2015 Update on AHA Coding Clinic for ICD-10-CM and ICD-10-PCS
Part One

Wednesday, June 17, 2015
12:00 – 1:15 pm CST

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Overview

• Evacuation of Hematoma
• Lymph Node Resection
• Discontinued Procedures
• Incision and Drainage of Abscess of Femoropopliteal Bypass Site
• Incision and Drainage of Groin Abscess
• Cesarean Delivery assisted by Vacuum Extraction
• Control of Bleeding
• Obstetrical Periurethral Laceration
• Excision of Multiple Fibroids
• Acute CVA with unilateral Weakness
• Mechanical Ventilation

Anita Rapier, RHIT, CCS
Senior Coding Consultant
Root Operation - Control

- ICD-10-PCS Official Guidelines for Coding and Reporting (B3.7) define the root operation “Control” 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.

Scenario #1

- Patient developed postoperative bleeding, following left brachial reverse saphenous vein bypass.
  - Hemorrhaging required a return to the operating room.
  - Fresh blood and hematoma was evacuated from the wound of the bypass.
  - Bleeding branch from the bypass graft was tied.
- Root operation “Control” is assigned since the procedure was performed to control postprocedural hemorrhage.
  - Assign ICD-10-PCS code:
    - \texttt{0X370ZZ} Control bleeding in left upper extremity, open approach
Lymph Node Resection Versus Excision

• The ICD-10-PCS Reference Manual, page 39, states:
  – When an entire lymph node chain is cut out, the appropriate root operation is resection.
  – When a lymph node(s) is cut out, the root operation is excision.
• Therefore code resection when a chain of lymph nodes is excised.
  – If a partial removal of the lymph node chain is done, code as excision.
  – If the intent is to remove all of the lymph nodes in an area, code as resection.
• Report lymph nodes sampling (i.e., sentinel nodes) as excision.

Lymph Node Resection Versus Excision (cont.)

• Radical resection implies removal of all of the lymph nodes.
• Radical resection of an organ does not necessarily imply the removal of adjacent nodes, it implies the entire organ was resected.
• Modified radical resection also involves the removal of all nodes and is coded as resection.
  – Radical procedures involve cutting out everything within a designated anatomic boundary.
Scenario #2

- Patient with adenoid cystic carcinoma underwent resection of the parotid tail, resection of the parapharyngeal space, and bilateral radical resection of level I lymph nodes.
- In this case the surgeon removed the entire level I lymph nodes.
  - Each level is considered a chain.
- The following ICD-10-PCS codes are assigned:
  - 07T10ZZ Resection of right neck lymphatic, open approach
  - 07T20ZZ Resection of left neck lymphatic, open approach

Discontinued Procedures

- ICD-10-PCS Official Guidelines for Coding and Reporting (B3.3) state:
  - If the intended procedure is discontinued, code the procedure to the root operation performed.
  - If a procedure is discontinued before any other root operation is performed, code the root operation Inspection of the body part or anatomical region inspected.
Scenario #3

• Patient presents for a planned carotid artery endarterectomy.
  — Diagnostic tests had demonstrated carotid artery stenosis and atherosclerotic disease.
  — Upon surgical exploration, no evidence of carotid artery stenosis or atherosclerotic disease.
  — Since surgery was discontinued, inspection of the carotid artery is the only procedure performed.
• Assign ICD-10-PCS code: **03JY0ZZ** Inspection of upper artery, open approach, for the exploration of the carotid artery.

Scenario #4

• Patient status post left femoral popliteal arterial bypass graft developed a surgical site infection of the left groin, group G Strep.
  — The postsurgical wound infection was at the incision site of the femoral popliteal bypass graft.
  — Incision and drainage (I&D) of subcutaneous tissue was performed lateral to the femoral incision site.
• Assign the following ICD-10-PCS code:
  — **0Y980ZZ**, Drainage of left femoral region, open approach.
Inguinal Region Versus Femoral Region

• ‘Groin’ can refer to either the inguinal region or the femoral region.
  – The inguinal region is above the inguinal ligament.
  – The femoral region is below the inguinal ligament.
• When the documentation does not specify, the default ICD-10-PCS body part value for groin is the inguinal region.

Scenario #5

• Patient presents with complaints of right groin pain, and was found to have a very large abscess of the right inguinal area.
  – Incision and drainage (I&D) of groin was done.
• Assign ICD-10-PCS code: 0Y950ZZ, Drainage of right inguinal region, open approach
  – For ICD-10-PCS coding groin is equivalent to inguinal unless a more specific body part is documented.
Cesarean Delivery with Vacuum Extraction

- Pregnant patient presents for repeat low cervical C-section
- Vacuum extraction assisted delivery
- What is qualifier for vacuum assisted C-section?

*Coding Clinic, Fourth Quarter 2014, pages 43-44*
Cesarean Delivery with Vacuum Extraction (cont.)

• Issue:
  – Index directed coder to table 10D

<table>
<thead>
<tr>
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<table>
<thead>
<tr>
<th>Body Part</th>
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<th>Device</th>
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<tr>
<td>0 Products of Conception</td>
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<td>Z No Device</td>
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<tr>
<td>1 Products of Conception, Retained</td>
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</tr>
<tr>
<td>2 Products of Conception, Ectopic</td>
<td>Via Natural or Artificial Opening Endoscopic</td>
<td>Z No Device</td>
</tr>
</tbody>
</table>

• Vacuum is option only with “via natural or artificial opening”
• Low cervical, no way to qualify the vacuum extraction.
  – Code 10D00Z1, Extraction of products of conception, low cervical, open approach
    • Code only the cesarean delivery
Duodenal Ulcer Clipping for Control of Bleeding

• Patient presents with bleeding ulcer
• EGD performed
• Clips applied to vessels to control bleeding
• What is the root operation?
  – Control
  – Occlusion
  – Other

(Coding Clinic, Fourth Quarter 2014, page 20)

Duodenal Ulcer Clipping for Control of Bleeding (cont.)

• Root operation:
  – Control – stopping, or attempting to stop, postprocedural bleeding
  – Occlusion – Completely closing an orifice or the lumen of a tubular body part
  – Repair – Restoring, to the extent possible, a body part to its normal anatomic structure and function
Duodenal Ulcer Clipping for Control of Bleeding (cont.)

- In ICD-10-PCS, “control” is only applicable for postoperative bleeding
- Not occluding the duodenum or totally occluding an artery
- Duodenal ulcers are being repaired
  - Code to body part repaired
  - Assign code 0DQ98ZZ, Repair duodenum, via natural or artificial opening, endoscopic

Control of Epistaxis

- Patient presents with epistaxis
- Sutures placed around ruptured arterial vessel
- Is the correct root operation, control, occlusion or other?

*Coding Clinic, Fourth Quarter 2014, pages 20-21*
Control of Epistaxis
(cont.)

• Epistaxis treated via externally placed sutures
• Root operation “control” not appropriate
• Repair of nose, not artery
  – Code to body part repaired
  – Assign code 09QKXZZ, Repair nose, external approach

Periurethral Laceration

• Periurethral laceration during delivery
  – What is the diagnosis code?
• Laceration repaired
• What is body part character for repair of this laceration?
  – Guideline B4.1 states that when a body part site is prefixed with “peri” the procedure should be coded to the body part named.

Coding Clinic, Fourth Quarter 2014, pages 18-19
Periurethral Laceration
(cont.)

• Periurethral tear
  – Occurs at the region around the urethra
  – Usually caused by sudden extension of baby’s head
  – Involves a tear of the vulvar tissue
  – Could be problematic because of large blood supply in this region of body

Periurethral Laceration
(cont.)

• Assign code O71.82, Other specified trauma to perineum and vulva
  – Conflicting index entries:
    • Laceration, periurethral tissue – see Laceration, urethra
    • Laceration, urethra
      – Obstetrical trauma O71.5
        » Excludes note
    • Tear, periurethral tissue, obstetrical trauma O71.82
Periurethral Laceration
(cont.)

• Assign to body part character “vulvar”
  – Code 0UQMXZZ, Repair vulva, external approach
• Look at documentation
• Apply guideline regarding “peri” when a more specific body part is not available

Multiple Uterine Fibroids

• Patient admitted for multiple fibroid removal
• 34 uterine fibroids were removed
• Is the procedure code for this procedure coded 34 times?
  – Multiple procedure guideline applicable?
Multiple Uterine Fibroids

- Guideline (B3.2) states: during the same operative episode, multiple procedures are coded if:
  - (a) same root operation performed on different body parts defined by distinct values of body part character
  - (b) same root operation repeated at different body sites included in same body part value
  - (c) multiple root operation with distinct objective performed on same body part
  - (d) intent root operation attempted with one approach, but converted to different approach

Multiple Uterine Fibroids (cont.)

- Assign code **0UB90ZZ**, Excision of uterus, open approach
  - This code is assigned only once
  - Guideline B3.2(b) does not apply
  - Code would be assigned multiple times only when the same procedure is repeated on two anatomic sites that are included in the same body part value
CVA with Unilateral Weakness

• Case #1:
  – Patient admitted because of GI bleed
  – Has history of cerebral infarction with residual right-sided weakness (dominant side)
  – Evaluated by physical and occupational therapy

• Case #2:
  – Patient admitted secondary to cerebral infarction
  – Provider documented, “acute cerebral infarction involving the right hemisphere with left-sided (nondominant) weakness.”

CVA with Unilateral Weakness (cont.)

• What is code for residual right/left-sided weakness from acute or old CVA without mention of hemiplegia/hemiparesis?

• Issue:
  – No index entry for left or right sided weakness following cerebral infarction
  – Can coder make leap and code hemiplegia when weakness documented as “with” or “following” CVA?
Answers

• Case #1:
  – Assign code I69.351, Hemiplegia and hemiparesis following cerebral infarction, affecting right side

• Case #2:
  – Assign codes:
    • I63.9, Cerebral infarction, unspecified
    • G81.94, Hemiplegia, unspecified affecting left nondominant side

Nelly Leon-Chisen, RHIA
Director, Coding and Classification
Mechanical Ventilation — ICD-10-PCS Root Operations

• Invasive mechanical ventilation
  — Root operation “Performance,” completely taking over the physiological function by extracorporeal means.

• Noninvasive mechanical ventilation
  — Root operation “Assistance,” taking over a portion of a physiological function by extracorporeal means.

Invasive Mechanical Ventilation

• 5A1935Z Respiratory ventilation, less than 24 consecutive hours
• 5A1945Z Respiratory ventilation, 24-96 consecutive hours
• 5A1955Z Respiratory ventilation, greater than 96 consecutive hours
Endotracheal (ET) Intubation

• 0BH17EZ Insertion of endotracheal airway into trachea, via natural or artificial opening
• 0BH18EZ Insertion of endotracheal airway into trachea, via natural or artificial opening endoscopic

Bi-Level Positive Airway Pressure (BiPAP)

• Noninvasive BiPAP (patients are not intubated) is coded as “Assistance”
  – For example, 5A09457, Assistance with respiratory ventilation, 24-96 consecutive hours, continuous positive airway pressure
• BiPAP delivered through an endotracheal tube or tracheostomy is coded as mechanical ventilation as “Performance”
  – For example, 5A1945Z, Respiratory ventilation 24-96 consecutive hours
Continuous Positive Airway Pressure (CPAP) Via Tracheostomy

- Code to root operation “Performance”
  - For example, 5A1945Z, Respiratory ventilation, 24-96 consecutive hours

Starting Time for Counting Mechanical Ventilation Hours

- Begins with one of these events:
  - Endotracheal intubation and subsequent initiation of mechanical ventilation
  - Initiation of mechanical ventilation through tracheostomy
  - At the time admission of a previously intubated patient or a patient with tracheostomy who is on mechanical ventilation
- Start counting hours on ventilation only after mechanical ventilation has actually been initiated.
Counting Mechanical Ventilation Hours

• The following are considered part of the duration of mechanical ventilation, and the counting of hours should continue:
  – Removal with immediate replacement of endotracheal tube.
  – Patients who are started on mechanical ventilation by means of an endotracheal tube may later receive a tracheostomy through which the ventilation continues.

(continued)

– The period during which the weaning process takes place is counted as part of the duration time.

– All of the period of weaning is counted during the process of withdrawing the patient from ventilatory support. The duration includes the time the patient is on the ventilator and the weaning period. It ends when the mechanical ventilation is turned off (after the weaning period).
Weaning from Mechanical Ventilation

• Purpose of weaning is to allow the patient to gradually resume spontaneous breathing, while being continually monitored.
  – Not all patients on mechanical ventilation require a period of weaning.
• Various methods available, including T-tubes, intermittent mandatory ventilation and pressure support ventilation.

Ending Time for Mechanical Ventilation

• Duration of mechanical ventilation ends with one of the following events:
  – Removal of the endotracheal tube (extubation).
  – Discontinuance of ventilation for patients with tracheostomy after any weaning period is completed.
  – Discharge or transfer while still on mechanical ventilation.
Subsequent Period of Mechanical Ventilation

• Occasionally the condition of a patient who has been on ventilation earlier in the hospital stay deteriorates and a subsequent period of mechanical ventilation may be required.
• Use the guidelines to calculate this additional period.
• In such cases, two codes should be assigned for the mechanical ventilation.

Counting Hours Example—Intubation and MV in ED and Admitted Same Hospital

• Begin counting duration of mechanical ventilation at the time the patient is intubated in the emergency department, if the patient is subsequently admitted to the same hospital.
• In that situation code both the mechanical ventilation and endotracheal intubation.
Counting Hours Example—Intubation and MV in ED and Transferred Another Hospital

• Patient intubated and begun on mechanical ventilation in the emergency department of Hospital A and then transferred and admitted to Hospital B
  – Begin counting the duration of mechanical ventilation for the second hospital at the time of the admission.
    • Do not code separately the intubation

Coding Clinic, Fourth Quarter 2014, pages 6-7

Mechanical Ventilation During Surgery

• Ventilatory support during surgery is integral part of surgical procedure
  – Do not code separately unless:
    • The patient has a specific problem and is maintained on the mechanical ventilation longer than expected
    • The patient remains on mechanical ventilation for an extended period of time (several days) postoperatively
    • The hours of mechanical ventilation should be counted starting from the point of intubation
      – Even if postsurgical patient not extubated and requires extended MV, the ET intubation is not “retroactively” coded.

Coding Clinic, Fourth Quarter 2014, page 6
Sequencing of Mechanical Ventilation

- The sequencing of mechanical ventilation with other procedures follows the guidelines for selection of principal procedure.

Sequencing of Mechanical Ventilation – Example #1

- Patient with history of endocarditis is admitted with severe acute meningitis causing respiratory decompensation.
  - Principal procedure: Lumbar puncture
  - Secondary procedure: Mechanical ventilation
  - Rationale: Lumbar puncture is the diagnostic procedure performed for the principal diagnosis of severe acute meningitis.
Sequencing of Mechanical Ventilation – Example #2

• Patient admitted with acute ischemic cerebral vascular accident, and is started on tissue plasminogen activator (tPA) infusion. Second, massive infarction requires and mechanical ventilation.
  – Principal procedure: tPA administration
  – Secondary procedure: Mechanical ventilation
  – Rationale: Thrombolytic therapy was directed at the principal diagnosis of cerebrovascular accident

Sequencing of Mechanical Ventilation – Example #3

• Premature newborn requires mechanical ventilation for respiratory distress syndrome and therapeutic lumbar puncture for relief of intracranial pressure.
  – Select the most significant procedure addressing the secondary diagnoses.
    • When the documentation is unclear regarding which is the most significant, query the physician for clarification.
  – Rationale: There were no procedures (definitive or non-definitive treatment) related to the principal diagnosis.
Sequencing of Mechanical Ventilation – Example #4

- Patient admitted with severe sepsis, treated with intravenous (IV) antibiotics and placed on mechanical ventilation.
  - No underlying respiratory condition; respiratory decompensation is due to severity of sepsis.
  - Principal procedure: Central venous catheter insertion
  - Secondary procedure: Mechanical ventilation
  - Rationale: Catheter inserted to administer IV antibiotics for severe sepsis. The mechanical ventilation was required to treat the respiratory condition.

Sequencing of Mechanical Ventilation – Example #5

- Patient admitted with sepsis and placed on mechanical ventilation. Patient’s initial respiratory decompensation is due to the sepsis. Presumed cause of the sepsis is spontaneous bacterial peritonitis.
  - Principal procedure: Paracentesis
  - Secondary procedure: Mechanical ventilation
  - Rationale: Paracentesis is most related to principal diagnosis
Addressing Questions to the Central Office

Please be sure to read the FAQ section to find out what types of questions we can and cannot answer.

Changes to AHA Coding Clinic
The paper version of the AHA Coding Clinic for ICD-10-CM/ICD-10-PCS and HCPCS will be phased out at the end of 2015. Look for more information in the coming months as we announce new ways to access these great resources.

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Thank you for your interest and participation.

Nelly Leon-Chisen, RHIA
Program Chairperson
American Hospital Association
2015 Update on AHA Coding Clinic for ICD-10-CM and ICD-10-PCS Part One

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