Coding Clinic for ICD-10-CM/PCS Update
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Coding Clinic for ICD-10-CM/PCS

Visit www.CodingClinicAdvisor.com
ICD-10 Coding Clinic Guidance

ICD-9 Coding Clinics (containing ICD-10 guidance)
Q4 2012
Q1 2013
Q2 2013
Q3 2013
Q4 2013

ICD-10 Coding Clinics
Q1 2014
Q2 2014
Q3 2014
Q4 2014
Q4 2014
Q1 2015
Q2 2015 (published 7/6/2015)
Q3 2015 (any day now...)
Coding Clinic transition

Coding Clinic first Quarter 2013

No plans to translate all previous issues of Coding Clinic for ICD-9-CM into ICD-10-CM/PCS since many of the questions published arose out of the need to provide clarification on the use of ICD-9-CM and would not be readily applicable to ICD-10-CM/PCS.
“These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself. The instructions and conventions of the classification take precedence over guidelines. These guidelines are based on the coding and sequencing instructions in the Tabular List and Alphabetic Index of ICD-10-CM, but provide additional instruction. Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA).”
Today’s topics

*Coding Clinic Guidance:*

……guidance that is the same as in ICD-9-CM
……guidance that is drastically different
……corrections to the classification
……corrections to previous CCs
……empowerment – CCs allow coders to decide
……complex issues with multiple examples

Plus, brief IPPS 2016 Update
Question:

Is there a guideline or rule that indicates that you should only use the medical record documentation for that specific visit/admission for diagnosis coding purposes?

Does each visit or admission stand alone?

Would the coder go back to previous encounter records to assist in the coding of a current visit or admission?
Answer:

Documentation for the current encounter should clearly reflect those diagnoses that are current and relevant for that encounter.

Conditions documented on previous encounters may not be clinically relevant on the current encounter.

The physician is responsible for diagnosing and documenting all relevant conditions. A patient’s historical problem list is not necessarily the same for every encounter/visit.

It is the physician’s responsibility to determine the diagnoses applicable to the current encounter and document in the patient’s record. When reporting recurring conditions and the recurring condition is still valid for the outpatient encounter or inpatient admission, the recurring condition should be documented in the medical record with each encounter/admission.
Answer (continued):

However, if the condition is not documented in the current health record, it would be inappropriate to go back to previous encounters to retrieve a diagnosis without physician confirmation.

This is an area where coders and/or department managers may need to educate physicians and/or practice managers on the need to include complete diagnoses when outpatient services are ordered and to continue to document chronic or longstanding conditions on each admission/encounter record.

Please note this advice applies to both ICD-9-CM and ICD-10-CM.
Question:

*Coding Clinic*, Third Quarter 2008, p. 12, states “decompensated indicates that there has been a flare-up (acute phase) of a chronic condition.”

Should this general definition of decompensated be applied when assigning ICD-10-CM codes as well?

For example, what is the appropriate ICD-10-CM code assignment for a diagnosis of chronic systolic heart failure, currently decompensated?
Answer:

Assign code I50.23, Acute on chronic systolic heart failure, for decompensated systolic heart failure.

As previously stated “decompensated” indicates there has been a flare-up (acute phase) of a condition.
Question:

A patient presents for transurethral treatment of a calculus of the left renal pelvis via ureteroscopy. The endoscope was inserted, the stone was initially fragmented by laser lithotripsy, and some of the remaining fragments were removed endoscopically by basket via the bladder.

What is the appropriate body part value as well as the root operation, fragmentation or extirpation?
Answer:

Assign the following ICD-10-PCS code for the fragmentation and removal of the stone from the left renal pelvis:

0TC48ZZ Extirpation of matter from left kidney pelvis, via natural or artificial opening endoscopic
Fragmentation would not be coded separately since it is inherent to the extirpation.

The removal of solid matter such as a calculus or other abnormal physiological byproduct from a body part is coded to the root operation “Extirpation,” and includes any previous fragmentation of the solid matter prior to its removal.

ICD-10-PCS’ index to procedures under the term “lithotripsy, with removal of fragments” instructs “see Extirpation.” Extirpation represents a range of procedures where the body part itself is not the focus of the procedure.

Instead, the objective is to remove solid material such as a foreign body, thrombus, or calculus from the body part.

The code selection of the body part value is based on the location of the stone at the beginning of the procedure.
Lithotripsy

Index ICD-9 2015
Lithotripsy
  ureter  56.0
transurethral removal of obstruction from ureter and renal pelvis

Index ICD-10-PCS 2016
Lithotripsy
  see Fragmentation
  with removal of fragments see Extirpation
Question:

*Coding Clinic*, First Quarter 2004, pages 14-15, indicated that “ICD-9-CM assumes a relationship between diabetes and osteomyelitis when both conditions are present, unless the physician has indicated in the medical record that the acute osteomyelitis is totally unrelated to the diabetes.”

Is the same relationship between diabetes and osteomyelitis true for ICD-10-CM?
Answer:

**No, ICD-10-CM does not presume a linkage between diabetes and osteomyelitis.**

The provider will need to document a linkage or relationship between the two conditions before it can be coded as such.
Osteomyelitis in the Index

Osteomyelitis M86.9
  acute M86.10
    carpus M86.14-
    clavicle M86.11-
    femur M86.15-
Question:

An 88-year-old male patient is admitted secondary to a cerebral infarction.

In the final diagnostic statement, the provider documented “acute cerebral infarction involving the right hemisphere with left-sided (nondominant) weakness.”

How should left-sided weakness due to an acute cerebral infarction be coded when there is no specific mention of hemiplegia/hemiparesis?
Answer:
Assign code I63.9, Cerebral infarction, unspecified, as the principal diagnosis. Assign code G81.94, Hemiplegia, unspecified affecting left nondominant side, as an additional diagnosis.

When unilateral weakness is clearly documented as being associated with a stroke, it is considered synonymous with hemiparesis/hemiplegia.

Unilateral weakness outside of this clear association cannot be assumed as hemiparesis/hemiplegia, unless it is associated with some other brain disorder or injury.
The patient is a 72-year-old male admitted to the hospital, because of gastrointestinal bleeding.

The provider documented that the patient had a history of acute cerebral infarction with residual right-sided weakness (dominant side), and ordered an evaluation ...

What is the appropriate code assignment for residual right-sided weakness, resulting from an old CVA without mention of hemiplegia/hemiparesis?
Residual Right-Sided Weakness Due to Previous Cerebral Infarction  Q1 2015

Answer:
Assign code I69.351, Hemiplegia and hemiparesis following cerebral infarction, affecting right dominant side, for the residual right-sided weakness due to cerebral infarction.

When unilateral weakness is clearly documented as being associated with a stroke, it is considered synonymous with hemiparesis/hemiplegia.

Unilateral weakness outside of this clear association cannot be assumed as hemiparesis/hemiplegia, unless it is associated with some other brain disorder or injury.
Question:
What is the correct code assignment for type 2 diabetes mellitus with diabetic ketoacidosis?
Answer:

Assign code E13.10, Other specified diabetes mellitus with ketoacidosis without coma, for a patient with type 2 diabetes with ketoacidosis.

Given the less than perfect limited choices, it was felt that it would be clinically important to identify the fact that the patient has ketoacidosis.

The National Center for Health Statistics (NCHS), who has oversight for volumes I and II of ICD-10-CM, has agreed to consider a future ICD-10-CM Coordination and Maintenance Committee meeting proposal.
# Diabetes Mellitus Type 2 with Ketoacidosis

<table>
<thead>
<tr>
<th>Description</th>
<th>Code</th>
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<tbody>
<tr>
<td>Diabetes, diabetic (mellitus) (sugar)</td>
<td>E11.9</td>
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<tr>
<td>- with</td>
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<tr>
<td>- amyotrophy</td>
<td>E11.44</td>
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<tr>
<td>- arthropathy NEC</td>
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<td>- autonomic (poly)neuropathy</td>
<td>E11.43</td>
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<td>- cataract</td>
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<td>E11.610</td>
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<td>E11.59</td>
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<tr>
<td>- complication</td>
<td>E11.8</td>
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<tr>
<td>- specified NEC</td>
<td>E11.69</td>
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<td>E11.620</td>
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<tr>
<td>- foot ulcer</td>
<td>E11.621</td>
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<td>- gangrene</td>
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<tr>
<td>- gastroparesis</td>
<td>E11.43</td>
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<tr>
<td>- glomerulosclerosis, intercapillary</td>
<td>E11.21</td>
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<tr>
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<td>- hyperosmolarity</td>
<td>E11.00</td>
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<tr>
<td>- with coma</td>
<td>E11.01</td>
</tr>
<tr>
<td>- hypoglycemia</td>
<td>E11.649</td>
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<tr>
<td>- with coma</td>
<td>E11.641</td>
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<tr>
<td>- kidney complications NEC</td>
<td>E11.29</td>
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<tr>
<td>- Kimmelsteil-Wilson disease</td>
<td>E11.21</td>
</tr>
</tbody>
</table>
Index and Diabetes

ICD-10-CM Index:
- out of control — code to Diabetes by type with hyperglycemia
- poorly controlled — code to Diabetes by type with hyperglycemia
- inadequately controlled — code to Diabetes by type with hyperglycemia

ICD-9-CM Index:
- poorly controlled — code to Diabetes by type with 5th digit for not stated as uncontrolled
DM with Hypoglycemia

What about hypoglycemia?

E11.64  Type 2 diabetes mellitus with hypoglycemia

E11.641  Type 2 diabetes mellitus with hypoglycemia with coma

E11.649  Type 2 diabetes mellitus with hypoglycemia without coma
A patient with hematemesis presents for esophagogastroduodenoscopy. The patient is found to have esophageal varices, and therefore, ligation of esophageal varices was performed using bands placed via a band ligation device.

What is the appropriate ICD-10-PCS body system for esophageal varices: gastrointestinal system or lower veins?
Question (continued):
In ICD-10-PCS, ligation is coded to the root operation occlusion. Therefore, if we use table “06L” for occlusion of lower veins, there is the appropriate body part and a device value for the bands (extraluminal device); however, there is no approach value for via natural or artificial opening endoscopic.
However, if we use the “0DL” table for occlusion of gastrointestinal system and use “esophagus” for the body part, there is the appropriate approach value but there is no device option for the bands.
What is the appropriate ICD-10-PCS code assignment for endoscopic banding of esophageal varices?
Answer:

Esophageal varices are enlarged veins in the esophagus, which can spontaneously rupture and cause severe bleeding. Endoscopic banding of esophageal varices involves completely occluding blood flow and meets the definition of root operation “occlusion.”

The lumen of the esophageal vein is being banded, not the esophagus.

The index under ligation states “See occlusion.”
Answer (continued):

Assign the following ICD-10-PCS code:

06L34CZ Occlusion of esophageal vein with extraluminal device, percutaneous endoscopic approach.

The ICD-10-PCS tables currently do not use approaches containing the phrase “via natural or artificial opening” for body part values in the cardiovascular body systems.

The use of this approach for blood vessel body parts could change over time if requests for additional codes are made through the ICD-10-PCS Coordination and Maintenance process.
Endoscopic Banding of Esophageal Varices  Q4 2013

06L34CZ Occlusion of esophageal vein with extraluminal device, percutaneous endoscopic approach

<table>
<thead>
<tr>
<th>Section</th>
<th>0</th>
<th>Medical and surgical</th>
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<tbody>
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<td>Body system</td>
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<td>Lower veins</td>
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<tr>
<td>Root operation</td>
<td>L</td>
<td>Occlusion</td>
</tr>
<tr>
<td>Body part</td>
<td>3</td>
<td>Esophageal vein</td>
</tr>
<tr>
<td>Approach</td>
<td>4</td>
<td>Percutaneous endoscopic</td>
</tr>
<tr>
<td>Device</td>
<td>C</td>
<td>Extraluminal device</td>
</tr>
<tr>
<td>Qualifier</td>
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<td>No qualifier</td>
</tr>
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</table>
### Endoscopic Banding of Esophageal Varices

#### 06L

<table>
<thead>
<tr>
<th>Section</th>
<th>0 Medical and Surgical</th>
</tr>
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<tbody>
<tr>
<td>Body System</td>
<td>6 Lower Veins</td>
</tr>
<tr>
<td>Operation</td>
<td>L Occlusion: Completely closing an orifice or the lumen of a tubular body part</td>
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</table>

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Inferior Vena Cava</td>
<td>0 Open</td>
<td>C Extraluminal Device</td>
<td>Z No Qualifier</td>
</tr>
<tr>
<td>1 Splenic Vein</td>
<td>3 Percutaneous</td>
<td>D Intraluminal Device</td>
<td></td>
</tr>
<tr>
<td>2 Gastric Vein</td>
<td>4 Percutaneous Endoscopic</td>
<td>Z No Device</td>
<td></td>
</tr>
<tr>
<td>3 Esophageal Vein</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>4 Hepatic Vein</td>
<td></td>
<td></td>
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<tr>
<td>5 Superior Mesenteric Vein</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Inferior Mesenteric Vein</td>
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<td></td>
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<tr>
<td>7 Colic Vein</td>
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<td></td>
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<tr>
<td>8 Portal Vein</td>
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<tr>
<td>9 Renal Vein, Right</td>
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<td></td>
<td></td>
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<tr>
<td>B Renal Vein, Left</td>
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<td></td>
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</tr>
</tbody>
</table>
Question:

...venous access port. An incision was made in the anterior chest wall and a subcutaneous pocket was created. The catheter was advanced into the vein, tunneled under the skin and attached to the port, which was anchored in the subcutaneous pocket. The incision was closed in layers.

When assigning an ICD-10-PCS code for insertion of a port-a-cath, what device character should we select?

Would a port-a-cath be considered a reservoir (character “W”) or a vascular access device (character “X”)?
Answer:
Code only the vascular access device (VAD). The device has a small reservoir, but it does not function as a reservoir to store medicine during the course of therapy.

Assign the ICD-10-PCS code as follows:

0JH63XZ Insertion of vascular access device into chest subcutaneous tissue and fascia, percutaneous approach.

In ICD-10-PCS, a percutaneous approach is defined as entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to reach the site of the procedure.
Question:

In Coding Clinic, Fourth Quarter 2013, pages 116-117, information was published about the device character for the insertion of a totally implantable central venous access device (port-a-cath).

Although we agree with the device value, the approach value is inaccurate. The approach value for placement of a port-a-cath should be “Open.” (rather than percutaneous)

Furthermore, a port-a-cath is a two-part device, and requires two ICD-10-PCS codes, for the insertions of the catheter as well as the infusion device. We are asking that the Coding Clinic Editorial Advisory Board (EAB) revisit this advice.
Answer:

Yes, you are correct.

In the published example, a subcutaneous pocket was created under direct visualization in order to place the vascular access port, and therefore the approach is “open” for that portion of the procedure.

In addition, a totally implantable central venous access device is a two part device; therefore two ICD-10-PCS codes are required to capture insertion of the device.
Assign the following ICD-10-PCS codes for placement of this type of venous access device:

0JH60XZ Insertion of vascular access device into chest subcutaneous tissue and fascia, open approach.

02HV33Z Insertion of infusion device into superior vena cava, percutaneous approach; and

This advice is specific to insertion of a totally implantable venous access device, and not for a cutdown to insert a central line.

Most central lines are inserted percutaneously without creating a subcutaneous pocket under direct visualization, and so they are not coded with an open approach.
The patient presents for decompressive lumbar laminectomy. The surgeon performed an open complete decompressive laminectomy of L3-L4, as well as superior partial laminectomy of L5, and inferior partial laminectomy of L2.

What is the appropriate root operation, “Excision” or “Release?”

How is this surgery coded in ICD-10-PCS?
Decompressive Laminectomy Q2 2015

Answer:
Decompressive laminectomy is done to release pressure and free up the spinal nerve root. Therefore the appropriate root operation is “Release.”
Assign the following ICD-10-PCS code:

01NB0ZZ Release lumbar nerve, open approach

Coding Clinic Fourth Quarter 2013, page 116, advised the assignment of the root operation “Excision” for decompressive laminectomy procedures. This advice was based on the ICD-10-PCS’ Index entry “Laminectomy,” which instructs see Excision. The Editorial Advisory Board for Coding Clinic revisited this advice and determined that the root operation “Release” is more appropriate.
Use of Imaging Report to Confirm Catheter Placement  Q3 2014

Question:
When coding the placement of an infusion device such as a peripherally inserted central catheter (PICC line), the code assignment for the body part is based on the site in which the device ended up (end placement).

For coding purposes, can imaging reports be used to determine the end placement of the device?
Use of Imaging Report to Confirm Catheter Placement  Q3 2014

Answer:
When the provider’s documentation does not specify the end placement of the infusion device, the imaging report may be used to identify the body part.
Use of Imaging Reports for Greater Specificity  CC Q3 2014

Question:
Previous *Coding Clinic (Q1 2013)* advice has supported the assignment of a more specific fracture code in ICD-9-CM and ICD-10-CM based on findings in imaging reports when a physician has documented a diagnosis of fracture.

Does this advice hold true for other conditions that may be further specified based on imaging reports?

For example, if a patient is diagnosed with a cerebral infarction or hemorrhagic stroke, can the imaging results be used to identify the specific vessel associated with these conditions?
Use of Imaging Reports for Greater Specificity  CC Q3 2014

Answer:

It is appropriate to utilize imaging reports to provide greater specificity of the anatomic site as documented by the physician.

Therefore, if a patient is diagnosed with a cerebral infarction or hemorrhagic stroke, it would be appropriate to utilize the imaging report to determine the location of the stroke or infarction.
ICD-10-CM Coding Issues for Long Term Care  Q4 2012

Question:
A patient is admitted to LTC following hospital treatment of a fracture of the right femur. The reason for the LTC admission is to allow the patient to regain strength and the fracture to heal.

What code is used to describe the LTC admission?
Answer:
Assign code S72.90XD, Unspecified fracture of right femur, subsequent encounter for closed fracture with routine healing, as the principal diagnosis.

The 7th character “D” is used for encounters after the patient has received active treatment for the condition and is now receiving routine care during the healing or recovery phase.

Code any other coexistent conditions that require treatment.

Do not assign an aftercare Z code.
Guideline 20.a.2

External cause code used for length of treatment

Assign the external cause code, with the appropriate 7th character (initial encounter, subsequent encounter or sequela) for each encounter for which the injury or condition is being treated.

example
S72.90XD  femur fracture, subsequent encounter
W11.XXXD  fall from ladder, subsequent encounter
Guideline 19.a

7th character “A”, initial encounter is used while the patient is receiving active treatment for the condition. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and continuing treatment by the same or a different physician.
Guideline 19.a
Application of 7th Characters

While the patient may be seen by a new or different provider over the course of treatment for an injury, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time.
While the patient may be seen by a new or different provider over the course of treatment for an injury, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time.

Many useful examples of 7th character assignment provided in CC Q1 2015
For complication codes, active treatment refers to treatment for the condition described by the code, even though it may be related to an earlier precipitating problem.

For example, code T84.50XA, Infection and inflammatory reaction due to unspecified internal joint prosthesis, initial encounter, is used when active treatment is provided for the infection, even though the condition relates to the prosthetic device, implant or graft that was placed at a previous encounter.
Nonhealing surgical wound  CC Q1 2014

Question:
How should a nonhealing surgical wound be coded?

Answer:
ICD-10-CM does not provide a specific code to describe nonhealing surgical wound.
Assign code T81.89X-, Other complications of procedures, not elsewhere classified, for an unspecified nonhealing surgical wound.

If a postsurgical wound does not heal due to infection, assign code T81.4XX- Infection following a procedure.

If the wound was closed at one time and is no longer closed, it is coded as disruption. In that case, code T81.3-, Disruption of wound, not elsewhere classified, should be assigned.
The ICD-10-PCS provides three codes to describe the duration patients are on mechanical (respiratory) ventilation as follows:

5A1935Z  Respiratory ventilation, less than 24 consecutive hours
5A1945Z  Respiratory ventilation, 24-96 consecutive hours
5A1955Z  Respiratory ventilation, greater than 96 consecutive hours
Question:
A patient, who had suffered acute respiratory failure, is admitted to the long term care hospital (LTCH) for ventilator weaning. On day one ... On day five, the ventilator was turned off and the patient was extubated.

According to clinical protocol at our facility, a patient is not “officially” weaned until he has been totally off of the ventilator for 72 hours. After the patient successfully completes the weaning trial, he is continually evaluated.

Can we count the additional 72 hours as vent time, since evaluation and monitoring is part of the weaning process?
Answer:
Assign ICD-10-PCS code 5A1955Z, Respiratory ventilation, greater than 96 consecutive hours, since the ventilator was turned off on day five.

After the mechanical ventilator is turned off, it is inappropriate to continue to count ventilation hours, even though the patient is continually being evaluated.

The additional 72 hours that the patient is evaluated is not included in the ventilation time.
Update your reference documents!!

Update: **FY 2016** version released 6/22/15

ICD-10-CM 2016 Guidelines
ICD-10-PCS 2016 Guidelines

Recommend reviewing the Addenda and new version

AHA - ICD-10-CM and ICD-10-PCS Coding Handbook with Answers - 2016 Revised
F.Y.I.

2015 PCS reference manual
Page 72
5. Anterior colporrhaphy with polypropylene mesh reinforcement, open approach: 0UUG0JZ

2016 PCS reference manual
Page 71
5. Anterior colporrhaphy with polypropylene mesh reinforcement, open approach: 0JUC0JZ
Posterior colporrhaphy/rectocele repair
CC Q4 2014

**Question**: How is an open posterior colporrhaphy/rectocele repair coded in PCS?

Should one or two codes be assigned for this procedure?
**Answer:** In the context of a rectocele, colporrhaphy refers to the indirect result of repairing the laxity between the vagina and the rectum caused by the stretching of the pelvic fascia. The site of the repair procedure is the pelvic region fascia.

A posterior colporrhaphy is the surgical intervention for repair of a rectocele. During the procedure, the rectum is pushed back into its normal position, and the support tissues between the back of the vagina and rectum are sutured to tighten the laxity in the fascia.

Assign the following ICD-10-PCS code:

**0JQC0ZZ** Repair pelvic region subcutaneous tissue and fascia, open approach
IPPS FY 2016 Final Rule

Federal Register August 17, 2015

No new ICD-10-CM Diagnosis Codes

!! new PCS codes !!

See Table 6B in Final Rule
What about the code freeze?


This updated schedule provided information on the extension of the partial code freeze until 1 year after the implementation of ICD–10.

“On October 1, 2015, there will be only limited code updates to ICD-10 code sets to capture new technologies and diagnoses as required by section 503(a) of Pub. L. 108-173.”
new codes added to Table 047

new X codes to reflect the addition of new technology

“We have developed Table 6B (New Procedure Codes) for new ICD-10-PCS codes which will be implemented on October 1, 2015.”
PCS Table Updates

047  Drug coated balloon

X2C  Orbital atherectomy

XR2  Intraoperative knee replacement sensor

XW0  Introduction of medication
047K041
Dilation of Right Femoral Artery with
Drug-eluting Intraluminal Device using
**Drug-Coated Balloon**
Open Approach
# PCS Table 047 FY 2015

**Section 0** Medical and Surgical

**Body System 4** Lower Arteries

**Operation 7** Dilation: Expanding an orifice or the lumen of a tubular body part

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
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<tbody>
<tr>
<td>Abdominal Aorta</td>
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<td>Celiac Artery</td>
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<td>Common Iliac Artery, Right</td>
<td>0 Open</td>
<td>4 Intraluminal Device, Drug-eluting</td>
<td>Z No Qualifier</td>
</tr>
<tr>
<td>Common Iliac Artery, Left</td>
<td>3 Percutaneous</td>
<td>4 Intraluminal Device</td>
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<td>Internal Iliac Artery, Right</td>
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<td>Popliteal Artery, Right</td>
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<tr>
<td>Popliteal Artery, Left</td>
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<td>Anterior Tibial Artery, Right</td>
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</tr>
<tr>
<td>Section</td>
<td>Body System</td>
<td>Operation</td>
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<td>-------------</td>
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</tr>
<tr>
<td>0</td>
<td>Medical and Surgical</td>
<td>Dilation: Expanding an orifice or the lumen of a tubular body part</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Abdominal Aorta</td>
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<td>2 Gastric Artery</td>
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<tr>
<td>4 Splenic Artery</td>
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<tr>
<td>5 Superior Mesenteric Artery</td>
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<tr>
<td>6 Colic Artery, Right</td>
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</tr>
<tr>
<td>7 Colic Artery, Left</td>
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</tr>
<tr>
<td>8 Colic Artery, Middle</td>
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</tr>
<tr>
<td>9 Renal Artery, Right</td>
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<tr>
<td>A Renal Artery, Left</td>
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<td></td>
</tr>
<tr>
<td>B Inferior Mesenteric Artery</td>
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</tr>
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<td>C Common Iliac Artery, Right</td>
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</tr>
<tr>
<td>D Common Iliac Artery, Left</td>
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</tr>
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<td>E Internal Iliac Artery, Right</td>
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<tr>
<td>F Internal Iliac Artery, Left</td>
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<td></td>
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</tr>
<tr>
<td>H External Iliac Artery, Right</td>
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</tr>
<tr>
<td>J External Iliac Artery, Left</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P Anterior Tibial Artery, Right</td>
<td></td>
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</tr>
<tr>
<td>Q Anterior Tibial Artery, Left</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R Posterior Tibial Artery, Right</td>
<td></td>
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</tr>
<tr>
<td>S Posterior Tibial Artery, Left</td>
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<tr>
<td>T Peroneal Artery, Right</td>
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<td>U Peroneal Artery, Left</td>
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<td>V Foot Artery, Right</td>
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<tr>
<td>W Foot Artery, Left</td>
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<td></td>
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<tr>
<td>Y Lower Artery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K Femoral Artery, Right</td>
<td>0 Open</td>
<td>4 Intraluminal Device, Drug-eluting</td>
<td>1 Drug-Coated Balloon</td>
</tr>
<tr>
<td>L Femoral Artery, Left</td>
<td>3 Percutaneous</td>
<td>D Intraluminal Device</td>
<td>Z No Qualifier</td>
</tr>
<tr>
<td>M Popliteal Artery, Right</td>
<td>4 Percutaneous Endoscopic</td>
<td>Z No Device</td>
<td></td>
</tr>
<tr>
<td>Body Part</td>
<td>Approach</td>
<td>Device</td>
<td>Qualifier</td>
</tr>
<tr>
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</tr>
<tr>
<td>K Femoral Artery, Right</td>
<td>0 Open</td>
<td>4 Intraluminal Device, Drug-eluting</td>
<td>1 Drug-Coated Balloon</td>
</tr>
<tr>
<td>L Femoral Artery, Left</td>
<td>3 Percutaneous</td>
<td></td>
<td>Z No Qualifier</td>
</tr>
<tr>
<td>M Popliteal Artery, Right</td>
<td>4 Percutaneous</td>
<td></td>
<td>Z No Device</td>
</tr>
<tr>
<td>N Popliteal Artery, Left</td>
<td>Endoscopic</td>
<td></td>
<td>Z No Qualifier</td>
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<tr>
<td>Section</td>
<td>X</td>
<td>New Technology</td>
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<td>---------</td>
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<tr>
<td>Body System</td>
<td>2</td>
<td>Cardiovascular System</td>
<td></td>
</tr>
<tr>
<td>Operation</td>
<td>C</td>
<td>Extirpation: Taking or cutting out solid matter from a body part</td>
<td></td>
</tr>
<tr>
<td>Body Part</td>
<td>Approach</td>
<td>Device / Substance / Technology</td>
<td>Qualifier</td>
</tr>
<tr>
<td>0 Coronary Artery, One Site</td>
<td>3 Percutaneous</td>
<td>6 Orbital Atherectomy Technology</td>
<td>1 New Technology Group 1</td>
</tr>
<tr>
<td>1 Coronary Artery, Two Sites</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Coronary Artery, Three Sites</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Coronary Artery, Four or More Sites</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Orbital atherectomy is the newest atherectomy procedure.

It is similar to rotational atherectomy in that it abrades plaque using an abrasive burr spinning at 80,000-200,000 rpm.

Also like rotational atherectomy, the grit size and high rotational speed of orbital atherectomy devices makes the tissue debris small enough to pass through the circulatory system harmlessly, minimizing the potential for distal embolic complications.
<table>
<thead>
<tr>
<th>Section</th>
<th>X</th>
<th>New Technology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body System</td>
<td>R</td>
<td>Joints</td>
</tr>
<tr>
<td>Operation</td>
<td>2</td>
<td>Monitoring: Determining the level of a physiological or physical function repetitively over a period of time</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Approach</th>
<th>Device / Substance / Technology</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knee Joint, Right</td>
<td>Open</td>
<td>2 Intraoperative Knee Replacement Sensor</td>
<td>1 New Technology Group 1</td>
</tr>
<tr>
<td>Knee Joint, Left</td>
<td></td>
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</tbody>
</table>
Ligament balancing during total knee arthroplasty (TKA) is a controllable and critical procedure necessary for the longevity of the prosthesis. Intraoperative knowledge of the magnitude and location of tibiofemoral forces, can guide the surgeon to an accurate balancing throughout the operation.
<table>
<thead>
<tr>
<th>Body Part</th>
<th>Approach</th>
<th>Device / Substance / Technology</th>
<th>Qualifier</th>
</tr>
</thead>
</table>
| 3 Peripheral Vein | 3 Percutaneous | 2 Ceftazidime-Avibactam Anti-infective  
3 Idarucizumab, Dabigatran Reversal Agent  
4 Isavuconazole Anti-infective  
5 Blinatumomab Antineoplastic Immunotherapy | 1 New Technology Group 1             |
| 4 Central Vein |            |                                                                                                |                                   |
Ceftazidime-Avibactam Anti-infective
complicated uti’s and intra-abdominal infections

Idarucizumab, Dabigatran Reversal Agent
reverses the anticoagulant effect of the direct oral thrombin inhibitor dabigatran

Isavuconazole Anti-infective
treatment of Aspergillosis, Mucormycosis, and Candidiasis

Blinatumomab Antineoplastic Immunotherapy
designed to harness T cells that destroy cancer cells
New Section X

New Technology Section in ICD-10-PCS
Public request to create new section in ICD-10-PCS for new technologies

Issue discussed at September 2014 C&M meeting

CMS agreed with this suggestion
New Section X

Objective of Section X is two-fold –

1. Create codes uniquely identifying procedures requested via the New Technology Application Process or

2. That capture services not routinely captured in ICD-10-PCS that have been presented for public comment at a Coordination and Maintenance meeting

[Link to CMS website]

After section X codes have served their purpose, proposals to delete X codes and create new codes in the body of ICD-10-PCS would be addressed at subsequent Coordination and Maintenance meetings.
After consideration of the public comments received, we are adopting as final our proposal to delete ICD–9–CM MS–DRGs 237 and 238…

237  Major Cardiovascular Proc w/ MCC
238  Major Cardiovascular Proc w/o MCC
New MS-DRGs FY 2016

“…add the following five new MS–DRGs to ICD–10 MS–DRGs Version 33…”

268  Aortic and Heart Assist Proc Except Pulsation Balloon w/ MCC
269  Aortic and Heart Assist Proc Except Pulsation Balloon w/o MCC
270  Other Major Cardiovascular Proc w/ MCC
271  Other Major Cardiovascular Proc w/ CC
272  Other Major Cardiovascular Proc w/o CC/MCC
New MS-DRGs FY 2016

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273  Percutaneous Intracardiac Procedures with MCC
274  Percutaneous Intracardiac Procedures without MCC
Questions?

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