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Surgery ICD 10 Documentation Tips

Presenters

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Abdominal Pain- ICD 10 The Hard Way!

Abdominal R10.9 **Colic R10.83** **Generalized R10.84** **with acute abdomen R10.0** **Lower R10.30** **left quadrant R10.32** **pelvic or perineal R10.2** **periumbilical R10.33** **right quadrant R10.31**	**Tenderness, abdominal R10.819** **epigastric R10.816** **generalized R10.817** **left lower quadrant R10.814** **left upper quadrant R10.812** **periumbilic R10.815**	**Abdominal and pelvic pain** **acute abdomen R10.0** **Localized to other parts of lower abdomen R10.30** **RUQ abdominal tenderness R10.811** **LUQ abdominal tenderness R10.813**
Upper R10.10 epigastric R10.13 left quadrant RR10.12 right quadrant R10.11	Tenderness right lower quadrant R10.823 right upper quadrant R10.821	Rebound abdominal tenderness R10.82 RUQ rebound R10.821 LUQ rebound R10.822
Acute R52 due to trauma G89.11 neoplasm related G89.3 postprocedural NEC G89.18 post-thoracotomy G89.12 Abdominal rigidity R19.3 unspecified site R19.30 RUQ rigidity R19.31 LUQ rigidity R19.32	RLQ rebound abdominal tenderness R10.823 LLQ rebound abdominal tenderness R10.824 Periumbilic rebound abdominal tenderness R10.825 Abdominal rigidity RLQ rigidity R19.33 LLQ rigidity R19.34	Generalized rebound abdominal tenderness R10.827 Rebound tenderness unspecified site R10.829 Colic NOS R10.83 Unspecified abdominal pain R10.9 Abdominal rigidity periumbilic R19.35 epigastric R19.36 generalized R19.37

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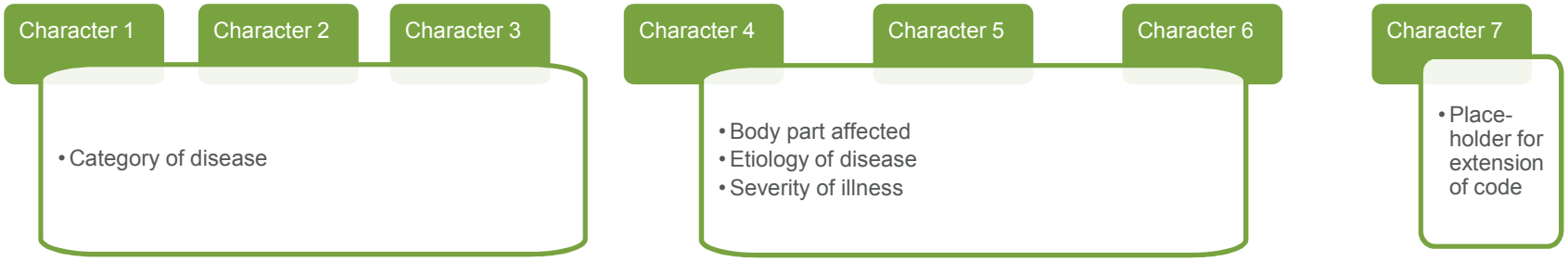
SOI *(Severity of Illness)* / ROM *(Risk of Mortality)*

- Documentation should reflect the acuity of the patient…
- If a patient dies because he or she was severely ill, but the documentation translates into codes that do not reflect the severity, the adjusted SOI and ROM poorly reflect the care provided.

Four Severity of Illness Subclasses	Four Risk of Mortality Subclasses
1. Minor	1. Minor
2. Moderate	2. Moderate
3. Major	3. Major
4. Extreme	4. Extreme

ICD-10 CM

- Diagnosis classification system developed by the Centers for Disease Control and Prevention for use in all U.S. health care treatment settings
- ICD 10 CM codes can have 3, 4, 5, 6 or 7 characters (alphanumeric)



L97.422	L97 – Non pressure chronic ulcer of lower limb	4 – Heel and mid foot	2 – Left	2 – Fat layer exposed

A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures

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ICD-10 Made Simple For Those That Have Coders- DOCUMENT!

Acuity- acute, chronic, intermittent

Severity- mild, moderate, severe

Etiology- trauma, diabetes, renal failure, exercise or infection induced

Location- where is it- be specific about which joint, chest, femur, posterior thorax

Laterality- which side is it? Left, right, both?

Detail: Present on admission status, associated symptoms (hypoxia, loss of consciousness), additional medical diagnoses, initial versus subsequent encounter

**Specifics on type and timing of injury

If you like mnemonics

Any: Acuity
Small: Severity
Error: Etiology
Loses: Location
Large: Laterality
Dollars: Detail- Present on admission status, associated symptoms, additional medical diagnoses, initial versus subsequent encounter

Key Words!

GI:

Specific Location: duodenum, jejunum, ileum, cecum, rectum, sigmoid, transverse colon, descending colon, ascending colon.

Associated findings: abscess, perforated, ruptured, with/without peritonitis, adhesions, bleeding, obstruction, gangrene

Breast:

Areolar, central portion, lower inner quadrant, lower outer quadrant, nipple, axillary tail

Trauma:

GCS should include scores on all 3 components and detail on incidents that led up to the injury

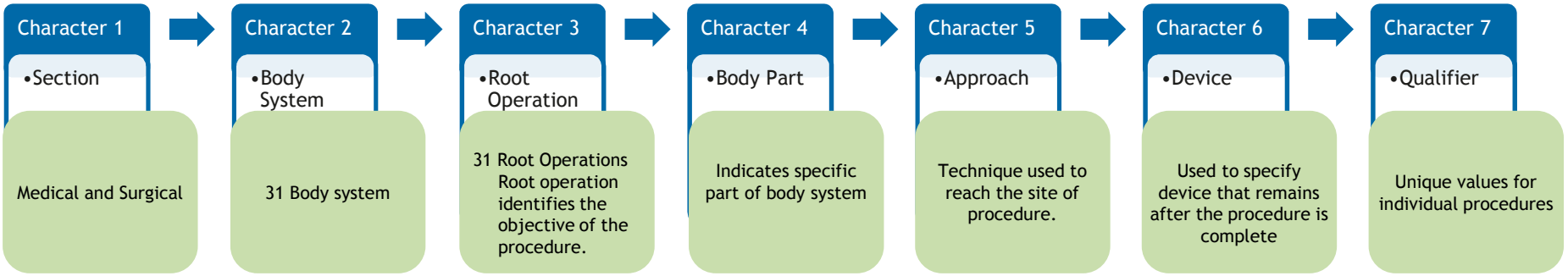
Ulcers:

Severity: skin breakdown only, exposed fat layer, muscle necrosis, bone necrosis,

Where on foot? Heel, mid-foot, toe

ICD-10 PCS

- ICD-10-PCS codes are composed of seven characters
- Each character is an axis of classification that specifies information about the procedure performed



Name	ICD-10 PCS coding	Medical and surgical	Gastrointestinal system	Resection	Body part	Approach (Open)	Device (None)	Qualifier (None)
Sigmoidectomy	**0DTNOZZ**	**0**	**D**	**T**	**N**	**0**	**Z**	**Z**

In ICD-10 PCS, the term *"procedure"* refers to the complete specification of the seven characters

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Important Documentation for Procedures

Type of Procedure (Root Operation): specifies the primary objective of the procedure

Ex: drainage, excision, resection

Body Part: the specific organ or site on which the procedure is performed

Approach: the technique/method used to access the operative site

Ex: Open, percutaneous, external, endoscopic

Devices: any device or material that remains at the site upon completion of the procedure

Qualifier: unique character for specific procedures

Ex: diagnostic, therapeutic

Common Coder Queries: Debridements

1) Document the deepest layer of tissue debrided (e.g., skin, subcutaneous tissue, soft tissue, muscle, or bone)

2) Document the type of debridement performed: "excisional" (e.g., definite cutting away of tissue, not the minor scissor removal of loose fragments) or "non-excisional" (e.g., brushing, scrubbing, ultrasonic, or water jet).

Common Coder Queries: Blood Loss

- "Blood loss anemia" or "post-operative anemia"
  Queries: ***acute vs chronic.* Per Coding Guidelines, postoperative anemia without specification of acute blood loss is coded to *Anemia, unspecified*

Case Study - Hernia

A 50 year old male presents with severe abdominal pain from a midline abdominal hernia which you suspect is strangulated and has associated obstruction. He has bilious emesis but no bloody stools. His vital signs are : temperature 101 F, HR 110 bpm, RR 24 breaths per minute, and a blood pressure of 80/50 mm Hg.

He has a history of Type II diabetes and smokes 2 packs of cigarettes per day
You are called to consult on this patient in the ED.

Example- Septic Shock Due to Strangulated Hernia

ACUITY	acute
SEVERITY	severe
ETIOLOGY	strangulation
LOCATION	abdominal
LATERALITY	midline
DETAILS	Initial encounter. Associated symptoms: obstruction, vomiting. History of Type II Diabetes, cigarette dependence. SIRS- Present on admission

ALL PUT TOGETHER

1. Acute, severe, septic shock due to midline abdominal hernia with strangulation and obstruction. Present on admission. Initial encounter
2. History of Type II Diabetes
3. Cigarette Dependence

***** note there is no code for urosepsis, results in code assignment of UTI!**

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Procedure Documentation Examples

Midline Abdominal Hernia with gangrene and obstruction

Type of Surgery (Root operation): Resection
Body Part: abdomen
Approach: Open
Device: Drain

Case Study – Gunshot Wound

A disorderly drunk teenager was shot at 10pm by police during a violent protest. The patient began attacking a police officer with a baseball bat and refused to put his weapon down despite multiple attempts at reasoning by bystanders and police officers. The teen was shot in the abdomen with a mild glance injury of his right buttock that was only through the subcutaneous tissue. You take him to the OR and find that he has a perforation of his transverse colon which you repair without complication.
He does not drink on a regular basis

Example- Gunshot Wound

ACUITY	acute
SEVERITY	severe
ETIOLOGY	trauma, GSW
LOCATION	buttock
LATERALITY	right
DETAILS	Initial encounter. Alcohol abuse.
ALL PUT TOGETHER	1. Acute, severe, perforation of transverse colon secondary to handgun shooting without obstruction. Initial encounter 2. Acute gunshot wound through subcutaneous tissue to right buttock 3. Acute Alcohol intoxication

Case Presentation: Sepsis

67 year old male presents with altered mental status, fever to 104F, and a blood pressure of 70/30 mm Hg, HR of 110 bpm and RR of 20 breaths/ minute. His oxygen saturation is 90% on RA but increases to 95% with 2 liters of oxygen. His WBC is 20,000 and his urine is positive. His BP does not improve with 2 boluses of normal saline and therefore you start him on pressors. He is admitted to the ICU.

PMH: History of MI

Social history: Smokes 2 packs of cigarettes per day

Sepsis: Example

ACUITY	acute
SEVERITY	**severe**
ETIOLOGY	**Urinary tract**
LOCATION	**N/A**
LATERALITY	**N/A**
DETAIL	Initial encounter. **Associated findings: Hypoxia, encephalopathy, present on admission**
ASSOCIATED FINDINGS	hypoxia, cigarette *(tobacco)* dependence
ALL PUT TOGETHER	1) Acute, severe septic shock due to urinary tract infection – present on admission 2) Acute hypoxia 3) Acute encephalopathy 4) History of Acute MI 5) Cigarette dependence

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Sepsis

The ICD-10-CM describes more than 65 categories of sepsis. Include the following:

The circumstances that preceded the sepsis (eg, due to device, implant, etc., during labor, post-procedural)

Causal organism

Presence of shock

Present On Admission or not present on admission

Urosepsis is not considered a classification!

Chest Tube

Type of Procedure (Root Operation): Drainage
Body Part: Left pleural cavity
Approach: Percutaneous
Device: 16 French chest tube

Case Study – Central Line

Type of Procedure (Root Operation): Insertion
Body Part: right atrium, SVC, IVC, innominate vein, subclavian vein
Approach: percutaneous
Device: infusion catheter

Procedure	ICD-10 PCS coding	Medical and surgical	Heart and great vessels	Insertion	Body part	Approach (Percutaneous)	Device (Infusion device)	Qualifier
PICC	**02H*33Z**	**0**	**2**	**H**	**6 Atrium RT V Superior vena cava**	**3**	**3**	**Z**

ICD-10 requires to specify the site where the tip of the catheter is placed for central line

Root Operations

ICD-9 Procedure	ICD-10 Root Operation	Example
Excision - Cutting and taking a body part out	**Excision** - Cutting out or off, without replacement, a portion of a body part **Resection** - Cutting out or off, without replacement, all of a body part	e.g. Partial nephrectomy, liver biopsy e.g. Total nephrectomy, total lobectomy of lung
Incision – Cutting into a body part	**Division** - Cutting into a body part, without draining fluids and/or gases from the body part, in order to separate or transect a body part **Release** - Freeing a body part from an abnormal physical constraint by cutting or by the use of force **Drainage** - Taking or letting out fluids and/or gases from a body part	e.g. Spinal cordotomy, osteotomy e.g. Adhesiolysis, carpal tunnel release e.g. Thoracentesis, incision and drainage
Repair – Suture a body part , repair of hernia, arthroplasty, angioplasty etc.	**Repair** - Restoring, to the extent possible, a body part to its normal anatomic structure and function **Control** - Stopping, or attempting to stop, postprocedural bleeding **Supplement**: Putting in or on biological or synthetic material that physically reinforces and/or augments the function of a portion of a body part **Reattachment**: Putting back in or on all or a portion of a separated body part to its normal location or other suitable location **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 **Dilation**: Expanding an orifice or the lumen of a tubular body part	e.g. Colostomy takedown, suture of laceration e.g. Control of post-prostatectomy hemorrhage, control of post-tonsillectomy hemorrhage e.g. Herniorrhaphy using mesh, mitral valve ring annuloplasty, e.g. Reattachment of hand, reattachment of avulsed kidney e.g. Total hip replacement, bone graft, free skin graft e.g. Percutaneous transluminal angioplasty, pyloromyotomy
Removal – Taking out of body	**Extirpation** - Taking or cutting out solid matter from a body part **Extraction** - Pulling or stripping out or off all or a portion of a body part by the use of force **Removal** - Taking out or off a device from a body part	e.g. Thrombectomy, choledocholithotomy e.g. Dilation and curettage, vein stripping, calculus removal e.g. Drainage tube removal, cardiac pacemaker removal
Arthrodesis	**Fusion** - Joining together portions of an articular body part rendering the articular body part immobile	e.g. Spinal fusion, ankle arthrodesis

Total 31 root operations in Medical & surgical section. Root operation is coded according to the objective of the procedure performed.

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Root Operations

ICD-9 Procedure	ICD-10 Root Operation	Example
Amputation	**Detachment**: Cutting off all or a portion of the upper or lower extremities	e.g. Below knee amputation, disarticulation of shoulder
Fulguration	**Destruction**: Physical eradication of all or a portion of a body part by the direct use of energy, force, or a destructive agent	e.g. Fulguration of rectal polyp, cautery of skin lesion
Bypass	**Bypass**: Altering the route of passage of the contents of a tubular body part	e.g. Coronary artery bypass, colostomy formation , gastric bypass
Replacement	**Change**: 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	e.g. Urinary catheter change, gastrostomy tube change
Reduction	**Reposition** - Moving to its normal location, or other suitable location, all or a portion of a body part	e.g. Reposition of undescended testicle, fracture reduction
Ligation	**Occlusion** - Completely closing an orifice or the lumen of a tubular body part	e.g. Fallopian tube ligation, ligation of inferior vena cava
Lithotripsy	**Fragmentation** - Breaking solid matter in a body part into pieces	e.g. Extracorporeal shockwave lithotripsy, transurethral lithotripsy
Arthroscopy	**Inspection**: Visually and/or manually exploring a body part	e.g. Diagnostic arthroscopy, exploratory laparotomy
Restriction	**Restriction**: Partially closing an orifice or the lumen of a tubular body part	e.g. Esophagogastric fundoplication, cervical cerclage, gastric banding

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For any questions: