Counting Down to ICD-10-PCS

by Melanie Endicott

Tune in to this monthly online coding column to learn from AHIMA's coding experts about challenging areas and documentation opportunities for ICD-10-CM/PCS.

In the hospital inpatient setting, ICD-10-PCS will replace the ICD-9-CM procedure codes (Volume 3). Have your inpatient coders and clinical documentation specialists begun preparing for ICD-10-PCS? With the implementation date quickly approaching, it is time to master the 31 Medical and Surgical root operations and review documentation to ensure readiness.

Root Operations

There are many misconceptions in the industry about how the root operations are to be applied. It is FALSE that physicians must use the root operation terms in their documentation. Refer to the ICD-10-PCS Official Guidelines for Coding and Reporting for specific guidance on this topic at Convention A.11., which states:

"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.

Example: When the physician documents "partial resection" the coder can independently correlate "partial resection" to the root operation Excision without querying the physician for clarification."

To prepare for implementation, inpatient coders and clinical documentation professionals should be proficient in the ICD-10-PCS root operation definitions and be able to apply the correct root operations for procedures performed within their facilities. By beginning this practice now, gaps in documentation should be identified and remedied prior to implementation. Working collaboratively with clinicians during this timeframe is key to ensuring that documentation is ready for the nuances of ICD-10-PCS.

Preparation Strategies

The focus should be on quality clinical documentation, not huge volumes of documentation. There must be sufficient documentation to support code assignment while allowing clinicians to document in clinical, not coding, terms. To achieve this, it takes collaboration between coders, clinical documentation professionals, and clinicians.

Facilities should be taking this last year to do a deep dive into their current documentation and identify areas that need improvement. Once gaps are identified, focused education can be conducted to specific groups needing the training. Take advantage of this time to cultivate trust and respect between clinical documentation professionals, clinicians, and coders. These three groups all bring important pieces of knowledge to the table and working collaboratively will benefit the quality of patient health record documentation which in turn enhances patient care and provides accurate reimbursement to both the facility and the clinician.

Case Study 1: Carpal Tunnel Release

ICD-9-CM

04.43 Release of carpal tunnel

ICD-10-PCS

01N50ZZ Release median nerve, open approach

In ICD-9-CM, the approach does not impact the code selection; however, it does in ICD-10-PCS with choices for open, percutaneous, or percutaneous endoscopic approaches. Also, in ICD-10-PCS, the coder must know the body part that was released (median nerve) to select the appropriate body part character.

Case Study 2: Excisional debridement of left trochanteric pressure ulcer, stage 4 to bone

ICD-9-CM

77.65 Local excision of lesion or tissue of femur

ICD-10-PCS

0QB70ZZ Excision left upper femur, open approach

For both ICD-9-CM and ICD-10-PCS, the deepest layer (bone) is coded. ICD-9-CM does not specify the approach, whereas ICD-10-PCS provides approach values for open, percutaneous endoscopic, or percutaneous.

Case Study 3: Open CABG x 1 from aorta to left anterior descending using autologous left greater saphenous vein (open)

ICD-9-CM

36.11 (Aorto)coronary bypass of one coronary artery

ICD-10-PCS

021009W Bypass coronary artery, one site to aorta with autologous venous tissue, open approach

06BQ0ZZ Excision of left greater saphenous vein, open approach

The ICD-10-PCS code for the bypass specifically states the areas of bypass (aorta, coronary artery) as well as the type of device used (autologous venous tissue) for the bypass and the approach. A second code is assigned for the harvesting of the saphenous vein in ICD-10-PCS.

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