COMMON ICD-10 CODING ERRORS - POST IMPLEMENTATION

Virginia Health Information Management Association Annual Meeting

April, 2016
ICD 10 Education Series

TIME SENSITIVE INFORMATION

This information contained in this presentation is valid as of the time of this presentation, April 2016.
The creator of this presentation is not responsible for the viewer’s lack of research for updated advice following this presentation.
Be sure to check subsequent official guidance in these areas following the presentation.
Official coding advice can change rapidly.

OBJECTIVES

Review common ICD-10 errors made by coders
- ICD-10-CM
- ICD-10-PCS
- Discussion of official guidance regarding problem areas
- Utilization of documentation examples
- What to do while you await official advice
ICD-10-CM

Excludes1 Notes

- If two ICD-10-CM diagnoses are not related to each other, but they exist at the same time, they may both be reported together despite an Excludes1 note according to the CDC.
- Original excludes1 advice stated that the two codes could NEVER be reported together
- I25.10 for CAD of native vessels without angina
- I25.810 for CAD of bypass grafts without angina
- Has Excludes1 note for I25.10 CAD of native coronary artery w/o angina
- HIA received AHA CC letter that states to code both if present

Excludes1 Notes

- Patient admitted with partial bowel obstruction also has a hiatal hernia. There is an excludes1 note at K56 that states intestinal obstruction with hernia (K40-K46) is not coded to K56.60, small bowel obstruction
- What if the intestinal obstruction is unrelated to the hiatal hernia?
  - Assign a code for both codes and sequence the reason for admission as principal.
The issue here is that there is a code J44.0 which is assigned for COPD with acute lower respiratory infection. HIA wrote to AHA to ask if "pneumonia" was considered an acute lower respiratory infection for coding purposes and they stated "yes." No sequencing advice was given.

Many vendors are stating that code J44.0 MUST be sequenced first when the pneumonia is documented in the same record. They are basing this on the index entry of "Disease, Lung, Obstructive, with, acute, lower respiratory infection" and the "use additional code to identify the infection" note at J44.0.

HIA has sent this back for sequencing advice.

Sent to AHA for advice. 2/9/16 Ref. #50013139.1215 sent to EAB for advice. Awaiting decision regarding proper sequencing.

Recommend coding as principal diagnosis, the condition found, after study, to be the chief reason for admission to the hospital.

Example A: Patient admitted with COPD and pneumonia. Placed on IV Levaquin for pneumonia. Continue with bronchodilators and inhaled steroids for COPD. What is your principal?

Example B: Patient admitted with COPD and pneumonia. Placed on IV SoluMedrol as patient was not responding to bronchodilators. Patient also placed on oxygen. IV Levaquin was prescribed for the pneumonia. What is your principal?

J44.0, COPD with acute lower respiratory infection
   DRG 194, Simple pneumonia and pleurisy with CC
   Relative Weight: 0.9695

J44.0, COPD with acute upper respiratory infection as PDX
J18.9, Pneumonia (MCC)
   DRG 190, COPD with MCC
   Relative Weight: 1.1578

What if J44.1, "acute exacerbation of COPD" is documented?
Periprosthetic Fractures

The primary issue here is what is considered a "periprosthetic" fracture? Consider a case where a patient falls and fractures the left shaft of the femur in the area around the prosthesis.

Does the coder assign:
- T84.041A periprosthetic fx MSDRG 482 1.62 OR
- 572.302A for the traumatic fx MSDRG 482 1.62 OR
- T84.041A and 572.302A MSDRG 480 2.99 OR
- 572.302A and T84.041A MSDRG 481 1.97

Clients argue that a traumatic fx, even in a patient with a prosthesis, is not a complication unless the MD states it. 

Sent to AHA for advice.

VALID? Mechanical complication of prosthetic joints

Coding Clinic, Fourth Quarter 2005 Page: 91 to 93 Effective with discharges: October 1, 2005

CAUTION: OLD

States that although the codes are in the complication section they do not indicate poor medical care or faulty devices. A fracture of a prosthetic joint due to trauma should be coded to a traumatic fracture code with an appropriate status code for joint replaced status.

Fractures around joint replacement prostheses are called peri prosthetic fractures. These fractures can occur with minimal trauma (especially with a previously loose prosthesis or osteoporotic bone). Eventually, wearing of the articular bearing surfaces can occur. This problem may lead to periprosthetic inflammation granuloma formation, bone resorption, and implant loosening.

"I sent a similar question to AHA exactly one year ago. I received a letter 3/2013 letting me know it was being referred to the Editorial Advisory Board. I finally received my response this week. In my example, the patient fell and the operative report said she had a peri-prosthetic femur fracture with loose femoral component. AHA said the advice published in CC 4th Qtr. 2005 pgs. 91-93 is not valid. I should code 996.44 (peri-prosthetic fx), 996.41 (mechanical loosening of prosthetic joint), and 820-821 (traumatic hip fracture)."

"They went on to say CC 2nd Qtr. 2013 pg. 5, states that an additional code should be assigned with categories 996-999 to identify the specific complication, when it provides information about the nature of the complication. The NCHS has agreed to consider a possible ICD-10-CM Coordination and Maintenance committee proposal to modify the ICD-10-CM so that a peri-prosthetic fracture is not classified as a complication."
No equivalent to old ICD-9-CM V57 codes
Assign the reason for admission to rehab as PDX
MSDRG assignments out of DRGS 985/986 with some denials
86 year old with mobility and self care dysfunction after hospitalization for CHF exacerbation. The patient has a history of multiple spinal fusion and laminectomy procedures. The patient continues to require inpatient rehabilitation for functional upgrade return to community living. He requires PT and OT for at least 3 hours daily 5 days a week to address his debility, focusing on improving mobility ambulation and ADLs. Patient’s functional goals are to get his strength back after his last few months of surgeries and illnesses and return home.
What is the PDX for the UB04? Debility? CHF?

Coding Clinic 4Q 2013 page 129
Patient transferred to rehab unit for OT and PT following prolonged stay at a LTCH where patient was weaned from mechanical vent. Patient received rehab due to decondition and debility. The provider documented that the patient presented with complex medical problems that included chronic hypoxic respiratory failure, COPD, diabetic neuropathy and obesity.
Assign J96.11, Chronic respiratory failure with hypoxia as PDX. This is the underlying reason for and deconditioning and the underlying reason is coded as the principal diagnosis.

Coding Clinic 4Q 2012 pages 90-98
When a patient is admitted to LTC nursing home for “deconditioning” how is this coded?
Answer is code the symptoms of deconditioning such as gait disturbance, weakness, etc.
This seems to conflict with Coding Clinic 4Q 2013 page 129 above.

When an injury is reason for rehabilitation
Coding Clinic 4Q 2013 pages 90-98 and 128-129
If a patient is transferred to LTC (or rehab) following hospital stay for treatment of fracture or injury such as pelvic and clavicular fracture, assign the S32.9XXD with 7th character of D, subsequent encounter.
Review Coding Clinic 3Q 2015 page 36
Discusses IRF-PAI vs UB04 coding
Review Coding Clinic 1Q 2015 page 21
Rehabilitation services are not considered active treatment and the encounter should be reported with the appropriate 7th character for “subsequent encounter.”
Rehabilitation Unit Principal Diagnosis

- OCG II PDX" K. Admissions/Encounters for Rehabilitation
  - When the purpose for the admission/encounter is rehabilitation, sequence first the code for the condition for which the service is being performed. For example, for an admission/encounter for rehabilitation for right-sided dominant hemiplegia following a cerebrovascular infarction, report code I69.351, Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, as the first-listed or principal diagnosis.
  - If the condition for which the rehabilitation service is no longer present, report the appropriate aftercare code as the first-listed or principal diagnosis. For example, if a patient with severe degenerative osteoarthritis of the hip, underwent hip replacement and the current encounter/admission is for rehabilitation, report code Z47.1, Aftercare following joint replacement surgery, as the first-listed or principal diagnosis.
  - See Section I.C.21.c.7, Factors influencing health states and contact with health services, Aftercare.

Rehabilitation Unit Procedures

- In some cases adding the rehabilitation ICD-10-PCS code when paired with a diagnosis code that is included within MDC 23 will change your DRG to 945/946
- Many diagnosis codes assigned for rehab patients do not end up in MDC 23.
  - Example, patient admitted to rehab with S02119D, Unspecified fracture of occiput, subsequent encounter for fracture with routine healing, is included in MDC 8. Adding a procedure code such as F0706GZ (Therapeutic Exercise Treatment of Neurological System – Head and Neck using aerobic endurance and conditioning equipment) would not lead to DRG 945/946.
  - However, assigning Z51.89, Encounter for other specified aftercare or Z44.9, Encounter for fitting and adjustment of other external prosthetic devices with this procedure will lead to DRG 945/946 assignment.

Rehabilitation Procedure Examples

<table>
<thead>
<tr>
<th>Code</th>
<th>Physical Rehab</th>
<th>Rehabilitation</th>
<th>Motor Treatment</th>
<th>Neurological System – Head and Neck</th>
<th>Therapeutic Exercise</th>
<th>Aerobic Endurance and Conditioning</th>
<th>Equipment</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 0779ZZ</td>
<td>F Physical Rehab</td>
<td>0 Rehabilitation</td>
<td>7 Motor Treatment</td>
<td>0 Neurological System – Head and Neck</td>
<td>6 Therapeutic Exercise</td>
<td>G Aerobic Endurance and Conditioning</td>
<td>Z No Equipment</td>
<td>Z No Qualifier</td>
</tr>
<tr>
<td>F 07L0ZZ</td>
<td>F Physical Rehab</td>
<td>0 Rehabilitation</td>
<td>7 Motor Treatment</td>
<td>L Musculoskeletal</td>
<td>Lower Back/Lower Extremity</td>
<td>O ROM &amp; Joint Mobility</td>
<td>Z No Equipment</td>
<td>Z No Qualifier</td>
</tr>
</tbody>
</table>
SIRS due to Infection vs. Sepsis

- No index entry for systemic inflammatory response syndrome (SIRS) due to infection. So this does not automatically translate to sepsis.
- Coders must not assume SIRS due to infection is coded to sepsis without query.
  - Clinical indicators must be met to query.
  - Increased amounts of queries
- Severe sepsis and septic shock must be documented in order to assign codes.

New Sepsis Criteria!

- New criteria is out for sepsis: The Third International Consensus Definitions for Sepsis and Septic Shock (sepsis-3)
  - http://www.esicm.org/news-article/ARTICLE-REVIEW-sepsis-3-Defin.html articles will be published today
- Note that this is CLINICAL criteria. No directives for coding have been released by the cooperating parties.
- Look for more information to

New Sepsis Criteria!

- Sepsis is defined as life-threatening organ dysfunction caused by a dysregulated host response to infection.
- In lay terms, sepsis is a life-threatening condition that arises when the body’s response to an infection injures its own tissues and organs.
- Patients with suspected infection who are likely to have a prolonged ICU stay or to die in the hospital can be promptly identified at the bedside with signs including alteration in mental status, systolic blood pressure ≤100 mm Hg, or respiratory rate ≥22/min.
New Sepsis Criteria!

- Septic shock is a subset of sepsis in which underlying circulatory and cellular/metabolic abnormalities are profound enough to substantially increase mortality.
- Patients with septic shock can be identified with a clinical construct of sepsis with persisting hypotension requiring vasopressors and having a high serum lactate level despite adequate volume resuscitation. With these criteria, hospital mortality is in excess of 40%.
- However SOFA criteria (Sequential Organ Failure Assessment) is clinical, and CMS criteria is quality oriented.
- A SOFA score ≥2 reflects an overall mortality risk of approximately 10% in a general hospital population with suspected infection.

New Sepsis Criteria SOFA

Table 1. Sequential Organ Failure Assessment (SOFA) Score

<table>
<thead>
<tr>
<th>System</th>
<th>Score</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory</td>
<td>PaO2/FiO2</td>
<td>&lt;400 (5.3)</td>
<td>&gt;400 (5.3)</td>
<td>&lt;300 (4.0)</td>
<td>&gt;300 or FiO2 &gt;1.0 or respiratory support</td>
</tr>
<tr>
<td>Renal</td>
<td>Creatinine</td>
<td>1.5</td>
<td>2.0</td>
<td>3.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>MAP</td>
<td>70</td>
<td>50</td>
<td>30</td>
<td>20</td>
</tr>
<tr>
<td>Intra-abdominal</td>
<td>Sepsis</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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</thead>
<tbody>
<tr>
<td>Hematologic</td>
<td>PaO2/FiO2</td>
<td>&lt;400 (5.3)</td>
<td>&gt;400 (5.3)</td>
<td>&lt;300 (4.0)</td>
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Obstetrical Principal Diagnosis

- Some codes that one would think would be acceptable principal diagnoses, are not. Example “Supervision of Pregnancy codes”
- O09.523, Supervision of elderly multigravida, third trimester is not a valid principal diagnosis. DRG 998, PDX Invalid.
- In ICD-9-CM this was code 659.53 and assigned to DRG 782, Other antepartum diagnoses.
- How can clients overcome this?
- Z38.1 for newborn delivered outside hospital is in CMS edits as an unacceptable principal diagnosis.
- May have to use Z38.2 until it is fixed
Coders struggled with choosing the obstetrical PDX.
Coders misinterpreted the guideline that states “when a delivery occurs, the principal diagnosis should correspond to the main circumstances or complication of the delivery.”
Coders literally thought the code that was related to the delivery, such as a 2nd degree perineal laceration MUST be PDX, even if the obstetrics patient was admitted with another obstetrical condition such as gestational hypertension.
1Q2016 page 3-6 clarifies that the reason for admission should be listed as PDX, not the diagnosis related to delivery, unless there is no other condition responsible for admission.

ICD-10-PCS

The seven characters for medical and surgical procedures section have the following meanings:

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<thead>
<tr>
<th>1</th>
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<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
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<tbody>
<tr>
<td>Section</td>
<td>Root</td>
<td>Operation</td>
<td>Approach</td>
<td>Qualifier</td>
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<td></td>
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<td>Body System</td>
<td>Body Part</td>
<td>Device</td>
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The seven characters for imaging procedures section have the following meanings:

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<tr>
<td>Section</td>
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<td>Contrast</td>
<td>Qualifier</td>
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<tr>
<td>Body System</td>
<td>Body Part</td>
<td>Contrast/Qualifier</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Biopsy Diagnostic Qualifier X:**

**PROBLEM:**

- Coder’s are not applying the 7th character “X-Diagnostic” correctly

**Biopsy Diagnostic Qualifier X: 83.4a**

- Biopsy procedures are coded using the root operations Excision, Extraction, or Drainage and the qualifier Diagnostic. The qualifier Diagnostic is used only for biopsies.
- Colonoscopy with biopsy of transverse colon is coded to root operation Excision and qualifier Diagnostic.

If a colonoscopy is done to remove a polyp, and the polyp is sent to pathology, do NOT use qualifier X – diagnostic.
Biopsy with Definitive Treatment: B3.4b

If a diagnostic Excision, Extraction, or Drainage procedure (biopsy) is followed by a more definitive procedure, such as Destruction, Excision or Resection at the same procedure site, both the biopsy and the more definitive treatment are coded.

Biopsy of lesion of the left parotid gland, followed by resection of entire left parotid gland.

Codes are assigned for both the diagnostic Excision and Resection of left parotid gland.

Example: Excision of RUL of Lung Due to Cancer

A patient has undergone previous CT of the lung with identification of a right upper lobe mass, and patient was scheduled for surgery to remove the mass. Patient is admitted inpatient and undergoes open right upper lobe removal which includes the mass. The specimen is sent to pathology where adenocarcinoma of the lung is diagnosed. The lung tissue margins are clear.

Would the coder assign the 7th character of “X-Diagnostic” to the resection code?

Example: Video-Assisted Thoracoscopic Wedge Resection

H&P “Mr. XXX is here today to discuss options for diagnosing his progressive diffusing capacity dysfunction, now down to 59% predicted. He has significant exposure history including smoking. Previous FOB/BAL showed eosinophilia and was thought to be related to medications that he has since stopped. He is here to discuss tissue diagnosis... Mr. XXX has what appears to be progressive and diffuse pulmonary interstitial disease. There is volume loss in the right hemithorax. No significant mediastinal lymphadenopathy. Would agree with tissue sampling to make a definitive diagnosis of the cause of the fibrosis...”
Example: Video-Assisted Thoracoscopic Wedge Resection

**Op note:** “...Right-sided video-assisted thoracoscopic exploration with wedge resection of the middle lobe and the upper lobe....

**Indication for the procedure:** ...an unfortunate 68 year old gentlemen who presents with worsening SOB and dyspnea on exertion. He has undergone bronchoscopy in the past with biopsies, brushing and cultures and these have been diagnostic. His disease has progressed and he was therefore, referred for possible tissue biopsy.

**Procedure ...** I palpated the lung, and along with the tactile stimulus, as well as CT scan findings, the areas were chosen in the upper lobe, as well as the middle lobe for biopsy. An Endo-GIA stapler was used to divide these small portions of lung from the remainder of the lung. These both were placed in an EndoCatch pouch ...A small portion of each specimen was sent for microbiology and gram stain, culture and sensitivity. The remaining majority of the specimen was sent for permanent analysis...

**Pathology:** Lung, Right middle lobe, wedge biopsy: “Advanced interstitial pneumonia with a usual interstitial pneumonia pattern...”
Example: Paracentesis

- Patient with alcoholic cirrhosis of the liver and ascites (K70.31) here for paracentesis.
- Ascites fluid is sent to pathology for analysis.
- Do you assign 7th character X-Diagnostic or Z-No Qualifier?
- In some cases if “X-Diagnostic” is assigned the DRG varies widely such as DRG 186 vs DRG 987. X-Diagnostic assigns the case to a surgical DRG.
- Many facilities are assigning “Z-No Qualifier” until CMS fixes the problem however contact your MAC and compliance department.

Example: Paracentesis

0W9G3ZZ 0W9G3ZX
0 Medical/Surgical 0 Medical/Surgical
W Anatomic Regions W Anatomic Regions
9 Drainage 9 Drainage
G Peritoneal Cavity G Peritoneal Cavity
3 Percutaneous 3 Percutaneous
Z No Device Z No Device
Z No Qualifier X Diagnostic

DRG 434, Cirrhosis and Alcoholic Hepatitis without CC/MCC 0.6235
DRG 422, Hepatobiliary Diagnostic Procedures without CC/MCC 1.2941

Vascular Access Devices

PROBLEM:

- There are several types of vascular access devices that are coded differently in ICD-10. Official advice has been conflicting and incomplete in how to code each type.
Different types of VADs require different types of ICD-10-PCS codes. PICC, CVC, implanted port, etc.

- Code to the “end” point of the catheter, not the entry point of the catheter for central lines.
- Code fluoro and U/S if utilized or guidance (B51).
- Confusing advice regarding approaches in this Coding Clinic for insertion of port devices. They stated “percutaneous” is correct however later in the article state “Open” approach be used for totally implanted port. Coding Clinic 4Q2013 pages 116-117 support that “open” be used for totally implantable ports.

VAD thru right subclavian to SVC sutured at insertion site by right subclavian vein.

02HV33Z

- Medical and Surgical
- Heart and Great Vessels
- Insertion
- Superior Vena Cava
- Percutaneous approach
- Infusion Device
- No Qualifier
Cavo-atrial Junction

- Coding Clinic 4Q 2015 pages 30-32 also addressed “cavo-atrial” junction VAD insertion is coded to body part “SVC” and not right atrium.
- CAUTION: Coding insertion of VAD to an “open” approach and to “right atrium” code 02H603Z will change your MS-DRG assignment to a surgical MS-DRG.

Tunneled Hemodialysis Catheter

- Two codes or one?
- Not a totally implanted port.
- Catheter tunneled under skin however the two ports are outside of the body, accessed for hemodialysis, etc. then capped when not in use.
- Sent to AHA Coding Clinic for official advice.
- Coding Clinic 4Q 2015 pages 26-32 also addressed this but it is very confusing.
- AHA Coding Clinic 2Q1996 stated that these were not considered “totally implantable VADs” and were coded to 38.93 or 38.95.
**Tunneled VAD from jugular to chest.**

**VAD in SVC**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>02HV33Z</td>
<td>0 Medical/Surgical</td>
</tr>
<tr>
<td>0 J</td>
<td>Medical/Surgical</td>
</tr>
<tr>
<td>2 H</td>
<td>Heart and Great Vessels</td>
</tr>
<tr>
<td>2 J</td>
<td>Subcutaneous Tissue and Fascia</td>
</tr>
<tr>
<td>3 V</td>
<td>Superior Vena Cava</td>
</tr>
<tr>
<td>6 H</td>
<td>Percutaneous</td>
</tr>
<tr>
<td>0 V</td>
<td>Open approach</td>
</tr>
<tr>
<td>0 Z</td>
<td>No Device</td>
</tr>
<tr>
<td>0 X</td>
<td>Vascular Access Device</td>
</tr>
<tr>
<td>0 Z No Qualifier</td>
<td>Subcutaneous and fascia body area.</td>
</tr>
</tbody>
</table>

**Totally Implantable Port with VAD**

- Two codes as there are two-part devices.
- Port is totally implanted plus code for central vein catheter insertion.
- Needle access through skin to reach port.
- Are sometimes called “Medi-port;” “Port-a-Cath;” “Groshong port.”
- Use open approach for implanted port and code to location within subcutaneous and fascia body area.
- For central venous cath, code percutaneous and to body area of where the tip ends up (i.e. right atrium, SVC)
- Coding Clinic 4Q 2015 pages 27-32 also addressed this but it is very confusing.

**Totally Implantable Port with VAD**

- Port Catheter; Port-O-Cath
- Code: Insertion, SubQ if chest, VAD port 0JH60VZ PLUS catheter to SVC 02HV33Z
- Code: Insertion, SubQ if chest, Pump 0JH60VZ and Reservoir 0JH60WZ PLUS Infusion device, into SVC 02HV33Z
Spinal Infusion Pump with Spinal Catheter

Totally Implantable Spinal Reservoir and Pump

See Coding Clinic 3Q 2014 pages 19-20
Baclofen Pump

Code: Insertion, SubQ if abdomen,
Pump 0JH80VZ PLUS
Infusion device, into Spinal Canal
00HU33Z

Totally Implantable Spinal Reservoir and Pump

Three codes:
- Reservoir implantation plus pump implantation plus central catheter insertion
- Needle access through skin to reach reservoir to fill it.
- Coding Clinic 4Q 2015 pages 26-32 also addressed this but it is very confusing.

http://www.cancernetwork.com/palliative-and-supportive-care/neuraxial-infusion-management-cancer-pain/page/0/2

Arterial Lines for Monitoring

PROBLEM:

A debate exists on how to assign ICD-10-PCS code for placement of arterial lines for the purpose of monitoring blood pressure or for ABG draws. Some codes affect DRG assignment.
Arterial Line for Monitoring

4A133B1 03HY32Z
4 Monitoring/Measuring 0 Medical/Surgical
A Physiological Systems 3 Upper Arteries
1 Monitoring H Insertion
3 Arterial Y Upper Artery
3 Percutaneous 3 Percutaneous
B Pressure Z Monitoring Device
1 Peripheral Z No Qualifier

If I10 as PDX;
DRG 305, Hypertension
RW 0.6626

AHA Coding Clinic 3Q 2015 page 35 for Swan Ganz recommends both codes; 02HP32Z for insertion of Swan Ganz and 4A1239Z for arterial pressure. (02HP32Z does NOT take you to a surgical DRG)

This is probably a DRG assignment error for arterial lines.
Most facilities are NOT reporting the insertion code to avoid the large DRG payment to avoid problems later.
AHIMA Train the Trainer book states “If a device used to perform the measurement or monitoring is left in, insertion of the device is coded as a separate procedure.”
RAC will most likely review these retrospectively.
Develop a facility policy after consulting compliance department so coders are all on the same page.

Control of Bleeding

PROBLEM:

There is confusion on whether or not intraoperative bleeding with clips should be coded in ICD-10-PCS to “Control” of the site. Some coders are coding “Control,” others are coding “Repair” of site and others nothing at all.
Control of Bleeding

- AHA Coding Clinic 3Q 2013 page 23 states that control of bleeding at the time of the procedure is inherent in the overall procedure and not reported separately, even if it requires additional time and effort.
- Root operation “Repair” is used when clips are used to stop bleeding from a duodenal ulcer, for example. Do not use root operation “Control” in this situation as this is not a postoperative bleeding.
- See AHA Coding Clinic 4Q 2014 page 20 for Control of bleeding of duodenal ulcer, 0DQ98ZZ Repair of duodenum.

Control: OCG B3.7

- 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.

Endarterectomy of Multiple Vessels with Patch Graft

PROBLEM:

- How many extirpation codes are assigned if plaque is removed from several arteries with different body part values? Is the patch graft done after the surgery coded?
### Endarterectomy of Multiple Vessels with Patch Graft

**Example sent to AHA Coding Clinic:**

- Endarterectomy of left external iliac artery, left common femoral artery and left profunda femoral artery.
- Superficial femoral artery portion excised to be used as a patch graft to the left external iliac upon closure.
- Is an “extirpation” code assigned three times, one each for the arteries named above?
- Should the harvest/excision of SFA for the graft be coded along with the patch graft to the left external iliac artery?

### Coding Examples

<table>
<thead>
<tr>
<th>Code</th>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Medical &amp; Surgical</td>
<td>0 Medical &amp; Surgical</td>
</tr>
<tr>
<td>4</td>
<td>Lower Arteries</td>
<td>4 Lower Arteries</td>
</tr>
<tr>
<td>C</td>
<td>Extirpation</td>
<td>C Extirpation</td>
</tr>
<tr>
<td>J</td>
<td>External Iliac artery, Left</td>
<td>J External Iliac artery, Left</td>
</tr>
<tr>
<td>0</td>
<td>Open</td>
<td>0 Open</td>
</tr>
<tr>
<td>Z</td>
<td>No Device</td>
<td>Z No Device</td>
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<tr>
<td>Z</td>
<td>No Qualifier</td>
<td>Z No Qualifier</td>
</tr>
<tr>
<td>Lt</td>
<td>external iliac endarterectomy</td>
<td>Lt external iliac endarterectomy (only 1 extirpation code)</td>
</tr>
</tbody>
</table>

**NOTE:** This answer is based on 1Q2016 page 31

AHA considers the “plaque” as one continues lesion and thus only assigned one extirpation code for left external iliac artery.

Profunda femoral artery (also called deep femoral artery) assigns to body part “Femoral artery” (Guideline B3.3b)
PROBLEM:
- There is confusion on how to assign ICD-10-PCS codes for various grafts. Coders seem to get confused as to when to assign “Transfer” or “Replacement.”

If tissue is being rearranged, it is coded to root operation “Transfer” because the flap is not disconnected from the vascular and nerve supply.
- A free skin graft is coded to root operation “Replacement.” An additional code is assigned for the excision of the donor skin if autograft is performed. This is a graft of skin completely removed from its original location.
- Look at the objectives of the procedures being performed.

REPLACEMENT – Root Operation R:
- Definition: 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.
- Explanation: The biological material is non-living, or the biological material is living and from the same individual. The body part may have been previously taken out, previously replaced or may be taken out concomitantly with the Replacement procedure. If the body part has been previously replaced, a separate Removal procedure is coded for taking out the device used in the previous replacement.
- Examples include free skin graft, total hip replacement, breast reconstruction after mastectomy.
Free Skin Grafts

Definition: 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: The body part transferred remains connected to its vascular and nervous supply.

Examples include skin pedicle flap transfer, rotation flap graft, tendon transfer.
Types of Grafts

- Tissue-cultured epidermal autograft utilizes patient’s own skin that is previously harvested and grown in a lab. 14 days later it is used as a skin replacement.
  - Use Device value 7, Autologous tissue for skin
  - Use Qualifier value 4, Partial thickness for skin
- TRAM (transverse rectus abdominis myocutaneous) flap is a free flap (Replacement) OR a pedicled flap (transfer).
- DIEP (deep inferior epigastric artery perforator) is a free flap and coded to Replacement in ICD-10-PCS
  - Free flaps or grafts are disconnected from their original vascular and nervous supply

Grafts coded to Transfer

- When tissue flaps are coded to the root operation of Transfer, the body system value used describes the deepest tissue layer in the flap. The qualifier is sometimes used to describe when more than one tissue layer is transferred. Example:
  - Skin and subcutaneous tissue.
  - Skin, subcutaneous tissue and fascia.
  - Example, Transfer of subcutaneous tissue via rotational graft from right side of trunk to abdomen. The body part is Subcutaneous tissue and fascia, Abdomen, the qualifier is B, Skin and Subcutaneous Tissue.

Examples of Skin Synthetic Substitutes

- Device or Sixth character “J-Synthetic Substitute”
  - Artificial skin, not otherwise specified
  - Creation of “Neodermis”
  - Integumentary matrix implants
  - Prosthetic implant of dermal layer of skin
  - Regenerate dermal layer of skin
**Graft Questions**

- What is the site of the graft?
- What type of graft is being placed? Free graft? Pedicle graft? Is it still attached to the vascular and nerve supply or is it totally excised from the body?
- Is it autologous, non-autologous, or synthetic?
- If tissue, what layers are involved in the graft? Skin? Subcutaneous tissue? Fascia? Muscle?
- What is the purpose of the graft?
- What is the site of the donor graft if from the same patient? (autograft)

**Summary**

- Continue to study the ICD-10-PCS Guidelines.
- Become very familiar with the root operations and their description for use in ICD-10-PCS.
- Carefully review Coding Clinic and if a situation is not addressed, send it to Coding Clinic for official advice.
- Look at coding forums such as “Engage” to see if someone else encountered the same problem and found a solution.
- Check with vendors to see if they have resolved the issue.