankle Region Left 0Y9L
Right 0Y9K
Anterior Chamber Left 0993
Right 0892
Anus 0D9Q

Index gives the 4th value
No entry for Drainage – Perianal
Guideline for this situation
### I&D External Perianal Abscess

<table>
<thead>
<tr>
<th>Section</th>
<th>0</th>
<th>Medical and Surgical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body System</td>
<td>D</td>
<td>Gastrointestinal System</td>
</tr>
<tr>
<td>Operation</td>
<td>9</td>
<td>Drainage: Taking or letting out fluids and/or gases from a body part</td>
</tr>
</tbody>
</table>

Two possible rows – Need Tie-breaker!

#### Diagnostic percutaneous paracentesis for ascites

- **Index**
  - No entry for Paracentesis
  - Coder must translate using medical knowledge
    - Taking out fluid from body part = Drainage
- **Drainage, Abdominal Wall 0W9F**
- **Drainage, Peritoneal Cavity 0W9G**

![Diagram of Abdominal Paracentesis](http://en.wikipedia.org/wiki/Paracentesis#mediaviewer/File:Blausen_0004_AbdominalParacentesis.png)
Diagnostic percutaneous paracentesis for ascites

Lumbar puncture, diagnostic

- Index
  - Puncture, see Drainage
- Drainage, Lumbar Spinal Cord 009Y
- Drainage, Spinal Canal 009U
- Drainage, Spinal Meninges 009T

Which one?

Lumbar puncture, diagnostic

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spinal Meninges</td>
<td>Open</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Spinal Canal</td>
<td>009U3ZX</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Cervical Spinal Cord</td>
<td>3 Percutaneous</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Thoracic Spinal Cord</td>
<td>4 Percutaneous Endoscopic</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Lumbar Spinal Cord</td>
<td></td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Be Careful!
Two rows with same body part values, but different values in last three columns

Thoracentesis

- Index
  - Thoracentesis
    - - see Drainage
    - - see Drainage, Anatomic General Regions 0W9
- Drainage, Pleura 0B9
- Drainage, Pleural Cavity 0W9

Which one?

Be Careful!
Two rows with the same body part values, but different values in the last three columns.

Must have Laterality documented.
Excision (B)

• Cutting out or off, without replacement, a portion of a body part

Explanation
• The qualifier DIAGNOSTIC is used to identify excision procedures that are biopsies

Examples
• Percutaneous biopsy of R gastrocnemius muscle
• Open excision of lesion from R Achilles tendon

Fusion (G)

• Joining together portions of an articular body part rendering articular body part immobile

Explanation
• Body part joined together by fixation device, bone graft, or other means

Examples
• Spinal fusion, Arthrodesis of R ankle, open
• Intercarpal fusion of L hand w/ bone bank bone graft, open
• Radiocarpal fusion of R hand with internal fixation, open
**Insertion (H)**

- Putting in a non-biological device that monitors, assists, performs or prevents a physiological function but does not physically take the place of a body part
- **Explanation** - N/A
- **Examples**
  - Insertion of radioactive implant
  - Percutaneous insertion of bone growth stimulator electrode, L femoral shaft
  - Tissue expander for skin graft

**Inspection (J)**

- Visually and/or manually exploring a body part
- **Explanation**
  - Visual exploration may be performed w/ or w/o optical instrumentation. Manual exploration may be performed directly or through intervening body layers
- **Examples**
  - Diagnostic arthroscopy, exploratory laparotomy
Reattachment (M)

- Putting back in or on all or a portion of a separated body part to its normal location or other suitable location
- **Explanation**
  - Vascular circulation and nervous pathways may or may not be reestablished
- **Examples**
  - Reattachment of hand, reattachment of avulsed kidney

Release (N)

- Freeing a body part from an abnormal physical constraint by cutting or by use of force
- **Explanation**
  - Some of the restraining tissue may be taken out but none of the body part is taken out
- **Examples**
  - Manual rupture of L shoulder joint adhesions under general anesthesia
  - Carpal tunnel release
Removal (R)

- Taking out or off a device from a body part

**Explanation**

- When device taken out & similar device put in w/out cutting or puncturing skin or mucous membrane, code to root operation CHANGE.
- Otherwise, procedure for taking out device is coded to root operation REMOVAL & procedure for putting in new device is coded to root operation performed.

**Examples**

- Incision w/ removal of K-wire fixation, L 2nd metacarpal

Repair (Q)

- Restoring, to extent possible, a body part to its normal anatomic structure and function

**Explanation**

- Used ONLY when method to accomplish repair is NOT one of the other root operations

**Examples**

- Herniorrhaphy, suture of laceration
Repair Root Operation

• In Medical/Surgical Section is a NEC option

• Default when procedure is NOT any other specific root operation

• Example: Suture R biceps tendon laceration

Replacement (R)

• Putting in/on biological/synthetic material that physically takes place and/or function of all or portion of body part

• Explanation
  • Biological material is non-living, or living & from same individual. The body part may have been previously taken out, previously replaced, or may be taken out concomitantly with Replacement procedure.

• Examples
  • Total hip replacement, bone graft, free skin graft
Replacement, Cont.

- If body part has been previously replaced, separate Removal procedure is coded for taking out device used in previous replacement
- **Examples**
  - Total hip replacement, bone graft, free skin graft
  - R hip hemiarthroplasty, open
  - Open tenonectomy w/ graft to L ankle using cadaver graft

Reposition (S)

- Moving to its normal location or other suitable location all or a portion of a body part
- **Explanation**
  - Body part is moved to new location from abnormal location, or from normal location where it is not functioning correctly. The body part may or may not be cut out or off to be moved to the new location
- **Examples**
  - Fracture reduction, Reposition of undescended testicle
Fracture Reduction

- Reposition – Root Operation
- Reposition procedures include moving
  - Body part to its normal location
  - Body part to new location to enhance its ability to function
- Reflects DISPLACED Fracture

Other Reposition Procedures

- ORIF, L tibia and ulna
- Open fx, displaced fx of R distal humerus
- Closed reduction w/ percutaneous internal fixation of L femoral neck fx
- R knee arthroscopy w/ reposition of patellar ligament
Non-Displaced Fracture Treatment

• Treatment of non-displaced fracture is coded to procedure performed

• Ex: Putting pin in non-displaced fx = Insertion Root Operation

• Ex: Casting non-displaced fx = Immobilization Root Operation

In Placement Section, NOT Med/Surg

Resection vs Excision

• Excision – cutting out or off, w/o replacement, A PORTION of a body part
  • Biopsy, with Diagnostic Qualifier

• Resection - cutting out or off, w/o replacement, ALL of a body part
  • Total Mastectomy, Complete Excision of nipple, Complete excision of nail
Supplement (U)

- Putting in/on biologic/synthetic material that physically reinforces and/or augments function of a portion of body part

- **Explanation**
  - Biological material is non-living, or living and from the same individual. Body part may have been previously replaced. If body part previously replaced, Supplement procedure performed to physically reinforce and/or augment function of replaced body part

Supplement, Cont.

- **Examples**
  - New acetabular liner in a previous hip replacement
  - Open tendon graft using autograft
  - Open resurfacing procedure on left acetabular surface
Transfer (X)

• Moving, without taking out, all or a portion of a body part to another location to take over the function of all or a portion of a body part

• Explanation
  • Body part transferred remains connected to its vascular and nervous supply

• Examples
  • R wrist palmaris longus tendon transfer, open
  • Transfer R index finger to right thumb position, open
  • Skin pedicle flap

1: Obstetrics
2: Placement
3: Administration
4: Measurement and Monitoring
5: Extracorporeal Assistance and Performance
6: Extracorporeal Therapies
7: Osteopathic
8: Other Procedures
9: Chiropractic

MED/SURG-RELATED SECTIONS
Placement – 1st Value = 2

- One of NINE Medical and Surgical-related sections of ICD-10-PCS
- Seven characters retain same meanings as in Med/Surg Section – 0
- 2nd Values =
  - Anatomical Regions 2W0-2W6
  - Anatomical Orifices 2Y0-2Y5
- 5th Value = Approach
  - EXTERNAL

Placement – 1st Value = 2

- Placement root operations – 3rd Value
  - Only procedures performed **without** making incision/puncture

- Placement has seven root operations
  - Five unique to Placement section
Placement – Root Operations

• 0 – Change:
  Taking out or off device from body region and putting back identical or similar device in or on same body region without cutting or puncturing skin or mucous membrane (SAME AS Section 0)

• 1 – Compression:
  Putting pressure on a body region

• 2 – Dressing:
  Putting material on a body region for protection

• 3 – Immobilization:
  Limiting or preventing motion of a body region

• 4 – Packing:
  Putting material in a body region
Placement – Root Operations

• 5 – Removal:
  Taking out or off a device from a body region   (SAME AS 0 Section)

• 6 – Traction:
  Exerting a pulling force on a body region in a distal direction
  • Using mechanical traction apparatus ONLY

Placement – Devices

• 6th Value
  • Specifies material/device used in procedure (splint, traction apparatus, pressure dressing, bandage, casts)
    • Off-the-Shelf Devices  - Do NOT require any extensive design, fabrication, or fitting
  • Placement of devices requiring extensive design, fabrication, or fitting coded in Rehabilitation section (F)
Placement Example

- Application of sterile dressing to head wound

<table>
<thead>
<tr>
<th>Character 1 Section</th>
<th>Character 2 Body System</th>
<th>Character 3 Root Type</th>
<th>Character 4 Body Part</th>
<th>Character 5 Contrast</th>
<th>Character 6 Qualifier</th>
<th>Character 7 Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placement</td>
<td>Anatomical Regions</td>
<td>Dressing</td>
<td>Head</td>
<td>External</td>
<td>Bandage</td>
<td>No Qualifier</td>
</tr>
<tr>
<td>2</td>
<td>W</td>
<td>2</td>
<td>0</td>
<td>X</td>
<td>4</td>
<td>Z</td>
</tr>
</tbody>
</table>

Placement Example

- Nasal packing

<table>
<thead>
<tr>
<th>Character 1 Section</th>
<th>Character 2 Body System</th>
<th>Character 3 Root Type</th>
<th>Character 4 Body Part</th>
<th>Character 5 Contrast</th>
<th>Character 6 Qualifier</th>
<th>Character 7 Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placement</td>
<td>Anatomical Orifices</td>
<td>Packing</td>
<td>Nasal</td>
<td>External</td>
<td>Packing Material</td>
<td>No Qualifier</td>
</tr>
<tr>
<td>2</td>
<td>Y</td>
<td>4</td>
<td>1</td>
<td>X</td>
<td>5</td>
<td>Z</td>
</tr>
</tbody>
</table>
Placement Example

• Pressure **dressing** on abdominal wall

<table>
<thead>
<tr>
<th>Character 1</th>
<th>Character 2</th>
<th>Character 3</th>
<th>Character 4</th>
<th>Character 5</th>
<th>Character 6</th>
<th>Character 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section</td>
<td>Body System</td>
<td>Root Type</td>
<td>Body Part</td>
<td>Contrast</td>
<td>Dressing</td>
<td>Qualifier</td>
</tr>
<tr>
<td>Placement</td>
<td>Anatomical Region</td>
<td>Compression</td>
<td>Abdominal Wall</td>
<td>External</td>
<td>Pressure</td>
<td>No Qualifier</td>
</tr>
<tr>
<td>2 W 1 3 X 6 Z</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Placement Example

• Use of intermittent pneumatic **compression** device, covering L lower leg

<table>
<thead>
<tr>
<th>Character 1</th>
<th>Character 2</th>
<th>Character 3</th>
<th>Character 4</th>
<th>Character 5</th>
<th>Character 6</th>
<th>Character 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section</td>
<td>Body System</td>
<td>Root Type</td>
<td>Body Part</td>
<td>Contrast</td>
<td>Device</td>
<td>Qualifier</td>
</tr>
<tr>
<td>Placement</td>
<td>Anatomical Region</td>
<td>Compression</td>
<td>Lower Leg, Left</td>
<td>External</td>
<td>Intermittent</td>
<td>No Qualifier</td>
</tr>
<tr>
<td>2 W 1 R X 7 Z</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ANCILLARY SERVICES

Ancillary sections

- Do NOT include root operations
- USE root type of procedure

- Different values for characters
  - NOT same as MED/SURG (0)
Imaging – B = 1st Value

• 2nd Value = Body system
  • Heart, GI, etc.
• 3rd Value = Imaging procedure type
  • Computerized Tomography (CT)
  • Fluoroscopy
  • Magnetic Resonance Imaging (MRI)
  • Plain Radiography
  • Ultrasonography
• NOT Nuclear medicine procedures, PET, uptakes, and scans
  • Nuclear Medicine Section

Imaging – B = 1st Value

• 4th value = Body part/region studied

• 5th value = Contrast used OR not used
  • High osmolar, Low osmolar, Other, None

• 6th value = Contrast qualifier
  • Unenhanced, Enhanced, Laser, Intravascular optical coherence
Imaging – B = 1st Value

• 7th value = qualifier with unique meaning for limited individual imaging procedures
  • Such as intravascular, transesophageal, guidance, and densitometry

Imaging Example

• CT of brain without contrast material followed by diatrizoate contrast

<table>
<thead>
<tr>
<th>Character 1</th>
<th>Character 2</th>
<th>Character 3</th>
<th>Character 4</th>
<th>Character 5</th>
<th>Character 6</th>
<th>Character 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section</td>
<td>Body System</td>
<td>Root Type</td>
<td>Body Part</td>
<td>Contrast</td>
<td>Qualifier</td>
<td>Qualifier</td>
</tr>
<tr>
<td>Imaging</td>
<td>Central Nervous System</td>
<td>CT Scan</td>
<td>Brain</td>
<td>High Osmolar</td>
<td>Unenhanced and Enhanced</td>
<td>None</td>
</tr>
<tr>
<td>B</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>Z</td>
</tr>
</tbody>
</table>
### Imaging Example

- Chest x-ray, AP/PA and lateral views

<table>
<thead>
<tr>
<th>Character 1 Section</th>
<th>Character 2 Body System</th>
<th>Character 3 Root Type</th>
<th>Character 4 Body Part</th>
<th>Character 5 Contrast</th>
<th>Character 6 Qualifier</th>
<th>Character 7 Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imaging</td>
<td>Anatomical Regions</td>
<td>Plain Radiography</td>
<td>Chest</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>B</td>
<td>W</td>
<td>0</td>
<td>3</td>
<td>Z</td>
<td>Z</td>
<td>Z</td>
</tr>
</tbody>
</table>

### Imaging Example

- X-ray of right clavicle, limited study

<table>
<thead>
<tr>
<th>Character 1 Section</th>
<th>Character 2 Body System</th>
<th>Character 3 Root Type</th>
<th>Character 4 Body Part</th>
<th>Character 5 Contrast</th>
<th>Character 6 Qualifier</th>
<th>Character 7 Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imaging</td>
<td>Non-axial Upper Bones</td>
<td>Plain Radiography</td>
<td>Clavicle, Right</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>B</td>
<td>P</td>
<td>0</td>
<td>4</td>
<td>Z</td>
<td>Z</td>
<td>Z</td>
</tr>
</tbody>
</table>
Imaging Example

- Ultrasound of prostate gland

<table>
<thead>
<tr>
<th>Character 1 Section</th>
<th>Character 2 Body System</th>
<th>Character 3 Root Type</th>
<th>Character 4 Body Part</th>
<th>Character 5 Contrast</th>
<th>Character 6 Qualifier</th>
<th>Character 7 Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imaging</td>
<td>Male Reproductive</td>
<td>Ultrasoundography</td>
<td>Prostate and Seminal Vesicles</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

B V 4 9 Z Z Z

Physical Rehabilitation and Diagnostic Audiology–F

- 2nd value = section qualifier
  - Rehab OR Diagnostic audiology
- 3rd value = general procedure root type
- 4th value = body system & body region combined, where applicable
- 5th value = further specification of procedure type
- 6th value = equipment used, if any
Rehab/Audio Root Types

- 0 – Speech Assessment: Measurement of speech and related functions
- 1 – Motor and/or Nerve Function Assessment: Measurement of motor, nerve, and related functions
- 2 – Activities of Daily Living Assessment: Measurement of functional level for activities of daily living
- 3 – Hearing Assessment: Measurement of hearing and related functions

Rehab/Audio Root Types

- 4 – Hearing Aid Assessment: Measurement of the appropriateness and/or effectiveness of a hearing device
- 5 – Vestibular Assessment: Measurement of the vestibular system and related functions
- 6 – Speech Treatment: Application of techniques to improve, augment, or compensate for speech and related functional impairment
Rehab/Audio Root Types

• 7 – Motor Treatment: Exercise or activities to increase or facilitate motor function
• 8 – Activities of Daily Living Treatment: Exercise or activities to facilitate functional competence for activities of daily living
• 9 – Hearing Treatment: Application of techniques to improve, augment, or compensate for hearing and related functional impairment
• B – Cochlear Implant Treatment: Application of techniques to improve the communication abilities of individuals with cochlear implant

Rehab/Audio Root Types

• C – Vestibular Treatment: Application of techniques to improve, augment, or compensate for vestibular and related functional impairment
• D – Device Fitting: Fitting of a device designed to facilitate/support achievement of higher level of function
• F – Caregiver Training: Training in activities to support patient’s optimal level of function
Treatment

- Procedures include
  - Swallowing dysfunction exercises
  - Bathing and showering techniques
  - Wound management
  - Gait training
  - Host of activities typically associated with rehabilitation

Assessments

- Classified into more than 100 different tests or methods
  - Most focus on faculties of hearing and speech
  - Others focus on
    - Various aspects of body function
    - On patient’s quality of life
      - Muscle performance, neuromotor development, and reintegration skills
**Device Fitting**

- Device fitted – NOT method used to fit device
- Appendix D of ICD-10-PCS
  - Character Meanings

**Physical Rehab Example**

- Wound care treatment of left calf ulcer using pulsatile lavage

<table>
<thead>
<tr>
<th>Character 1 Section</th>
<th>Character 2 Section Qualifier</th>
<th>Character 3 Root Type</th>
<th>Character 4 Body System &amp; Region</th>
<th>Character 5 Type Qualifier</th>
<th>Character 6 Equipment</th>
<th>Character 7 Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation &amp; Diagnostic Audiology</td>
<td>Rehabilitation</td>
<td>ADLs Treatment</td>
<td>Musculoskel. Lower Extremity</td>
<td>Wound Management</td>
<td>Physical Agents</td>
<td>None</td>
</tr>
</tbody>
</table>

| F | 0 | 8 | L | 5 | B | Z |
### Physical Rehab Example

- Individual fitting of moveable brace, right knee

<table>
<thead>
<tr>
<th>Character 1</th>
<th>Character 2</th>
<th>Character 3</th>
<th>Character 4</th>
<th>Character 5</th>
<th>Character 6</th>
<th>Character 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section</td>
<td>Section Qualifier</td>
<td>Root Type</td>
<td>Body System &amp; Region</td>
<td>Type Qualifier</td>
<td>Equipment</td>
<td>Qualifier</td>
</tr>
<tr>
<td>Physical Rehabilitation &amp; Diagnostic Audiology</td>
<td>Rehabilitation</td>
<td>Device Fitting</td>
<td>None</td>
<td>Dynamic Orthosis</td>
<td>Orthosis</td>
<td>None</td>
</tr>
</tbody>
</table>

F 0 D Z 6 E Z

### Physical Rehab Example

- Caregiver training in feeding, no special equipment used

<table>
<thead>
<tr>
<th>Character 1</th>
<th>Character 2</th>
<th>Character 3</th>
<th>Character 4</th>
<th>Character 5</th>
<th>Character 6</th>
<th>Character 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section</td>
<td>Section Qualifier</td>
<td>Root Type</td>
<td>Body System &amp; Region</td>
<td>Type Qualifier</td>
<td>Equipment</td>
<td>Qualifier</td>
</tr>
<tr>
<td>Physical Rehabilitation &amp; Diagnostic Audiology</td>
<td>Rehabilitation</td>
<td>Caregiver Training</td>
<td>None</td>
<td>Feeding and Eating</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

F 0 F Z 2 Z Z
ICD-10-PCS CODING PROCESS

Codes are constructed:
1. ID Root Operation based on documentation
   Then, Using Index (But NOT required)
2. ID Body System, Body Part
3. After finding the 1st 3-4 values, go to Table
4. Using documentation, ID last 3-4 values
   Once 4th Character selected, MUST stay in Row

Selection Process

0JHW3VZ is NOT valid code - Why?

<table>
<thead>
<tr>
<th>Section</th>
<th>Body System</th>
<th>Operation</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Medical and Surgical</td>
<td>J Subcutaneous Tissue and Fascia</td>
<td>H Insertion</td>
<td>Open</td>
<td>1 Radioactive Element</td>
<td>Z No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3 Percutaneous</td>
<td>3 Infusion Device</td>
<td>Qualifier</td>
</tr>
<tr>
<td></td>
<td>W Subcutaneous Tissue and Fascia, Lower Extremity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>T Subcutaneous Tissue and Fascia, Trunk</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Coding Process Example

• Intramedullary rod insertion, L femoral shaft for non-displaced fx

• 1. Insertion =

• 2. Index Main Term
  • By Body system – Lower Bones 0QH
  • By Device – Intramedullary Fixation Device 0QH
  • By Body part - not under this Main Term

• 3. Use Table 0 Q H Insertion: Putting in nonbiological appliance that monitors, assists, performs or prevents physiological function, but does not physically take place of body part

<table>
<thead>
<tr>
<th>Body Part Character 4</th>
<th>Approach Character 5</th>
<th>Device Character 6</th>
<th>Qualifier Character 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 Upper Femur, R</td>
<td>0 Open</td>
<td>4 Internal Fixation Device</td>
<td>Z No Qualifier</td>
</tr>
<tr>
<td>7 Upper Femur, L</td>
<td>3 Percutaneous</td>
<td>6 Intramedullary Fixation Device</td>
<td></td>
</tr>
<tr>
<td>8 Femoral Shaft, R</td>
<td>4 Percutaneous</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Femoral Shaft, L</td>
<td>Endoscopic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B Lower Femur, R</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C Lower Femur, L</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G Tibia, R</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H Tibia, L</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J Fibula, R</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K Fibula, L</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Intramedullary rod insertion, L femoral shaft for non-displaced fx 0QH906Z

This is one of four rows in this Table

Values for characters 4 thru 7 MUST come from same row in Table
Case 1

- **Preoperative Diagnosis**: Extensive laceration, distal left index finger with partial severance of distal phalanx
- **Postoperative Diagnosis**: Same
- **Operation**: Open reduction internal fixation distal phalanx L index finger with Kirschner wire stabilization; nonexcisional debridement of laceration of L index finger; repair laceration L middle finger
- **Procedure**: Pt prepped & draped in the usual manner after axillary block administered. Pt had a Miter saw go into his index finger, lacerating the dorsal radial aspect of index finger at distal phalangeal phalanx level.
- Saw went into base of nail.

Case 1, Cont.

- We used C-arm fluoroscopy to thoroughly evaluate area & then inflated tourniquet to 280 mm of Mercury after arm exsanguinated. Wound thoroughly irrigated w/saline solution to which antibiotics were added & subcutaneous tissue debrided of all devitalized tissue, trash, & foreign bodies present in tissue. Then used Kirschner wire of 0.045 inches in dia. & drilled across fracture site in joint to totally stabilize area. Once this in place, then very carefully closed skin w/ interrupted running 5-0 Ethibond suture. Area of laceration on middle finger just distal to insertion of extensor tendon. Looked like bulk of nail bed would be viable, some damage to base of nail bed. Laceration of left middle finger, which extended into subcutaneous tissue, then repaired w/ 4-0 Vicryl sutures. Large compression dressing applied.
Case 1 ANSWER

- 0PSV04Z Reposition, Phalanx, Finger, Left
  - (0PSV) In Index
  - Reduction, Fracture, *see Reposition*
- 0JDK0ZZ Extraction, Subcutaneous Tissue and Fascia, Hand, Left (0JDK)
  - Debridement, Non-Excisional, *see Extraction*
- 0JQK0ZZ Repair, Subcutaneous Tissue and Fascia, Hand, Left (0JQK)
  - Suture, Laceration repair, *see Repair*

If a procedure is performed on a portion of a body part that does not have a separate body part value, code the body part value corresponding to the whole body part. **B4.1a**
Case 2

- **Preoperative Diagnosis:**
  - Left upper eyelid laceration
  - & chin laceration

- **Postoperative Diagnosis:** Same

- **Operation:** Repair of L upper eyelid & chin lacerations

- **Procedure:** After patient suitably prepared under general anesthesia, left upper eyelid & chin were dressed & draped with Betadine. Left upper eyelid laceration (3 cm) inspected. It did appear to go through left upper eyelid canaliculus.
Case 2

- Distal end could be seen, proximal end could not. It was elected not to try to repair canaliculus. **One interrupted 6-0 silk suture placed through lid margin & then 3 interrupted 5-0 Vicryl sutures placed through deep tissue.** Running 6-0 silk suture then placed through skin. **2.0 cm chin laceration of skin closed w/three interrupted 6-0 silk sutures.** Gentamicin ointment applied to lacerations and dressing placed over left eye. Patient tolerated procedure well & left OR in stable condition.

Case 2 ANSWER

- 08QPXZZZ Repair, Eyelid, Upper, Left (08QP)
  - Suture, Laceration repair, see Repair
- 0HQ1XZZZ Repair, Skin, Face (0HQ1XZZZ)

Components of a procedure specified in the root operation definition and explanation are not coded separately. Procedural steps necessary to reach the operative site and close the operative site are also not coded separately.

*Example:* Resection of a joint as part of a joint replacement procedure is included in the root operation definition of Replacement and is not coded separately. Laparotomy performed to reach the site of an open liver biopsy is not coded separately.
### Case 2 Explanation

<table>
<thead>
<tr>
<th>Section</th>
<th>Medical and Surgical</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body System</td>
<td>Eye</td>
<td>8</td>
</tr>
<tr>
<td>Root Operation</td>
<td>Repair</td>
<td>Q</td>
</tr>
<tr>
<td>Body Part</td>
<td>Upper Eyelid, Left</td>
<td>P</td>
</tr>
<tr>
<td>Approach</td>
<td>External</td>
<td>X</td>
</tr>
<tr>
<td>Device</td>
<td>No Device</td>
<td>Z</td>
</tr>
<tr>
<td>Qualifier</td>
<td>No Qualifier</td>
<td>Z</td>
</tr>
</tbody>
</table>

**Index:** Repair

<table>
<thead>
<tr>
<th>Section</th>
<th>Medical and Surgical</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body System</td>
<td>Skin and Breast</td>
<td>H</td>
</tr>
<tr>
<td>Root Operation</td>
<td>Repair</td>
<td>Q</td>
</tr>
<tr>
<td>Body Part</td>
<td>Skin, Face</td>
<td>1</td>
</tr>
<tr>
<td>Approach</td>
<td>External</td>
<td>X</td>
</tr>
<tr>
<td>Device</td>
<td>No Device</td>
<td>Z</td>
</tr>
<tr>
<td>Qualifier</td>
<td>No Qualifier</td>
<td>Z</td>
</tr>
</tbody>
</table>

**Index:** Repair

---

**One of 2 Rows in 0HQ Table; Only Row with Body Part Value of 1**

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Skin, Scalp</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Skin, Face</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Skin, Right Ear</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Skin, Left Ear</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Skin, Neck</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Skin, Chest</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Skin, Back</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Skin, Abdomen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Skin, Buttock</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Skin, Perineum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1A Skin, Genitalia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1B Skin, Right Upper Arm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1C Skin, Left Upper Arm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1D Skin, Right Lower Arm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X External</td>
<td></td>
<td>Z No Device</td>
<td>Z No Qualifier</td>
</tr>
</tbody>
</table>
Case 3

- **Preoperative Diagnosis:** Full thickness burn to right foot
- **Postoperative Diagnosis:** Same
- **Operation:** Split thickness skin graft from right thigh to right foot
- **Indications:** The patient is a 33-year-old male who suffered a full thickness burn to his right foot. The patient has a history of cardiac disease and hypertension. Pt is 40-pack-a-year smoker who quit 10 yrs ago. Pt presents for elective debridement of wound and split thickness skin graft.

Case 3

- **Operative Description:** Pt taken to OR & placed supine on operating table. After adequate IV sedation provided, right lower extremity prepped & draped in standard sterile fashion. Sharp debridement of ulcer carried out. Ulcer approx. 4 × 5 cm in area, lateral dorsum of R foot. Debridement carried down to viable tissue. 4 × 5 cm split thickness skin graft harvested from upper aspect of R thigh. Graft then meshed & applied to R foot wound. Graft secured w/running locked #3-0 chromic suture. Two centrally located chromic sutures placed for further attention. Attention placed to donor site; dressed w/Xeroform & 4 × 4 gauze. R lower extremity wrapped in Kerlix dressing. Sponge & instrument counts correct at end of case. Pt tolerated procedure well and transported to recovery room.
Case 3 Answer

- 0HRMX74 Replacement, Skin, Foot, Right (0HRM)
  - Graft, see Replacement
- 0HBHXZZZ Excision, Skin, Upper Leg, Right (0HBHXZ)

Coding Guideline B 3.9. 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.

Case 3 Explanation

<table>
<thead>
<tr>
<th>Section</th>
<th>Body System</th>
<th>Operation</th>
<th>Approach</th>
<th>Body Part</th>
<th>Device</th>
<th>Qualifier</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>H</td>
<td>R</td>
<td>X</td>
<td>B</td>
<td>7</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Medical and Surgical</td>
<td>Skin and Breast</td>
<td>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</td>
<td>External</td>
<td>Skin, Right Upper Arm</td>
<td>Autologous Tissue Substitute</td>
<td>Full Thickness</td>
<td></td>
</tr>
</tbody>
</table>

One of 6 Rows in 0HR Table; Only Row with Body Part Value for Right Foot; Body Part 1-7 Values not shown
Case 3 Explanation

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Skin, Scalp</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Skin, Face</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Skin, Right Ear</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Skin, Left Ear</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Skin, Neck</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Skin, Chest</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Skin, Back</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Skin, Abdomen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Skin, Buttock</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Skin, Perineum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Skin, Genitalia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B Skin, Right Upper Arm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C Skin, Left Upper Arm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D Skin, Right Lower Arm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E Skin, Left Lower Arm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F Skin, Right Hand</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G Skin, Left Hand</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H Skin, Right Upper Leg</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J Skin, Left Upper Leg</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K Skin, Right Lower Leg</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L Skin, Left Lower Leg</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M Skin, Right Foot</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N Skin, Left Foot</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q Finger Nail</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R Toe Nail</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

One of two Rows in 0HB Table; Only Row with H Body Part

Case 4

- **Preoperative Diagnosis:** Displaced comminuted fracture of shaft of right humerus
- **Postoperative Diagnosis:** Same
- **Procedure:** Open reduction, internal fixation of fracture of shaft of right humerus
- **History:** Pt is 4th-grader whose class was on field trip at local bowling alley. Pt tripped over object on alley & fell sustaining fracture of right humerus.
- **Description:** Pt anesthetized & prepped w/ Betadine, sterile drapes applied, and pneumatic tourniquet inflated around arm.
Case 4

• Incision made in area of lateral epicondyle through Steri-drape, and carried through subcutaneous tissue, & fracture site easily exposed. Inspection revealed fragment to be rotated in two planes about 90 degrees. It was possible to manually reduce this quite easily, and judicious manipulation resulted in almost anatomic reduction. Fixed w/ two pins across humerus. Pins cut off below skin level. Wound closed w/ some plain catgut subcutaneously & 5-0 nylon in skin. Dressings applied to pt and tourniquet released.

Case 4 ANSWER

• 0PSF04Z
• Reduction, Fracture see Reposition
• Reposition, Humeral Shaft, Right (0PSF)

Coding Guideline B3.15. Reposition for Fracture Treatment
Reduction of a displaced fracture is coded to the root operation Reposition, and the application of a cast or splint in conjunction with the Reposition procedure is not coded separately. Treatment of a nondisplaced fracture is coded to the procedure performed.
Case 4 Explanation

One of 8 Rows in 0PS Table; Two Rows have F Body Part Value and same Approach Values; Have to go to DEVICE column to determine correct row

Case 5

• **Case Summary:** Pt is 22-year-old male, admitted thru ED after motorcycle he was driving collided with elk while driving in mountains. Pt was driving in mountains & not on road when accident occurred. Pt not wearing helmet & sustained skull fracture over L temporal & orbital roof areas w/ depressed zygomatic arch on L side. Pt unconscious at scene & upon examination in ED, w/ Glasgow coma scale (GCS) score of 3: Eyes, never open; No verbal response; No motor response. Left pupil was blown (fixed and dilated), indicating intracranial injury. Hypoxemia, hypotension, and cerebral edema were noted.
Case 5

• Pt admitted to ICU w/ continuous monitoring of intracranial pressure (percutaneous). Pt experienced increasing periods of apnea & placed on ventilator following endotracheal intubation. Pt’s family (in another state) notified & arrived 2 days later. No improvement in pt’s status over following five days.

• Pt continued to be monitored & was unconscious. Attempts to wean from ventilation unsuccessful. Brain wave measurement showed no brain wave electrical activity. Family decided to discontinue life support and life-sustaining efforts were discontinued.

Case 5 ANSWER

• 0BH17EZ Insertion of device in, Trachea (0BH1)
  • Intubation, Airway, see Insertion of device in, Trachea (0BH1)

• 5A1955Z Performance, Respiratory, Greater than 96 Consecutive Hours, Ventilation (5A1955Z)

• 4A103BD Monitoring, Central Nervous, Pressure, Intracranial (4A10)

• 4A00X4Z Measurement, Central Nervous, Electrical Activity (4A00)
### Case 5 Explanation

**Section**: Extracorporeal Assistance and Performance

**Body System**: Physiological Systems

**Operation**: 1 Performance: Completely taking over a physiological function by extracorporeal means

<table>
<thead>
<tr>
<th>Body System</th>
<th>Duration</th>
<th>Function</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Cardiac</td>
<td>0 Single</td>
<td>1 Output</td>
<td>Z Manual</td>
</tr>
<tr>
<td>2 Cardiac</td>
<td>1 Intermittent</td>
<td>3 Pacing</td>
<td>Z No Qualifier</td>
</tr>
<tr>
<td>2 Cardiac</td>
<td>2 Continuous</td>
<td>1 Output</td>
<td>Z No Qualifier</td>
</tr>
<tr>
<td>5 Circulatory</td>
<td>2 Continuous</td>
<td>2 Oxygenation</td>
<td>3 Membrane</td>
</tr>
<tr>
<td>9 Respiratory</td>
<td>0 Single</td>
<td>5 Ventilation</td>
<td>4 Nonmechanical</td>
</tr>
<tr>
<td>9 Respiratory</td>
<td>3 Less than 24 Consecutive Hours</td>
<td>5 Ventilation</td>
<td>Z No Qualifier</td>
</tr>
<tr>
<td></td>
<td>4 24-96 Consecutive Hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5 Greater than 96 Consecutive Hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C Biliary</td>
<td>0 Single</td>
<td>0 Filtration</td>
<td>Z No Qualifier</td>
</tr>
<tr>
<td>D Urinary</td>
<td>6 Multiple</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Complete 5A1 Table
### Case 5 Explanation

**First 7 Rows of 27 Rows in 4A1 Table**

<table>
<thead>
<tr>
<th>Body System</th>
<th>Approach</th>
<th>Function / Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Central Nervous</td>
<td>0 Open</td>
<td>2 Conductivity</td>
<td>Z No Qualifier</td>
</tr>
<tr>
<td></td>
<td>0 Open</td>
<td>B Pressure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 Percutaneous</td>
<td>4 Electrical Activity</td>
<td>G Intraoperative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>B Pressure</td>
<td>Z No Qualifier</td>
</tr>
<tr>
<td></td>
<td>3 Percutaneous</td>
<td>D Intracranial</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7 Via Natural or Artificial Opening</td>
<td>B Pressure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>X External</td>
<td>2 Conductivity</td>
<td>Z No Qualifier</td>
</tr>
<tr>
<td>0 Central Nervous</td>
<td>X External</td>
<td>4 Electrical Activity</td>
<td>G Intraoperative</td>
</tr>
</tbody>
</table>

### Case 5 Explanation

**Measurement: Determining the level of a physiological or physical function at a point in time**

<table>
<thead>
<tr>
<th>Body System</th>
<th>Approach</th>
<th>Function / Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Central Nervous</td>
<td>0 Open</td>
<td>2 Conductivity</td>
<td>Z No Qualifier</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 Electrical Activity</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>B Pressure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 Percutaneous</td>
<td>D Intracranial</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7 Via Natural or Artificial Opening</td>
<td>B Pressure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>X External</td>
<td>2 Conductivity</td>
<td>Z No Qualifier</td>
</tr>
<tr>
<td>0 Central Nervous</td>
<td>X External</td>
<td>4 Electrical Activity</td>
<td></td>
</tr>
<tr>
<td>1 Peripheral Nervous</td>
<td>0 Open</td>
<td>2 Conductivity</td>
<td>9 Sensory Motor</td>
</tr>
<tr>
<td></td>
<td>3 Percutaneous</td>
<td>4 Electrical Activity</td>
<td>Z No Qualifier</td>
</tr>
<tr>
<td></td>
<td>X External</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Peripheral Nervous</td>
<td>0 Open</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 Percutaneous</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>X External</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Case 6

• Preoperative Diagnosis:
• Bucket-handle tear left medial meniscus

• Postoperative Diagnosis:
• Bucket-handle tear left medial meniscus

• Procedure: Arthroscopic partial medial meniscectomy

• Indications: Pt is 16-year-old male who torn his L medial meniscus while playing football at local high school football field. Pt is wide receiver for football team & was tackled resulting in torn medial meniscus. I saw & treated pt initially in ED three weeks ago for this injury.

Case 6

• Technique: After induction w/ general anesthesia, standard three-portal approach of knee was evaluated. Mild synovitic changes were noted in suprapatellar pouch. No chondromalacia changes were noted. Anterior portion of medial meniscus had flap tear, which was removed. After all instruments withdrawn, 4-0 nylon horizontal mattress stitches used to close wound, & pressure dressings applied. Pt awakened and taken to recovery room in good condition.
Case 6 ANSWER

• 0SBD4ZZ Excision, Joint, Knee, Left (0SBD)
  • Meniscectomy, see Excision, Lower Joints (0SB)

Root operation = Excision - only portion (anterior) of medial meniscus removed.
Approach = Percutaneous Endoscopic because procedure was arthroscopic

---

Case 6 Explanation

<table>
<thead>
<tr>
<th>Section</th>
<th>Medical and Surgical</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body System</td>
<td>Lower Joints</td>
<td>S</td>
</tr>
<tr>
<td>Root Operation</td>
<td>Excision</td>
<td>B</td>
</tr>
<tr>
<td>Body Part</td>
<td>Knee Joint, Left</td>
<td>D</td>
</tr>
<tr>
<td>Approach</td>
<td>Percutaneous Endoscopic</td>
<td>4</td>
</tr>
<tr>
<td>Device</td>
<td>No Device</td>
<td>Z</td>
</tr>
<tr>
<td>Qualifier</td>
<td>No Qualifier</td>
<td>Z</td>
</tr>
</tbody>
</table>

Index: Excision
Case 6 Explanation

- Laryngoscopy with intraluminal dilation of laryngeal stenosis

Case 7

- Laryngoscopy with intraluminal dilation of laryngeal stenosis
Case 7 ANSWER

<table>
<thead>
<tr>
<th>Section</th>
<th>Body System</th>
<th>Operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Medical and Surgical</td>
<td>7 Dilat: Expanding an orifice or the lumen of a tubular body part</td>
</tr>
<tr>
<td>0</td>
<td>C Mouth and Throat</td>
<td>7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>B Parotid Duct, Right</td>
<td>0 Open</td>
<td>D Intraluminal Device</td>
<td>Z No Device</td>
</tr>
<tr>
<td>C Parotid Duct, Left</td>
<td>3 Percutaneous</td>
<td>Z No Qualifier</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7 Via Natural or Artificial Opening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M Pharynx</td>
<td>7 Via Natural or Artificial Opening</td>
<td>D Intraluminal Device</td>
<td>Z No Device</td>
</tr>
<tr>
<td></td>
<td>8 Via Natural or Artificial Opening Endoscopic</td>
<td>Z No Qualifier</td>
<td></td>
</tr>
<tr>
<td>S Larynx</td>
<td>0 Open</td>
<td>D Intraluminal Device</td>
<td>Z No Device</td>
</tr>
<tr>
<td></td>
<td>3 Percutaneous</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 Percutaneous Endoscopic</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7 Via Natural or Artificial Opening</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8 Via Natural or Artificial Opening Endoscopic</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Case 8

- PreOp Dx: Rectal Mass, change in bowel habits
- PostOp Dx: Rectal prolapse, tubular adenoma of sigmoid colon, bx x 2, sigmoid diverticulosis, nonspecific colitis
- Procedure: Colonoscopy to level of cecum (110cm)
- Path Report Dx: Tubular adenoma of sigmoid colon
Case 8

Procedure: Pt prepped, placed in L lateral decubitus position. I administered 3 mg Versed. Monitoring of sedation assisted by trained RN. Next, endoscope passed thru rectal verge after negative digital exam & advanced to cecum. Scope then slowly retracted w/circular tip motion. Mild nonspecific colitis noted. Pt also had significant sigmoid diverticulosis & several small polyps in sigmoid colon area. Also, large prolapsing mass of mucosa approx. 5 cm inside the rectum. Appears to have prolapsed previously. 2 small polyps biopsied using cold biopsy forceps & sent to path for exam. Remainder of exam unremarkable. Pt tolerated procedure well.

Case 8 ANSWER

- 0DBN8ZX Excision, by body system, Gastrointestinal System (0DB)

<table>
<thead>
<tr>
<th>Section</th>
<th>Medical and Surgical</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body System</td>
<td>Gastrointestinal System</td>
<td>D</td>
</tr>
<tr>
<td>Root Operation</td>
<td>Excision</td>
<td>B</td>
</tr>
<tr>
<td>Body Part</td>
<td>Sigmoid Colon</td>
<td>N</td>
</tr>
<tr>
<td>Approach</td>
<td>Via natural opening</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>endoscopic</td>
<td></td>
</tr>
<tr>
<td>Device</td>
<td>None</td>
<td>Z</td>
</tr>
<tr>
<td>Qualifier</td>
<td>Diagnostic</td>
<td>X</td>
</tr>
</tbody>
</table>
Case 8 ANSWER

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Esophagus, Upper</td>
<td>Open</td>
<td>Z No Device</td>
<td>X Diagnostic</td>
</tr>
<tr>
<td>2 Esophagus, Middle</td>
<td>Percutaneous</td>
<td>Z No Device</td>
<td>Z No Qualifier</td>
</tr>
<tr>
<td>3 Esophagus, Lower</td>
<td>Percutaneous Endoscopic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Esophagogastric Junction</td>
<td>Via Natural or Artificial Opening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Stomach, Pylorus</td>
<td>Via Natural or Artificial Opening Endoscopic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Small Intestine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Large Intestine, Right</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Large Intestine, Left</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Ovary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Appendix</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B Bladder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C Ileocecal Valve</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D Large Intestine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E Large Intestine, Right</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F Large Intestine, Left</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G Ovary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H Appendix</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I Ascending Colon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J Descending Colon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K Rectum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L Transverse Colon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M Sigmoid Colon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N Rectum</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

0DB Table has 3 rows; Only this one has N value

Case 9

- Accidental amputation of right ring finger, initial encounter
- Degloving injury; Ring caught on Handrail screw while leaving Subway

- Procedure
  - Amputation at
  - Metacarpophalangeal joint
Case 9 Coding Process

• Index Entry
• Amputate – see Detachment
• Amputation – see Detachment

• Detachment
  • by Body System
    • Anatomical Regions, Upper Extremities 0X6
  • by Body Part
    • Ring Finger 0X6

Detachment Qualifiers

• For thumb, fingers, and toes
• Complete –
  • amputation at metacarpophalangeal or metatarsophalangeal joint
• High –
  • amputation anywhere along proximal phalanx
• Mid –
  • amputation through proximal interphalangeal (PIP) joint or anywhere along middle phalanx
• Low –
  • amputation through distal interphalangeal (DIP) joint or anywhere along distal phalanx
Tables (HO)

• 0X6

• Find correct row
• Stay in row to find rest of values

Code is

• 0X6S0Z0

<table>
<thead>
<tr>
<th>Section</th>
<th>Body System</th>
<th>Operation</th>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Medical/Surgical</td>
<td>Anatomical Regions, Upper Extremities</td>
<td>Detachment: Cutting off all or a portion of the upper or lower extremities</td>
<td>Ring Finger, Right</td>
<td>Open</td>
<td>No Device</td>
</tr>
</tbody>
</table>

From Table
ICD-10-PCS HOMEWORK

- Chapter 2 Review Exercises
  - 1, 9, 15, 19, 23
- Chapter 13 Review Exercises
  - 1, 3, 5, 7, 9, 11, 13, 15, 17, 19
- Chapters 14
  - 15 - 20
- Chapter 22A
  - 16 - 20
- Chapter 22B
  - 16 - 20

HOMEWORK ANSWERS

2nd Webinar

- Sent out Answers
- Any issues when you coded?
ICD-10-PCS Resources – Ancillary Sections

• Gowan, P. A. ICD – 10 – PCS Ancillary Section "Have No Fear, ICD10 Is Here" March 5 - 6, 2014.
  • [http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_050696.hcsp?dDocName=bok1_050696]
• Romero, A. ICD-10-PCS: Beyond Medical/Surgical. NHIMA. 9/13/2013,
  • [http://dbrvisuals.com/nmhima/docs/ICD-10-PCS-Beyond-Medical-Surgical.pdf]

ICD-10-PCS Resources – Drainage

• Barta, Ann. "ICD-10-PCS Root Operation Groups, Part 2." Root Operations that Take Out Solids, Fluids, Gases from a Body Part, Involve Cutting or Separation Only, and Put In OR put Back or Move Some OR All of a Body Part
  • [https://www.codeitrightonline.com/ciri/root-operations-drainage-and-fragmentation.html]
ICD-10-PCS Resources – Drainage

- Coding for biopsies in ICD-10-PCS. *HIM-HIPAA Insider*, January 13, 2014

ICD-10-PCS Resources – Drainage

- Howe, S. Drainage vs. Extirpation: Overview of Two ICD-10 Root Operations. ICD-10 Monitor.

- ICD-10-PCS root operations: Drainage. HCPro Blog.
ICD-10-PCS Resources - General

- AAPC. ICD-10 hub. AAPC.
- AHIMA. Codewrite e-newsletter. Members only. Back issues in Body of Knowledge.
- AHIMA. ICD-10-CM/PCS
  - http://www.ahima.org/topics/icd10
- AHIMA. ICD-TEN Newsletters.
  - https://newsletters.ahima.org/newsletters/ICDTen/

ICD-10-PCS Resources - General

- AMA. ICD-10 Code Set.
- CMS. ICD-10 Resources
ICD-10-PCS Resources - General

- CMS Sponsored ICD-10 Teleconferences
- CMS. ICD-10 Coding Basics 01/14/14. Video. 26 min.
  - [https://www.youtube.com/watch?v=tCY9aPiA-5c&feature=youtu.be](https://www.youtube.com/watch?v=tCY9aPiA-5c&feature=youtu.be)
- CMS. 2014 ICD-10 PCS and GEMs

ICD-10-PCS Resources - General

  - (ICD-TEN: Top Emerging News July 2011)
- Funny ICD-10 Codes - PART 1. Target Coding
  - [https://www.youtube.com/watch?v=_U7GWbYUM8c](https://www.youtube.com/watch?v=_U7GWbYUM8c)
- GA Dept. of Community Health.
  - ICD-10 - Documentation Improvements for Clinical Staff (Part 4 of 4). 56 minutes
  - [https://www.youtube.com/watch?v=x1KnUljxWRE](https://www.youtube.com/watch?v=x1KnUljxWRE)
- HIMSS. ICD-10 Playbook
  - [http://www.himss.org/ASP/topics.ICD10Playbook.asp](http://www.himss.org/ASP/topics.ICD10Playbook.asp)
ICD-10-PCS Resources – General

• ICD-10 Articles and Coding Guidelines. G2N, Inc.
  • http://www.g2n.org/icd-10-articles.html
• ICD-10 For Coders & Clinical Staff - Part 3 of 4
  https://www.youtube.com/watch?v=9tsUPA4tS6Y

  • www.cms.gov/Medicare/Coding/ICD10/2014-ICD-10-PCS.html

ICD-10-PCS Resources - General

• Just Coding. Free Quiz Archive.
  • http://www.justcoding.com/free-quizzes
• Top 100 Inpatient ICD-9 Codes Mapped to ICD-10.
  Online .pdf file
• Understanding the ICD-10 Code Structure
  http://www.webpt.com/blog/post/understanding-icd-10-code-structure
The Web’s Free 2014 ICD-10-CM and ICD-10-PCS Medical Coding Reference
  http://www.icd10data.com/
• 3M ICD-10 Coding Contest Archives.
  http://3mhealthinformation.wordpress.com/category/3m-coding-contest/
ICD-10-PCS Resources – General

- Simmons, C. R. Understanding the Differences within ICD-10-PCS. *ICD-TEN: Top Emerging News* (September 2010).


ICD-10-PCS Resources – Placement

- Bissonette, D. Coding Procedures in the Medical and Surgical-Related Sections. IHS.

Questions ???

ILEMten@gmail.com

Thank You!