2014 ICD-10-CM/PCS Updates

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This article highlights the 2014 ICD-10-CM/PCS updates as approved by the ICD-9-CM Coordination and Maintenance Committee, which includes representatives from the Centers for Medicare and Medicaid Services and the National Center for Health Statistics. As a result of the partial code set freeze, only limited code updates were made to capture new technologies and diagnoses as required by section 503(a) of Public Law 108-173.

ICD-10-CM Updates, Code Changes

No new diagnosis codes were added to ICD-10-CM for fiscal year 2014. Review of the 2014 ICD-10-CM addenda reveals that the minimal updates include some Excludes1 notes being changed to Excludes2 notes.

Examples of these updates include:

- Chapter 1: Excludes1 note at the beginning of the chapter has been deleted and replaced with Excludes2: infectious and parasitic diseases complicating pregnancy, childbirth and the puerperium (O98.-), Influenza and other acute respiratory infections (J00-J22)
- Chapter 6: Excludes1 note under category G08, Intracranial and intraspinal phlebitis and thrombophlebitis, has been deleted and replaced with Excludes2: intracranial phlebitis and thrombophlebitis complicating nonpyogenic intraspinal phlebitis and thrombophlebitis (G95.1)
- Chapter 6: Excludes1 note under category G43, Migraine, has been deleted and replaced with Excludes2: headache syndromes (G44.-)
- Chapter 11: Excludes1 note under K72, Hepatic failure, not elsewhere classified, has been deleted and replaced with Excludes2: hepatic failure complicating abortion or ectopic or molar pregnancy (O00-O07, O08.8), Hepatic failure complicating pregnancy, childbirth and the puerperium (O26.6-)

ICD-10-CM Coding Guideline Changes

Minimal updates were made to the *2014 ICD-10-CM Official Guidelines for Coding and Reporting*. The following are the new or revised ICD-10-CM Coding Guidelines for 2014.

New ICD-10-CM Guidelines

I.B.18. Use of Sign/Symptom/Unspecified Codes
Sign/symptom and "unspecified" codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the healthcare encounter. Each healthcare encounter should be coded to the level of certainty known for that encounter.

If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information isn't known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate "unspecified" code (i.e., a diagnosis of pneumonia has been determined, but not the specific type). Unspecified codes should be reported when they are the codes that most accurately reflect what is known about the patient's condition at the time of that particular encounter. It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code.

II.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 was performed 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, as the first-listed or principal diagnosis.

Revised ICD-10-CM Guidelines

The following are the revised portions for a selection of the 2014 ICD-10-CM revised guidelines.

I.A.7. Parentheses
The nonessential modifiers in the Alphabetic Index to Diseases apply to subterms following a main term except when a nonessential modifier and a subentry are mutually exclusive. In this case, the subentry takes precedence. For example, in the ICD-10-CM Alphabetic Index under the main term Enteritis, “acute” is a nonessential modifier and “chronic” is a subentry. In this case, the nonessential modifier “acute” does not apply to the subentry “chronic.”

I.C.20. Chapter 20: External Causes of Morbidity (V00-Y99)
The external causes of morbidity codes should never be sequenced as the first-listed or principal diagnosis. There is no national requirement for mandatory ICD-10-CM external cause code reporting. Unless a provider is subject to a state-based external cause code reporting mandate or these codes are required by a particular payer, reporting of ICD-10-CM codes in Chapter 20, External Causes of Morbidity, is not required. In the absence of a mandatory reporting requirement, providers are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies.

I.C.21.c.11. Encounters for Obstetrical and Reproductive Services
Codes in category Z3A, Weeks of gestation, may be assigned to provide additional information about the pregnancy. The date of the admission should be used to determine weeks of gestation for inpatient admissions that encompass more than one gestational week.

Section IV: Diagnostic Coding and Reporting Guidelines for Outpatient Services
The following has been added to the second paragraph of Section IV of the ICD-10-CM Coding Guidelines: “Section I.B. contains general guidelines that apply to the entire classification. Section I.C. contains chapter-specific guidelines that correspond to the chapters as they are arranged in the classification.”

ICD-10-PCS Updates, Code Changes

For fiscal year 2014 there is an addition of seven new procedural codes and a deletion of three codes, resulting in a total of 71,924 ICD-10-PCS codes. Table 1 provides a breakdown of the codes for each section of ICD-10-PCS.

Four new procedure codes were added under the new technology application, which became effective on October 1, 2013. The codes are:

- 08H005Z, Insertion of Epiretinal Visual Prosthesis into Right Eye, Open Approach
- 08H105Z, Insertion of Epiretinal Visual Prosthesis into Left Eye, Open Approach
- 30280B1, Transfusion of Nonautologous 4-Factor Prothrombin Complex Concentrate into Vein, Open Approach
- 30283B1, Transfusion of Nonautologous 4-Factor Prothrombin Complex Concentrate into Vein, Percutaneous Approach

To correct the body part value for temporary occlusion of an abdominal aorta, three new codes were added and three codes were deleted. The new codes include:

- 04V00DJ, Restriction of Abdominal Aorta with Intraluminal Device, Temporary, Open Approach
- 04V03DJ, Restriction of Abdominal Aorta with Intraluminal Device, Temporary, Percutaneous Approach
- 04V04DJ, Restriction of Abdominal Aorta with Intraluminal Device, Temporary, Percutaneous Endoscopic Approach

The deleted codes include:

- 02VW0DJ, Restriction of Thoracic Aorta with Intraluminal Device, Temporary, Open Approach
- 02VW3DJ, Restriction of Thoracic Aorta with Intraluminal Device, Temporary, Percutaneous Approach
- 02VW4DJ, Restriction of Thoracic Aorta with Intraluminal Device, Temporary, Percutaneous Endoscopic Approach

In response to public comments, the section title for Radiation Oncology was revised to Radiation Therapy. There were no code title revisions as a result of this section title change, as the phrase “Radiation Oncology” is not contained in any of the code titles from this section of ICD-10-PCS.

Table 1: Breakdown of ICD-10-PCS Codes by Section

For fiscal year 2014 there is an addition of seven new procedural codes and a deletion of three codes, resulting in a total of 71,924 ICD-10-PCS codes. Code sections containing the changes appear in bold in the table below.

PCS Codes by Section	**Number of Codes**
Medical and Surgical	61,898
Obstetrics	300
Placement	861
Administration	1,388
Measurement and Monitoring	339
Extracorporeal Assistance and Performance	41
Extracorporeal Therapies	42
Osteopathic	100
Other Procedures	60
Chiropractic	90
Imaging	2,934

Nuclear Medicine	463
Radiation Therapy	1,939
Rehabilitation and Diagnostic Audiology	1,380
Mental Health	30
Substance Abuse Treatment	59

ICD-10-PCS Coding Guideline Changes
Two updates were made to the *2014 ICD-10-PCS Official Guidelines for Coding and Reporting*. The first update was the addition of ICD-10-PCS Coding Guideline B3.4a for Biopsy Procedures. This new guideline states that biopsy procedures are coded using the root operations Excision, Extraction, or Drainage and the qualifier Diagnostic. The qualifier Diagnostic is used only for biopsies. The addition of this new guideline resulted in the guideline for Biopsy to be followed by more definitive treatment and renumbered to B3.4b.

The second update was the addition of a fourth section to the ICD-10-PCS Coding Guidelines, Selection of Principal Procedures. This fourth section provides guidance in the selection of the principal procedure and clarification on the importance of the relation to the principal diagnosis when more than one procedure is performed.

References

Centers for Medicare and Medicaid Services “2014 ICD-10-PCS Official Guidelines for Coding and Reporting.” 2013. http://www.cms/gov/Medicare/Coding/ICD10/Downlads/pcs-2014-guidelines.pdf.

National Center for Health Statistics. “2014 ICD-10-CM Official Guidelines for Coding and Reporting. 2013. http://www.cdc.gov/nchs/data/icd9/icd10cm_guidelines_2014.pdf.

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