Operation PCS

Complete guide to ICD-10-PCS coding conventions and guidelines

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Introduction

ICD-10 Essentials: Operation PCS is a new coding reference for ICD-10-PCS focusing on application of the coding guidelines. This book provides a comprehensive look at each ICD-10-PCS guideline along with supporting examples, case studies, and in-depth coding rationale designed to ensure accurate application of the guideline in real-life coding situations. New and veteran coding professionals will find this book to be a valuable resource that explains and clarifies key coding concepts related to ICD-10-PCS.

The coding guidance found in ICD-10 Essentials: Operation PCS is based on the official version of the ICD-10 Procedure Coding System (ICD-10-PCS), effective October 1, 2016.

Changes reflecting the dynamic world of coding are ongoing, and Optum encourages input for inclusion in future editions of the book.

How to Use ICD-10 Essentials: Operation PCS

The organization of ICD-10 Essentials: Operation PCS follows the format of ICD-10-PCS Official Guidelines for Coding and Reporting 2017. There is a chapter devoted to each of the topics covered in the guidelines as follows:

• Conventions
• Medical and Surgical Body System Guidelines
• Medical and Surgical Root Operation Guidelines
• Medical and Surgical Body Part Guidelines
• Medical and Surgical Approach Guidelines
• Medical and Surgical Device Guidelines
• Obstetric Section Guidelines
• New Technology Section Guidelines

Shaded boxes in different colors allow the user to quickly differentiate the various components of each chapter. Blue boxes enclose the focus guideline in each section. Supporting guidelines included to assist in explaining case studies are shown in orange boxes. Spotlights in yellow boxes alert the user to key facts, important information, and coding advice, while pink boxes highlight definitions.

Valuable information has been provided in case studies, tables, and figures that include illustrations and decision trees, all of which are listed in the front of the book and are easily searchable. Located in the back of the book are appendices to supplement the material contained in the chapters, as well as an alphabetical index to search pertinent information.
Chapter 1. ICD-10-PCS Overview

History of ICD-10-PCS

The World Health Organization (WHO) has maintained the International Classification of Diseases (ICD) for recording cause of death since 1893. It has updated the ICD periodically to reflect new discoveries in epidemiology and changes in medical understanding of disease.

The International Classification of Diseases, Tenth Revision (ICD-10), published in 1992, is the latest revision of the ICD. The WHO authorized the National Center for Health Statistics (NCHS) to develop a clinical modification of ICD-10 for use in the United States. This version, called ICD-10-CM, replaced the previous U.S. clinical modification, ICD-9-CM, which had been in use since 1979. ICD-9-CM contained a procedure classification; ICD-10-CM does not.

In order to provide a procedural classification system to accompany the ICD-10-CM code set, the Centers for Medicare and Medicaid Services (CMS), the agency responsible for maintaining the inpatient procedure code set in the United States, funded a project with 3M in 1993 to develop a design for a replacement of the limited four-digit ICD-9 procedural classification. After several trials, it was determined that an entirely new system was needed and the alphanumeric, seven-digit system was developed. After requesting bids for the project, CMS contracted with 3M Health Information Systems in 1995 to design and develop the procedure classification system to replace volume 3 of ICD-9-CM. The result, ICD-10-PCS, was initially completed in 1998. The code set has been updated annually since that time. ICD-10-PCS has unique, precise codes to differentiate body parts, surgical approaches, and devices used. It can be used to identify resource consumption differences and outcomes for different procedures, and describes precisely what was done to the patient.

After legislative delays in 2013 and 2014, implementation of ICD-10-CM and ICD-10-PCS went into effect on October 1, 2015.

The development of ICD-10-PCS had as its goal the incorporation of the following major attributes:

- **Completeness:** A unique code should be available for all significantly different procedures.
- **Unique definitions:** Because ICD-10-PCS codes are constructed of individual values rather than lists of fixed codes and text descriptions, the unique, stable definition of a code in the system is retained. New values may be added to the system to represent a specific new approach, device, or qualifier, but whole codes by design cannot be given new meanings and reused.
- **Expandability:** As new procedures are developed, the structure of ICD-10-PCS should allow them to be easily incorporated as unique codes.
- **Multiaxial:** ICD-10-PCS codes should consist of independent characters, with each individual axis retaining its meaning across broad ranges of codes to the extent possible.
- **Standardized terminology:** ICD-10-PCS should include definitions of the terminology used. While the meaning of specific words varies in common usage, ICD-10-PCS should not include multiple meanings for the same term, and each term must be assigned a specific meaning.
- **Structural integrity:** ICD-10-PCS can be easily expanded without disrupting the structure of the system. ICD-10-PCS allows unique new codes to be added to the system because values for the seven characters that make up a code can be combined as needed. The system can evolve as medical technology and clinical practice evolve, without disrupting the ICD-10-PCS structure.
Guideline B3.2b

B3.2 During the same operative episode, multiple procedures are coded if:

b. The same root operation is repeated in multiple body parts, and those body parts are separate and distinct body parts classified to a single ICD-10-PCS body part value.

*Examples:* Excision of the sartorius muscle and excision of the gracilis muscle are both included in the upper leg muscle body part value, and multiple procedures are coded.

Extraction of multiple toenails are coded separately.

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2016, 4Q, 134 Changes to the ICD-10-PCS Official Guidelines for Coding and Reporting
2015, 2Q, 19 Multiple Decompressive Cervical Laminectomies
2014, 4Q, 16 Excision of Multiple Uterine Fibroids
2014, 3Q, 26 Coil Embolization of Gastroduodenal Artery with Chemoembolization of Hepatic Artery

In PCS, some body part values include anatomical structures that are separate and distinct body parts. A good understanding of anatomy, along with use of the Body Part Definitions Table, is required to accurately apply guideline B3.2b.

A list of many separate and distinct body parts included in a particular body part value can be found in the Body Part Definitions Table in appendix D of this book. The Body Part Definitions table lists the ICD-10-PCS value for the body part in the first column and the anatomical structures that are included in the PCS body part in the second column labeled Definition. However, it should be noted that some terms in the Definition column are synonyms and not separate and distinct body parts. Only procedures performed on separate and distinct body parts are coded separately.

The upper leg muscles are used in the example provided for guideline B3.2b above. There are 14 muscles reported with the body part Upper Leg Muscle, Right and Upper Leg Muscle, Left. An excerpt from the Body Part Definitions Table for the Upper Leg Muscle is provided below.

<table>
<thead>
<tr>
<th>PCS Value</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper Leg Muscle, Left</td>
<td>Includes:</td>
</tr>
<tr>
<td></td>
<td>• Adductor brevis muscle</td>
</tr>
<tr>
<td>Upper Leg Muscle, Right</td>
<td>• Adductor longus muscle</td>
</tr>
<tr>
<td></td>
<td>• Adductor magnus muscle</td>
</tr>
<tr>
<td></td>
<td>• Biceps femoris muscle</td>
</tr>
<tr>
<td></td>
<td>• Gracilis muscle</td>
</tr>
<tr>
<td></td>
<td>• Pectineus muscle</td>
</tr>
<tr>
<td></td>
<td>• Quadriceps (femoris)</td>
</tr>
<tr>
<td></td>
<td>• Rectus femoris muscle</td>
</tr>
<tr>
<td></td>
<td>• Sartorius muscle</td>
</tr>
<tr>
<td></td>
<td>• Semimembranosus muscle</td>
</tr>
<tr>
<td></td>
<td>• Semitendinosus muscle</td>
</tr>
<tr>
<td></td>
<td>• Vastus intermedius muscle</td>
</tr>
<tr>
<td></td>
<td>• Vastus lateralis muscle</td>
</tr>
<tr>
<td></td>
<td>• Vastus medialis muscle</td>
</tr>
</tbody>
</table>

When documentation identifies that the same root operation was performed on multiple distinct and separate muscles included in body part Upper Leg Muscle, Right or Upper Leg Muscle, Left, the same procedure code is reported for each separate and distinct muscle. This means that the same seven-character code is repeated multiple times.
Practical Application for Guideline B3.2b

Case Study 4.12. Orbital Bone Fracture Repair

The patient was struck in the face by a baseball, resulting in a complex facial injury. Upon further evaluation, nondisplaced fractures were noted in the orbital portions of the right maxilla and right zygomatic bones. Treatment included the insertion of plates at both sites via an open approach.

Code(s):
0NHP04Z Insertion of Internal Fixation Device into Right Orbit, Open Approach
0NHP04Z Insertion of Internal Fixation Device into Right Orbit, Open Approach

Rationale:
The orbit consists of seven bones that are part of the Head and Facial Bones (N) body system, including the maxilla, lacrimal bone, ethmoid, palatine bone, sphenoid, frontal bone, and zygomatic bone, all shown in the illustration that follows. Since the orbital portions of the maxilla and zygomatic bone were treated and they are two separate and distinct anatomical body parts included in the Body Parts Definition Table for Orbit, Left (Q) and Orbit, Right (P), two codes are required.

Plates are fixation devices that are coded using root operation Insertion (H), which is defined as “putting in a nonbiological appliance that monitors, assists, performs, or prevents a physiological function but does not physically take the place of a body part.” The following Guideline B3.15 specifies that nondisplaced fractures are coded to the procedure performed, which is Insertion (H) of plates in this example, as opposed to a displaced fracture, which is coded to root operation Reposition (S).

<table>
<thead>
<tr>
<th>PCS Value</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orbit, Left</td>
<td>Includes:</td>
</tr>
<tr>
<td>Orbit, Right</td>
<td>• Bony orbit</td>
</tr>
<tr>
<td></td>
<td>• Orbital portion of ethmoid bone</td>
</tr>
<tr>
<td></td>
<td>• Orbital portion of frontal bone</td>
</tr>
<tr>
<td></td>
<td>• Orbital portion of lacrimal bone</td>
</tr>
<tr>
<td></td>
<td>• Orbital portion of maxilla</td>
</tr>
<tr>
<td></td>
<td>• Orbital portion of palatine bone</td>
</tr>
<tr>
<td></td>
<td>• Orbital portion of sphenoid bone</td>
</tr>
<tr>
<td></td>
<td>• Orbital portion of zygomatic bone</td>
</tr>
</tbody>
</table>

Although the code description identifies the body part as Orbit, Right (P), it is appropriate to list the code twice since the procedure was performed on two separate and distinct bones comprising the orbit—the orbital portion of maxilla and the orbital portion of zygomatic bone—which are classified as a single body part character.

The approach is listed as Open (0) and the plates are represented by Internal Fixation Device (4).
Figure 4.3. Orbital Structures

Case Study 4.13. Pulmonary Vein Angioplasty
Non-drug eluting stents were placed percutaneously in the left inferior and superior pulmonary veins to treat severe pulmonary vein stenosis (PVS) that resulted after catheter ablation of atrial fibrillation (AF).

Code(s):
Ø27T3DZ Dilation of Left Pulmonary Vein with Intraluminal Device, Percutaneous Approach
Ø27T3DZ Dilation of Left Pulmonary Vein with Intraluminal Device, Percutaneous Approach

Rationale:
Stents hold the vein open after a catheter has been placed and a special balloon has been inflated to widen the passage through the vein. The stent stays in the vein while the catheter and balloon are taken out. Therefore, the correct root operation for this procedure is Dilation (7).

Root Operation

<table>
<thead>
<tr>
<th>Root Operation</th>
<th>Definition</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dilation (7)</td>
<td>Expanding an orifice or the lumen of a tubular body part</td>
<td>The orifice can be a natural orifice or an artificially created orifice. Accomplished by stretching a tubular body part using intraluminal pressure or by cutting part of the orifice or wall of the tubular body part.</td>
</tr>
</tbody>
</table>

The PCS index for Dilation, Vein, Pulmonary directs the user to table Ø27T for the Left Vein (T). Reviewing the Body Part Definitions table, which can be found in appendix D, the Pulmonary Vein, Left includes the left inferior and left superior pulmonary veins. Reporting the same code twice is appropriate in this procedure since both veins are separate and distinct body parts classified to a single ICD-10-PCS body part value.

PCS Value

<table>
<thead>
<tr>
<th>Pulmonary Vein, Left</th>
<th>Includes:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Left inferior pulmonary vein</td>
</tr>
<tr>
<td></td>
<td>• Left superior pulmonary vein</td>
</tr>
</tbody>
</table>

A Percutaneous approach (3) was used with the correct device value being Intraluminal Device (D) since non-drug eluting stents were placed.
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