Why Words Matter

Through a General Surgery Lens
### 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
- Care Team
- Other Doctors
- Patients
- State Government
- Federal Government
- Insurance Companies
Increased Transparency For Patients
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

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 in ICD-9-CM, such as causal agent, type, laterality, approach, episode of care, root operation, etc.

Why so many new codes?


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

- **Category**
- **Sub-categories** *(Etiology, Anatomic Site, Severity, Laterality, Complication)*
- **Extension** *(3-16 options depending on category)*

<table>
<thead>
<tr>
<th>Key ICD-10-CM Documentation Concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specific anatomical location</strong></td>
</tr>
<tr>
<td><strong>Type</strong> <em>(primary, secondary, unspecified)</em></td>
</tr>
<tr>
<td><strong>Acuity</strong> <em>(acute, subacute, chronic, acute on chronic, or unspecified)</em></td>
</tr>
<tr>
<td><strong>Trimester</strong> <em>(1, 2, 3, unspecified)</em></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

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

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
## ICD-10-CM/PCS General Surgery Procedures & Diagnoses Covered Today

<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>Digestive Diagnoses</td>
</tr>
<tr>
<td>8</td>
<td>Diabetes/Diabetic Procedures</td>
</tr>
<tr>
<td>9</td>
<td>Pressure Ulcers</td>
</tr>
<tr>
<td>10</td>
<td>Excisional Debridement</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 Approach in ICD-10-PCS

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

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

Four General Types of Devices

1. Grafts and Protheses
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**: Gastrointestinal System
- **Root Operation**: Resection
- **Body Part**: Rectum
- **Approach**: Open
- **Device**: No Device
- **Qualifier**: 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.

### Two Key Components to Remember:

| ICD-10-CM has replaced the term post-operative with “post-procedural” or “post-surgical” |
| Conditions occurring in the post-operative period should be clarified as: |
| • 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
**Outpatient Procedures & ICD-10-PCS**

**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.
**Digestive System**

ICD-10-CM Concepts for Major Digestive Disorders

1. **GI Hemorrhage Documentation Concepts**
   - Low SOI diagnoses
     - Hematemesis
     - Melena
     - Gastrointestinal “hemorrhage” or “GI bleed”
   - Document more specific diagnoses when possible
     - Acute hemorrhagic gastritis
     - Diverticular disease with hemorrhage
     - Peptic ulcer with hemorrhage
     - Hemorrhage of anus/rectum
   - With all hemorrhages need to have cause of the bleed, acuity, and link to potential anemia

2. **Hernia Documentation Concepts**
   - Site
     - Inguinal, femoral, umbilical, ventral (incisional or parastomal), diaphragmatic, etc.
   - Laterality
   - Recurrent or not
   - Complications
     - With gangrene
     - Without obstruction or gangrene

3. **Ulcer Documentation Concepts**
   - Location
     - Gastric, duodenal, peptic, gastrojejunal ulcer
   - Acuity
     - acute, chronic, or acute on chronic
   - Associated conditions/etiology
   - Complications
     - Hemorrhage
     - Perforation
     - Neither or both

**Document:**
- Acuity
- Link to anemia
- Link to underlying cause
- Alcohol/tobacco abuse or dependence
**Digestive System**

**ICD-10-CM Concepts for Enteritis**

<table>
<thead>
<tr>
<th>Documentation Concepts for Crohn’s and Colitis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Crohn’s Disease</strong></td>
</tr>
<tr>
<td>• Document Site:</td>
</tr>
<tr>
<td>- Small intestine</td>
</tr>
<tr>
<td>- Large intestine</td>
</tr>
<tr>
<td>- Both small and large intestine</td>
</tr>
<tr>
<td><strong>Ulcerative Colitis</strong></td>
</tr>
<tr>
<td>• Type:</td>
</tr>
<tr>
<td>- Pancolitis</td>
</tr>
<tr>
<td>- Proctitis</td>
</tr>
<tr>
<td>- Rectosigmoiditis</td>
</tr>
<tr>
<td>• Inflammatory polyps of colon</td>
</tr>
<tr>
<td>• Left-sided colitis</td>
</tr>
</tbody>
</table>

**Document:**

• Always document complications of:
  • Rectal bleeding
  • Intestinal obstruction
  • Fistula
  • Abscess

• Alcohol/tobacco abuse or dependence
# Digestive System

## ICD-10-CM Concepts for Other GI Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Documentation Concepts</th>
</tr>
</thead>
</table>
| Vascular or ischemic colitis | • Acute or chronic  
|                            | • With or without hemorrhage                                 |
| Ileus                      | • Paralytic  
|                            | – Important to document normal (expected) or complication (unexpected) |
| Diverticulitis             | • Site  
|                            | • Complications: bleeding, perforation, abscess              |
| Fissure                    | • Acute or chronic                                           |
| Fistula                    | • Location                                                   |
| Abscesses/Cellulitis       | • Location (e.g. anal, perianal, ischiorectal)               |
| Hemorrhoids                | • Degree 1-4                                                 
|                            | • If thrombosed                                              |
| Polyp                      | • Location                                                   |
Diabetes

Specificity in diabetes documentation may increase severity of illness captured in the record

<table>
<thead>
<tr>
<th>Document</th>
<th>Potential Specifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Diabetes</td>
<td>• DM Type 1&lt;br&gt;• DM Type 2&lt;br&gt;• DM due to underlying condition (e.g. Cushing’s syndrome)&lt;br&gt;• Drug/chemical induced DM (Document the drug/chemical)&lt;br&gt;• Gestational DM</td>
</tr>
<tr>
<td>Use of Insulin</td>
<td>• Long term&lt;br&gt;• Current</td>
</tr>
<tr>
<td>Any manifestations or complications related to DM</td>
<td><strong>Example:</strong> Hyperglycemia, Hyperosmolarity</td>
</tr>
</tbody>
</table>

**ICD-10-CM Key Terminology Change**

- If left unspecified, diabetes will default to the DM Type 2
- It is no longer required to specify ‘controlled’ or ‘uncontrolled’ diabetes

**Physician Documentation Example**

ICD-10-CM allows the capture of related conditions with one code instead of multiple codes

“Type 1 diabetes with nonproliferative diabetic retinopathy”

“Type 1 diabetes with ketoacidosis without coma”
Diabetic Manifestations & Complications

DM manifestations and complications increase SOI when linked to DM

Two Ways to Capture Documentation:

The term “with”:
- Diabetes “with”:
  - Hypoglycemia
  - Hyperglycemia
  - Hyperosmolarity
  - Ketoacidosis
  - Coma/nonketotic hyperglycemic-hyperosmolar coma

The term “Diabetic”:
- Diabetic nephropathy
- Diabetic chronic kidney disease stage 4
- Diabetic gastroparesis
- Diabetic neuropathy (mono/poly/autonomic)

Example: “Type 2DM with hypoglycemia without coma with diabetic gastroparesis”

Common Insufficient Documentation Diagnosis Lists

Impression:
- DM Type 2
- Debridement
- Foot ulcer

Best Practice Documentation

- Excisional debridement of Type 2 DM L mid foot ulcer with necrosis of muscle

Key Terminology Changes:
- The term “uncontrolled” or “controlled” does not exist in ICD-10-CM.
- When diabetes is documented as “inadequately controlled, poorly controlled, or out of control” it will be coded to diabetes by type with the complication of hyperglycemia.
Pressure Ulcers

Always specify stage, laterality and site of ulcer

<table>
<thead>
<tr>
<th>ICD-10-CM Documentation Concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pressure ulcer synonyms</strong></td>
</tr>
<tr>
<td>• Bed sore</td>
</tr>
<tr>
<td>• Decubitus ulcer</td>
</tr>
<tr>
<td>• Plaster ulcer</td>
</tr>
<tr>
<td>• Pressure ulcer</td>
</tr>
<tr>
<td>• Pressure area</td>
</tr>
<tr>
<td>• Pressure sore</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Laterality</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Right or Left</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Sites</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ankle</td>
</tr>
<tr>
<td>• Elbow</td>
</tr>
<tr>
<td>• Back (Upper, Lower or Sacral region)</td>
</tr>
<tr>
<td>• Buttock</td>
</tr>
<tr>
<td>• Hip</td>
</tr>
<tr>
<td>• Heel</td>
</tr>
<tr>
<td>• Head</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Severity</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify Stage: I-IV</td>
</tr>
<tr>
<td><em>(Stage III and IV are MCCs if POA)</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Is it new or healing pressure ulcer?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Gangrenous or not</td>
</tr>
</tbody>
</table>

<p>| <strong>Identify if other type of ulcer</strong>     |</p>
<table>
<thead>
<tr>
<th><em>(specify if different then pressure ulcer)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Diabetic</td>
</tr>
<tr>
<td>• Non-pressure, chronic</td>
</tr>
<tr>
<td>• Traumatic wound</td>
</tr>
</tbody>
</table>
Pressure Ulcers

Pressure ulcer of right buttock, stage 4

Example:
- Excisional debridement bed sore of left lower back, stage 4 with gangrene
- New pressure ulcer, stage 1, left buttock
### Debridement

**Table: Critical to Specify Type of Debridement**

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excisional</td>
<td>Cutting out or off, without replacement, a portion of a body part</td>
</tr>
<tr>
<td>Non-Excisional</td>
<td>Pulling or stripping out or off all or a portion of a body part by the use of force</td>
</tr>
</tbody>
</table>

**Documentation needed**
- Excisional or non-excisional
- Instruments used (e.g. scalpel, scissors)
- Location
- Depth
  - Epidermis/dermis
  - Subcutaneous tissue
  - Muscle
  - Bone
Excisional Debridement
Subcutaneous Tissue & Fascia, Excision, Left Upper Leg, Open, No Device, No Qualifier

Procedure Codes Capture Approach Usage Excision

0 J B M 0 Z Z
Section Body System Root Operation Body Part Approach Device Qualifier
Medical & Surgical Subcutaneous Tissue & Fascia Excision Left Upper Leg Open None

Note:
Physician documentation must specify if debridement is excisional or nonexcisional and performed at bedside or in the OR.
Summary of Best Practice Documentation Teaching Points

Key Documentation Concepts

• Conflicting, incomplete, or ambiguous documentation will lead to a query
• Carry all documentation from diagnostic test into progress notes to ensure it will be captured
• Documentation of tobacco exposure is crucial
• Sign, symptoms and test results do not contribute to SOI unless their significance is documented or they are linked to a named disease
• 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
• Remember to clarify documentation of any procedural complications
• Link all pieces of an illness in order to get the highest severity of illness to support tests or procedures - use the terms “with” or “due to”
• Pressure ulcer documentation should include Site and Stage.
• Physician documentation must specify if debridement is “excisional” or “nonexcisional”
# For Reference: Approach Definitions for ICD-10-PCS

<table>
<thead>
<tr>
<th>Approach</th>
<th>Definition</th>
<th>Example</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>
<td>Colectomy</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>
<td>Needle biopsy of liver</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>
<td>Arthroscopy</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>
<td>Endotracheal tube insertion</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>
<td>Sigmoidoscopy</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>
<td>Laparoscopic lap band</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>
<td>Closed fracture reduction</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alteration</td>
<td>Modifying the natural anatomic structure of a body part without affecting the function of the body part</td>
<td>Face lift, breast augmentation</td>
</tr>
<tr>
<td>Bypass</td>
<td>Altering the route of passage of the contents of a tubular body part</td>
<td>Coronary artery bypass, colostomy</td>
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<tr>
<td>Change</td>
<td>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</td>
<td>chest tube replacement, gastrostomy tube change</td>
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<tr>
<td>Control</td>
<td>Stopping, or attempting to stop, post procedural bleeding</td>
<td>Control of post-prostatectomy bleeding</td>
</tr>
<tr>
<td>Creation</td>
<td>Making a new genital structure that does not take over the function of a body part</td>
<td>creation of penis in a female or vagina in a male</td>
</tr>
<tr>
<td>Detachment</td>
<td>Cutting off all or a portion of the upper or lower extremities</td>
<td>BKA</td>
</tr>
<tr>
<td>Dilation</td>
<td>Expanding an orifice or the lumen of a tubular body part</td>
<td>PTCA</td>
</tr>
<tr>
<td>Division</td>
<td>Cutting into a body part without draining fluids and/or gases from the body part in order to separate or transect a body part</td>
<td>Spinal cordotomy, osteotomy</td>
</tr>
<tr>
<td>Drainage</td>
<td>Taking or letting out fluids/or gases from a body part</td>
<td>I&amp;D, thoracentesis</td>
</tr>
<tr>
<td>Excision</td>
<td>Cutting out or off, without replacement, a portion of a body part</td>
<td>Liver biopsy, partial nephrectomy, sigmoid polypectomy</td>
</tr>
<tr>
<td>Extirpation</td>
<td>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)</td>
<td>Thrombectomy, endarterectomy, choledocholithotomy</td>
</tr>
<tr>
<td>Extraction</td>
<td>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)</td>
<td>D&amp;C, vein stripping, toenail extraction</td>
</tr>
</tbody>
</table>
# Root Definitions Continued

<table>
<thead>
<tr>
<th>Term</th>
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</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                                                   |
## Root Definitions Continued

<table>
<thead>
<tr>
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</table>
| Repair          | Restoring, to the extent possible, a body part to its normal anatomic structure and function  
Examples: Colostomy takedown, suture of laceration |
| Replacement     | 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  
Examples: Total hip replacement, bone graft |
| Reposition      | Moving to its normal location or other suitable location all or a portion of a body part  
Example: Fracture reduction, reposition undescended testicle |
| Resection       | Cutting out or off, without replacement, all of a body part  
Example: Total nephrectomy |
| Restriction     | Partially closing the orifice or lumen of a tubular body part  
Example: Esophagogastric fundoplication |
| Revision        | Correcting, to the extent possible, a malfunctioning or displaced device  
Examples: Adjustment of position of pacemaker leads, recementing of hip prosthesis |
| Supplement      | Putting in or on biological or synthetic material that physically reinforces and/or augments the function of a portion of a body part  
Examples: Herniorrhaphy using mesh, mitral valve ring annuloplasty |
| Transfer        | 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  
Example: Tendon transfer, pedicle flap transfer |
| Transplantation | 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  
Examples: Kidney transplant, heart transplant |