ICD-10-PCS Root Operation Guidelines

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ICD-10-PCS has a completely different structure than ICD-9-CM. Each ICD-10-PCS code consists of individual values rather than lists of fixed codes and text descriptions, with each value containing a unique definition. The objective of the procedure is identified in the third character, the root operation. There are 31 root operations in the medical and surgical section, arranged by groups with similar attributes.

This article discusses the general and root operation guidelines in ICD-10-PCS. Early preparation and study of these concepts will prepare coding professionals for the transition to ICD-10-PCS.

General ICD-10-PCS Guidelines

In ICD-10-PCS it is not possible to construct a procedure code from the alphabetic index; the purpose of the alphabetic index is to locate the appropriate table containing all information necessary to construct a procedure code. The first three characters (section, body system, and root operation) are provided in the index.

While the index contains a hierarchical look-up for finding a table and supplemental procedure terms to the corresponding root operation options, the index does not contain exclusive coding instruction. Users are not required to consult the index first before proceeding to the tables to complete the code.

The ICD-10-PCS tables and definitions, the body part key, and the draft guidelines contain the complete information for correct coding. The user may choose a valid code directly from the tables.

In ICD-10-PCS, all seven characters must contain valid values to be a valid procedure code. The columns in the tables contain the values for characters four through seven, while the rows delineate the valid combinations of values. Any combination of values not contained in a single row of the tables is invalid. If documentation is incomplete for coding purposes, the physician should be queried for the necessary information.

When used in a code description, the term “and” means “and/or.” For example, lower arm and wrist muscle means lower arm and/or wrist muscle. This guideline is also present in ICD-10-CM.

The guidelines are numbered sequentially within each category, with the medical and surgical section having the most extensive list of guidelines, including guidelines for:

- Body system
- Root operation
- Body part
- Approach
- Device

Root Operation Guidelines

General Guidelines

When determining the appropriate root operation, the full definition of the root operation as contained in the tables must be applied. The current root operations have definitions, explanations, and examples for each root operation identified in the classification system.

Components of a procedure necessary to complete the objective of the procedure specified in the root operation are considered integral to the procedure and are not coded separately.

Example: The resection of a joint is integral to joint replacement. Other integral components of a procedure include exploration, visualization, incision, suture, ligatures, radiological markers, and temporary postoperative wound drains.

Multiple Procedures

Multiple procedures are indicated during the same operative episode when:

- The same root operation is performed on different body parts as defined by distinct values of the body part character (e.g., a diagnostic excision of kidney and liver are coded separately).
- The same root operation is repeated at different body sites included in the same body part value (e.g., an excision of the biceps and triceps brachii muscle are both included in the upper arm muscle body part value, with multiple procedures coded; destruction of separate sites on the skin of the face are included in body part value skin, face, therefore multiple procedures are coded).
- Multiple root operations with distinct objectives are performed on the same body part (e.g., an excision of descending colon lesion and bypass of descending colon are coded separately).
- The intended root operation is attempted using one approach, but is converted to a different approach (e.g., a laparoscopic appendectomy converted to an open appendectomy is coded as endoscopic inspection and open resection).

Discontinued Procedures

If the intended procedure is discontinued, the procedure should be coded to the root operation that was actually performed. If a procedure is discontinued before any other root operation is performed, the root operation inspection of the body part or anatomical region inspected should be coded.

Example: A ureteroscopy with unsuccessful fragmentation of ureteral stone is coded to inspection of ureter.

Several specific root operations have particular guidelines directing correct coding. The draft guidelines affecting specific root operations (character value 3 in the code) are identified as B3.5–B3.17 and discussed below.

Bypass

Bypass procedures are coded according to the direction of flow of the contents of the tubular body part. The body part value identifies the origin of the bypass, and the qualifier identifies the destination of the bypass.

Examples: For a femoral-popliteal artery bypass, the femoral artery (origin) is the body part, and popliteal artery (destination) is the qualifier. For a colostomy formation of descending colon to abdominal wall, the descending colon (origin) is the body part, and cutaneous (destination) is the qualifier.

Coronary arteries are coded differently; the body part value identifies the number of coronary artery sites bypassed with the qualifier identifying the origin of the bypass. If multiple coronary artery sites are bypassed, a separate procedure is coded for each coronary artery site using a different device or qualifier.

Example: An aortocoronary artery bypass and internal mammary coronary artery bypass are coded separately.

Control

The root operation control is used to stop postprocedural bleeding. If, however, the attempt is unsuccessful and requires performing bypass, detachment, excision, extraction, reposition, replacement, or resection to stop the bleeding, then that root operation is coded instead of control.

Example: A resection of the spleen to stop postprocedural bleeding is coded to resection instead of control.

Diagnostic Excision

If a diagnostic excision (biopsy) is followed by a therapeutic excision at the same procedure site or by resection of the body part during the same operative episode, only the therapeutic excision or resection is coded.

Example: For a colon biopsy followed by a colectomy at the same procedure site, only the colectomy procedure is coded.

Excision versus Resection

Resection is defined as the cutting out or off, without replacement, all of a body part, while excision pertains to only a portion of a body part. “All of a body part” includes any anatomical subdivision having its own body part value. Therefore, resection of a specific anatomical subdivision body part is coded whenever possible, rather than excision of the less specific body part.

It is important to review the tables to ascertain the body parts because some body parts consist of the entire organ (breast), while other organs have subdivisions (upper, middle, and lower lobes of the lungs).

Example: An upper lung lobectomy is coded to resection of upper lung lobe and not to excision of the entire lung, because the upper lobe has its own distinct body part.

Inspection

Inspection of a body part(s) integral to the performance of the procedure is not coded separately.

Example: For a bronchoscopy with dilation of bronchus, only the dilation procedure is coded.

If multiple body parts are inspected, the body part character is defined as the general body part value identifying the entire area inspected. If no general body part value is provided, the body part character is defined as the most distal body part inspected.

Example: A laparoscopy of pelvic organs is coded to the pelvic region body part value; a cystoureteroscopy with inspection of bladder and ureters is coded to the ureter body part value.

When both an inspection procedure and another procedure are performed on the same body part during the same episode, but the inspection is performed using a different approach, the inspection is coded separately.

Example: A percutaneous endoscopic inspection of the small intestine during a procedure in which open excision of the jejunum is performed is coded separately.

Division and Release

If the sole objective of the procedure is separating a nontubular body part, the root operation is division; if the sole objective is freeing a body part without cutting the body part, the root operation is release. In release, the body part value coded is the body part being freed and not the tissue being manipulated or cut to free the body part.

Example: Lysis of intestinal adhesions is coded to one of the intestine body part values.

Fusion of Vertebral Joints

If multiple vertebral joints included in the same body part value are fused, a separate procedure is coded for each joint using a different device or qualifier. Joints between two areas of the spine (e.g., cervicothoracic vertebral joint) have their own body part values and are coded separately.

Example: The fusion of C-4/5 with fixation device and C-5/6 with bone graft are coded separately; a fusion of the C-5/6 joint and the C7-T1 joint are coded separately.

Fracture Treatment

Reduction of a displaced fracture is coded to the root operation reposition, while treatment of a nondisplaced fracture is coded to the actual procedure performed.

Example: Putting a pin in a nondisplaced fracture is coded to the root operation insertion; casting a nondisplaced fracture is coded to immobilization in the placement section.

Transplantation

Putting in a mature and functioning living body part taken from another individual or animal is coded to the root operation transplantation. Putting in autologous or nonautologous cells is coded to the administration section.

Example: Putting in autologous or nonautologous bone marrow, pancreatic islet cells, or stem cells is coded to the administration section, while a liver transplant is coded to transplantation.

Reference

Health and Human Services. “ICD-10-PCS Draft Coding Guidelines.” Appendix B in “ICD-10-PCS Reference Manual.” 2010. Available online at www.cms.hhs.gov/ICD10.

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