Why Words Matter

Through a General Surgery/Breast Surgery Lens

General Surgery Module I + Breast Surgery
Key Objectives for Today’s Session

1. Develop understanding of the role documentation plays in determining patient severity of illness (SOI), risk of mortality (ROM) and physician quality scores

2. Understand definition and key terminology changes in ICD-10-CM and ICD-10-PCS

3. Understand the concepts of linking conditions and manifestations for more accurate depiction of patient’s clinical status
Road Map for Discussion

1. Importance of Documentation and Basics of ICD-10-CM/PCS

2. Concepts Drive Documentation Requirements

3. Examples of Diagnoses in ICD-10
The Evolution of Clinical Documentation

What was once a tool for communication between providers and clinicians is now the primary data source to determine quality of patient care. Market forces are leading to increase in documentation scrutiny.

Who is the audience for your notes?

- Self
- Other Doctors
- Care Team
- Patients
- State Government
- Federal Government
- Insurance Companies
- Patients
Increased Transparency For Patients

MyCigna.com

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Leapfrog - all material and images are sourced from www.leapfroggroup.org (accessed on 6/18/2012)
Transition from ICD-9-CM to ICD-10-CM/PCS

Per Bill H.R. 4302, “The Secretary of Health and Human Services may not, prior to October 1, 2015, adopt ICD–10-CM/PCS code sets”.

Benefits and Goals of ICD-10-CM/PCS

• Provides better detail, a more accurate depiction, and improved communication of patients clinical status
• Allows for more accurate payment for new procedures
• Improves capture of morbidity and mortality data
• Reduces the number of miscoded, rejected and improper claims for reimbursement
ICD-9-CM vs. ICD-10-CM/PCS: A Comparison

Why so many new codes?

The main difference between ICD-9-CM and ICD-10-CM/PCS codes, outside of structural changes, is the SPECIFICITY of the code.

ICD-10-CM/PCS codes specify several components not found ICD-9-CM, such as causal agent, type, laterality, approach, episode of care, root operation, etc.

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1) Code Volume Expansion in ICD-10-CM/PCS

Introduction to ICD-10-CM Diagnosis Coding Structure

ICD-10-CM Codes will Contain 3-7 Alphanumeric Characters with the Following Structure

![Structure Diagram]

**Key ICD-10-CM Documentation Concepts**

<table>
<thead>
<tr>
<th>Specific anatomical location</th>
<th>Degree (mild, moderate, severe, or unspecified; total/complete vs. partial/incomplete)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type (primary, secondary, unspecified)</td>
<td>Episode of Care (Initial, Subsequent, Sequelae)</td>
</tr>
<tr>
<td>Acuity (acute, subacute, chronic, acute on chronic, or unspecified)</td>
<td>Laterality (Right, Left, bilateral, or unspecified)</td>
</tr>
<tr>
<td>Trimester (1,2,3, unspecified)</td>
<td>Number of fetus (1-5, other)</td>
</tr>
</tbody>
</table>
Introduction to ICD-10-PCS Coding Structure

In this exercise, we will dissect the structure of an ICD-10-PCS code

\[ \alpha/\# \]  
\[ \alpha/\# \]  
\[ \alpha/\# \]  
\[ \alpha/\# \]  
\[ \alpha/\# \]  
\[ \alpha/\# \]

<table>
<thead>
<tr>
<th>Section</th>
<th>Body System</th>
<th>Root Operation</th>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
</table>

1. **Section** – 16 options identifying the general type of procedure. Example: Medical/Surgical Section represents the vast majority of procedures reported in an inpatient setting

2. **Body System** - e.g. circulatory system, respiratory system

3. **Root Operation** - 31 options, based on the objective of the procedure

4. **Body Part** - e.g. pericardium, coronary artery, heart, atrium, mitral valve

5. **Approach** - 7 options, e.g. open, percutaneous, percutaneous endoscopic

6. **Device** - 4 basic groups: Grafts/prostheses, implants, simple or mechanical appliances, and electronic appliance

7. **Qualifier** - e.g. identify destination site in a Bypass, Diagnostic, Full thickness burn

**Physician documentation required:**

- **Type and intent** of procedure (root operation)
- Specific anatomic sites treated
- Approach
- Specific type of device used
- Validate surgical complications
- Diagnoses that support inpatient medical necessity

Source: AHIMA; The Advisory Board Company research
Road Map for Discussion

1. Importance of Documentation and Basics of ICD-10-CM/PCS

2. Key Concepts To Capture in Your Documentation

3. Examples of Diagnoses in ICD-10
Remember: Signs, Symptoms & Test Results Must Be Linked to Related Diagnoses

While important pieces of the medical record, signs, symptoms and test results are not sufficient for coders to assign a diagnosis.

- Linking signs and symptoms to diagnoses may increase SOI and ROM in the inpatient setting. (The terms ‘probable’, ‘likely’, or ‘suspected’ are all acceptable on the **inpatient** record)

- In the ambulatory setting, documentation regarding patient condition should be to the highest level known, treated or evaluated

- Abnormal findings (laboratory, x-ray, pathology and other diagnostic test results) cannot be coded and reported unless the clinical significance is identified by the treating provider **ICD-10-CM Official Coding Guidelines III.B**

Reminder: The attending physician is responsible for:

- Documenting all conditions in the progress notes and discharge summary
- Resolving conflicts in the documentation
Linking Conditions Critical to Capturing Patient Severity

There is a significant increase in the number of “combination codes” available in the ICD-10-CM/PCS code set. These codes can help capture the highest level of complexity and acuity in the public eye.

Linking clinically relevant conditions, where appropriate, is the key takeaway for physicians. Coders cannot assume clinical relationships.

Examples: Linking Diseases

- Hypertension with heart disease
- Endocarditis due to staph aureus
- Right heart failure due to primary pulmonary hypertension

Use terms like “due to” or “with”

Note: Lists, commas, and the word “and” do not link conditions
Severity of Illness (SOI) and Risk of Mortality (ROM)

Documentation drives SOI and ROM level assignment. These levels are used to measure patient acuity, and therefore drive expected patient LOS and mortality rate.

Breakdown of SOI/ROM and their Implication on Quality Measures

Four mutually exclusive SOI/ROM categories exist (1-4), and are determined based on a number of factors including primary and secondary diagnoses, comorbidities, demographics, patient history, treatment/procedure delivered, etc.

<table>
<thead>
<tr>
<th>Level</th>
<th>Assigned SOI/ROM Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor</td>
<td>1</td>
</tr>
<tr>
<td>Moderate</td>
<td>2</td>
</tr>
<tr>
<td>Major</td>
<td>3</td>
</tr>
<tr>
<td>Extreme</td>
<td>4</td>
</tr>
</tbody>
</table>
Road Map for Discussion

1. Importance of Documentation and Basics of ICD-10-CM/PCS

2. Key Concepts To Capture in Your Documentation

3. Examples of Diagnoses in ICD-10
Let's move on to these procedures to help explain what documentation will be like in ICD-10-CM/PCS

<table>
<thead>
<tr>
<th></th>
<th>Procedure Documentation (Root Operation, Body Part, Approach, Device)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Common Bile Duct Anastomosis</td>
</tr>
<tr>
<td>3</td>
<td>Rectal Resection</td>
</tr>
<tr>
<td>4</td>
<td>Best Practice Complications of Care Documentation</td>
</tr>
<tr>
<td>5</td>
<td>Pain Best Practice Procedure Notes</td>
</tr>
<tr>
<td>6</td>
<td>Outpatient Procedures</td>
</tr>
<tr>
<td>7</td>
<td>Neoplasms</td>
</tr>
<tr>
<td>8</td>
<td>Lumpectomy and Mastectomy</td>
</tr>
</tbody>
</table>
Documenting Root Operations in ICD-10-PCS

Coding guidelines state coders must assign root operations from documentation.

Documentation Should Include:

- What was removed: portion or all of an organ/body part
  - Clarify if it is solid matter
  - Identify the mechanism used (e.g. stripping, cutting, or destruction)
- Intended and performed procedure
  - If they differ identify/document why
  - If the intended procedure is modified or discontinued, the root operation is determined by the procedure actually performed

Key Takeaways:

There are 31 separate root operations in ICD-10-PCS. Physicians do not need to memorize or document the specific root operation term. Instead provide specific and clear documentation so coders can assign the appropriate root operation.
Documenting Body Part in ICD-10-PCS

Documentation Should Include:

• **Specific anatomic site** of the body system on which the procedure is performed
  • Identify the **specific** nerves, arteries or veins, portion of the spinal cord, etc.
• Tubular body parts are hollow body parts that provide a route of passage for solids, liquids or gases
### Documenting Approach in ICD-10-PCS

<table>
<thead>
<tr>
<th>Documentation of Surgical Approach Should Include:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access Location</strong></td>
</tr>
<tr>
<td>[1] 1. Skin or mucous membranes</td>
</tr>
<tr>
<td>2. External orifice</td>
</tr>
<tr>
<td><strong>Method of Approach</strong></td>
</tr>
<tr>
<td>2. Percutaneous</td>
</tr>
<tr>
<td>3. Percutaneous endoscopic</td>
</tr>
<tr>
<td>4. Via Natural or Artificial Opening</td>
</tr>
<tr>
<td>5. Via Natural or Artificial Opening Endoscopic</td>
</tr>
<tr>
<td>6. Via Natural or Artificial Opening with Percutaneous Endoscopic</td>
</tr>
<tr>
<td>7. External</td>
</tr>
<tr>
<td><strong>Type of Instrumentation</strong></td>
</tr>
<tr>
<td>2. Incision</td>
</tr>
</tbody>
</table>
ICD-10-PCS: Devices

Start now developing a procedure note that captures ICD-10-PCS terminology

Four General Types of Devices
1. Grafts and Prostheses
2. Implants
3. Simple or Mechanical Appliances
4. Electronic Appliances

Common General Surgery Devices
• Drainage device
• Monitoring device
• Feeding device
• Infusion device
• Extraluminal device
• Intraluminal device
• Autologous Tissue Substitute
• Synthetic Substitute
• Nonautologous tissue substitute

Not Considered a Device:
• Sutures
• Ligatures
• Radiological Markers
• Temporary postoperative wound drains
Common Bile Duct Anastomosis

**Bypass** Common Bile Duct to **Left Hepatic Duct** with Intraluminal Device, **Percutaneous Endoscopic Approach**

**Root Operation Definition:** Altering the route of passage of the contents of a tubular body part

**Approach Options:**
- Open
- Percutaneous Endoscopic

**Qualifier Options:**
- Duodenum
- Stomach
- Hepatic Duct, Right
- Hepatic Duct, Left
- Hepatic Duct, Caudate
- Cystic Duct
- Common Bile Duct
- Small Intestine
Rectal Resection

Resection of Rectum, Open Approach

**Section**: 0

**Body System**: D

**Root Operation**: T

**Body Part**: P

**Approach**: O

**Device**: Z

**Qualifier**: Z

**Medical & Surgical**

**Gastrointestinal System**

**Resection**

**Rectum**

**Open**

**No Device**

**No Qualifier**

**Body Part Options:**
- Esophagus, Upper
- Esophagus, Middle
- Esophagus, Lower
- Esophagogastric Junction
- Esophagus
- Stomach
- Stomach, Pylorus
- Small Intestine
- Duodenum
- Jejunum
- Ileum
- Ileocecal Valve
- Large Intestine
- Large Intestine, Right
- Large Intestine, Left
- Cecum
- Appendix
- Ascending Colon
- Transverse Colon
- Descending Colon
- Sigmoid Colon
- Rectum
- Anus

**Approach Options:**
- Open
- Percutaneous Endoscopic
- Via Natural or Artificial Opening
- Via Natural or Artificial Opening Endoscopic
## Documentation of Complications of Care

ICD-10-CM coding terminology will change to more accurately identify when complications occur.

<table>
<thead>
<tr>
<th>Two Key Components to Remember:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-10-CM has replaced the term post-operative with “post-procedural” or “post-surgical”</td>
</tr>
<tr>
<td>Conditions occurring in the post-operative period should be clarified as:</td>
</tr>
</tbody>
</table>

- An expected post-procedural or post-surgical condition
- An unexpected post-procedural or post-surgical condition related to surgical care (a complication of care)
- An unexpected post-procedural or post-surgical condition, unrelated to surgical procedure
- An unexpected post-procedural or post-surgical condition, related to the patient’s underlying medical comorbidities
Best Practice for Procedure Notes

Start now developing a procedure note that captures ICD-10-PCS terminology

Best Practice ICD-10-PCS Concepts To Include

Date/Time
Procedure Intended
Procedure Performed (*document reason for difference*)
Additional procedures performed

Procedure checklist:
  • Device Identified
  • What made the procedure difficult/longer
  • Unusual findings
  • Complication
    • Accidental or complication?
    • Due to:
      • Disease/condition
      • Patient characteristics
      • Surgery
      • Drugs

Heart Failure Combination Codes Examples:
  • Body system
  • Root operation
  • Body part
  • Approach
  • Devices
  • Qualifier
  • Common complications
Key Considerations When Documenting Procedures in the Outpatient or Ambulatory Setting

1. ICD-10-PCS is only used on inpatient procedures
2. If you do an outpatient procedure on a patient who is admitted within 3 days, then that procedure is rolled into the inpatient admission if the admission is for a related diagnosis
3. Physician should document outpatient procedures to satisfy ICD-10-PCS, HCPCS and CPT in case the patient is admitted as an inpatient

ICD-10-PCS and CPT Billing

If this information is not accurate and not coded correctly, the provider may not receive payment due to new Part A/Part B cross claim audits (pre-payment audits). As a result, your surgical fees can be denied because the new ICD-10-PCS codes are not in sync.
Components to Best Practice Documentation

• **Specify Site**
  • Each specific site
  • Primary vs Secondary:
    • Metastases - where is it from and where did it go to

• **Laterality** – Right, left, bilateral

• **Behavior** – Benign, In situ, Malignant, Uncertain

• **Personal history of** – Is utilized only when the primary neoplasm has been previously excised or eradicated from its site and is no longer under any type of treatment, and there is no evidence of any existing primary malignancy
  • Documentation that is unclear may result in a query to clarify the status of the neoplasm

• Always **link** to complications and comorbidities
  • Anemia “due to” neoplastic disease
Best Practice for Neoplasm Documentation

Components to Best Practice Documentation

• Identify when neoplasms are in different locations in the same site, or they are “overlapping” (previously known as contiguous)
  • Which lung(s), which lobe(s)
  • Is it a tumor or a mass
  • Is it benign, malignant or uncertain behavior
  • Is the neoplasm a primary or secondary site

Specificity is Required

• “Tumor” and “mass” are coded differently and have different meanings
  • Tumor = neoplasm
  • Mass = lump
• Lack of clarity in documentation on primary vs secondary sites will generate a query
**Breast Neoplasm**

Malignant neoplasm of upper-outer quadrant of right female breast

<table>
<thead>
<tr>
<th>Location</th>
<th>C</th>
<th>5</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malignant neoplasms of breast</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Anatomic Site, Gender</th>
<th>4</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper-outer quadrant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central portion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper inner quadrant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nipple &amp; areola</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower-inner quadrant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower outer quadrant</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Laterality</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right</td>
<td></td>
</tr>
<tr>
<td>Left</td>
<td></td>
</tr>
<tr>
<td>Unspecified</td>
<td></td>
</tr>
</tbody>
</table>
Lumpectomy

Excision of Left Breast, Percutaneous Approach, Diagnostic

Root Operation Definition:
Cutting out or off, without replacement, a portion of a body part

Approach Options:
- Open
- Percutaneous
- Via Natural or Artificial Opening
- Via natural of Artificial Opening
- Endoscopic
- External

Qualifier Options:
- Diagnostic
- No Qualifier

Source:
Mastectomy

Resection of Bilateral Breast, Open Approach


Root Operation Definition: Cutting out or off, without replacement, all of a body part

Body Part Options:
- Breast, Right
- Breast, Left
- Breast, Bilateral
- Supernumerary Breast

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Summary of Best Practice Documentation Teaching Points

Key Documentation Concepts

- Coding terminology for key procedure types will change with ICD-10-PCS. Understand definitions to better recognize codes in your daily practice (problem lists, etc.)
- ICD-10-PCS is only used on inpatient procedures
- Always specify the type of device used
- Capture the approach by documenting the access location, method, and type of instrument used
- Conflicting, incomplete, or ambiguous documentation may result in a query
- Remember to clarify documentation of any procedural complications
- Remember ICD-10-CM requires documentation of tobacco exposure
# ICD-10-PCS: Approach

<table>
<thead>
<tr>
<th>Approach</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Open</td>
<td>Cutting through the skin or mucous membrane and any other body layers necessary to expose the site of the procedure</td>
</tr>
<tr>
<td>2. Percutaneous</td>
<td>Entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and/or any other body layers necessary to reach the site of the procedure</td>
</tr>
<tr>
<td>3. Percutaneous Endoscopic</td>
<td>Entry, by puncture or minor inclusion, of instrumentation through the skin or mucous membrane and/or any other body layers necessary to reach and visualize the site of the procedure</td>
</tr>
<tr>
<td>4. Via Natural or Artificial Opening</td>
<td>Entry of instrumentation through a natural or artificial external opening to reach the site of the procedure</td>
</tr>
<tr>
<td>5. Via Natural or Artificial Opening Endoscopic</td>
<td>Entry of instrumentation through a natural or artificial external opening to reach the site of the procedure</td>
</tr>
<tr>
<td>6. Via Natural or Artificial Opening Endoscopic with Percutaneous Endoscopic Assistance</td>
<td>Entry of instrumentation through a natural or artificial external opening to reach and visualize the site of the procedure, and entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to aid in the performance of the procedure</td>
</tr>
<tr>
<td>7. External</td>
<td>Procedures performed directly on the skin or mucous membrane and procedures performed indirectly by the application of external force through the skin or mucous membrane</td>
</tr>
</tbody>
</table>
## For Reference: Root Definitions for ICD-10-PCS

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
</table>
| Alteration | Modifying the natural anatomic structure of a body part without affecting the function of the body part  
Examples: Face lift, breast augmentation |
| Bypass     | Altering the route of passage of the contents of a tubular body part  
Example: Coronary artery bypass, colostomy |
| Change     | Taking out or off a device from a body part and putting back an identical or similar device in or on the same body part without cutting or puncturing the skin or a mucous membrane  
Example: chest tube replacement, gastrostomy tube change |
| Control    | Stopping, or attempting to stop, post procedural bleeding  
Example: Control of post-prostatectomy bleeding |
| Creation   | Making a new genital structure that does not take over the function of a body part  
Example: creation of penis in a female or vagina in a male |
| Detachment | Cutting off all or a portion of the upper or lower extremities  
Example: BKA |
| Dilation   | Expanding an orifice or the lumen of a tubular body part  
Example: PTCA |
| Division   | Cutting into a body part without draining fluids and/or gases from the body part in order to separate or transect a body part  
Examples: Spinal cordotomy, osteotomy |
| Drainage   | Taking or letting out fluids/or gases from a body part  
Examples: I&D, thoracentesis |
| Excision   | Cutting out or off, without replacement, a portion of a body part  
Examples: Liver biopsy, partial nephrectomy, sigmoid polypectomy |
| Extirpation| Taking or cutting out solid matter from a body part (the solid matter may be an abnormal byproduct, imbedded or may be or may not have been broken into pieces)  
Examples: Thrombectomy, endarterectomy, choledocholithotomy |
| Extraction | Pulling or stripping out or off all or a portion of a body part by the use of force (A qualifier of diagnostic is used for biopsies)  
Examples: D&C, vein stripping, toenail extraction |
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
</table>
| **Fragmentation** | Breaking solid matter in a body part into pieces  
Examples: Lithotripsy of kidney stones          |
| **Fusion**   | Joining together portions of an articular body part rendering the articular body part immobile  
Example: Spinal fusion                           |
| **Insertion** | 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  
Examples: ET tube, Central venous catheter        |
| **Inspection** | Visually and/or manually exploring a body part  
Example: Diagnostic bronchoscopy, endoscopy, exploratory-lap, diagnostic arthroscopy |
| **Map**      | Locating the route of passage of electrical impulses and/or locating functional areas in a body part  
Example: EP studies, cortical mapping             |
| **Occlusion** | Completely closing an orifice or lumen of a tubular body part  
Examples: Fallopian tube ligation                |
| **Reattachment** | Putting back in or on all or a portion of a separated body part to its normal location or other suitable location  
Example: Reattachment of hand, finger reattachment |
| **Release**  | Freeing a body part from an abnormal physical constraint by cutting or by use of force  
Examples: Adhesiolysis, carpal tunnel syndrome    |
| **Removal**  | Taking out or off a device from a body part  
Examples: Drainage tube removal, pacemaker removal |
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repair</td>
<td>Restoring, to the extent possible, a body part to its normal anatomic structure and function</td>
<td>Colostomy takedown, suture of laceration</td>
</tr>
<tr>
<td>Replacement</td>
<td>Putting in or on biological or synthetic material that physically takes the place and/or function of all or a portion of a body part</td>
<td>Total hip replacement, bone graft</td>
</tr>
<tr>
<td>Reposition</td>
<td>Moving to its normal location or other suitable location all or a portion of a body part</td>
<td>Fracture reduction, reposition undescended testicle</td>
</tr>
<tr>
<td>Resection</td>
<td>Cutting out or off, without replacement, all of a body part</td>
<td>Total nephrectomy</td>
</tr>
<tr>
<td>Restriction</td>
<td>Partially closing the orifice or lumen of a tubular body part</td>
<td>Esophagogastric fundoplication</td>
</tr>
<tr>
<td>Revision</td>
<td>Correcting, to the extent possible, a malfunctioning or displaced device</td>
<td>Adjustment of position of pacemaker leads, recementing of hip prosthesis</td>
</tr>
<tr>
<td>Supplement</td>
<td>Putting in or on biological or synthetic material that physically reinforces and/or augments the function of a portion of a body part</td>
<td>Herniorrhaphy using mesh, mitral valve ring annuloplasty</td>
</tr>
<tr>
<td>Transfer</td>
<td>Moving, without talking out, all or a portion of a body part to another location to take over the function of all or a portion of a body part</td>
<td>Tendon transfer, pedicle flap transfer</td>
</tr>
<tr>
<td>Transplantation</td>
<td>Putting in or on all or a portion of a living body part taken from another individual or animal to physician take the place and/or function of all or a portion of a similar body part</td>
<td>Kidney transplant, heart transplant</td>
</tr>
</tbody>
</table>