Challenging Procedure Scenarios and ICD-10-PCS Update

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Pre-Test (Don’t Peek at the Handout)

1. X is ______________.
2. Root operation for attempting to stop acute bleeding is ______________.
3. Unicondylar refers to ________________.
4. Versajet is used for ________________.
5. A TAVR is a
   _______________________________________________________________________
   ________.
Challenging Procedure Scenarios

When I started this topic, what made it challenging was we didn’t have codes for some of our challenging procedures.

Well....

....be careful what you wish for!
## ICD-10-PCS FY2017 Update

<table>
<thead>
<tr>
<th>2016 Total Procedure Codes</th>
<th>New Procedure Codes</th>
<th>Revised Procedure Titles</th>
<th>Deleted Procedure Codes</th>
<th>2017 Total Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>71,974</td>
<td>3,827</td>
<td>491</td>
<td>12</td>
<td>75,789</td>
</tr>
</tbody>
</table>

**Federal Register:**
(Don’t automatically print this link!)
1,585-page rule
## ICD-10-PCS Codes FY 2017 by Section

<table>
<thead>
<tr>
<th>Section</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Surgical</td>
<td>65,676</td>
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<tr>
<td>Obstetrics</td>
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<tr>
<td>Placement</td>
<td>861</td>
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<tr>
<td>Administration</td>
<td>1,427</td>
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<tr>
<td>Measurement and Monitoring</td>
<td>342</td>
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<tr>
<td>Extracorporeal Assistance and Performance</td>
<td>41</td>
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<tr>
<td>Extracorporeal Therapies</td>
<td>46</td>
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<tr>
<td>Osteopathic</td>
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<tr>
<td>Other Procedures</td>
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<td>Chiropractic</td>
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<td>Imaging</td>
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<tr>
<td>Nuclear Medicine</td>
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<td>Radiation Oncology</td>
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<tr>
<td>Rehabilitation and Diagnostic Audiology</td>
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<tr>
<td>Mental Health</td>
<td>30</td>
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<tr>
<td>Substance Abuse Treatment</td>
<td>59</td>
</tr>
<tr>
<td>New Technology</td>
<td>41</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>75,789</strong></td>
</tr>
</tbody>
</table>
ICD-10-PCS Codes

• YouTube Videos of the ICD-10-PCS March 9-10 meeting can be found at these links:
  
  March 9 morning session:
  http://www.youtube.com/watch?v=QwAk_NS7vsg

  March 9 afternoon session:
  http://www.youtube.com/watch?v=843uqzmkONQ

  March 10 morning session:
  http://www.youtube.com/watch?v=1FUrNRf84k4
PCS Guideline Changes

- B2.1 addresses when clinical documentation is not present and the coder may use the general anatomic region as an unspecified code (used only rarely).
- B3.2 (Multiple procedures) has been changed in the examples in this guideline.
- B3.4a “The qualifier Diagnostic is used only for biopsies” was removed from this guideline.
- B3.6b and B3.6c adjusted the guideline to match the changes from coronary sites to coronary arteries in the Tables.
- B3.7 added “other acute bleeding” to reflect the change in the definition of root operation Control.
- B3.9 addresses the excision of an autograft includes different procedure site, to determine if a separate code should be reported.
- B3.11b If multiple tubular body parts are inspected, the most distal body part inspected (the body part furthest from the starting point of the inspection) is coded. If multiple non-tubular body parts in a region are inspected, the body part that specifies the entire area inspected is coded.
- B4.2 adds information regarding cardiovascular structures that could have branches and how to assign a code when the specific artery or vein is not available in the correct table, but a general body part is available.
- B4.4 uses coronary arteries as a body part value.

Note: Complete Guideline Changes may be found at this link:
Revision of Root Operation: Control and Creation

New Definition of Control: Stopping, or Attempting to Stop, Post-Procedural or Other Acute Bleeding.

New Definition of Creation: Putting in or on biological or synthetic material to form a new body part that to the extent possible replicates the anatomic structure or function of an absent body part; changed focus of this root operation from only sex-change operations to operations in other body systems.
New Root Operation: Perfusion

The new root operation, Perfusion, was added to the Extracorporeal Therapies section.

Definition: Extracorporeal treatment by diffusion of therapeutic fluid.
New Cardiovascular PCS Codes

Majority Cardiovascular System, related to:
* congenital cardiac procedures
* placement of an intravascular neurostimulator
* additional specific body parts
* unique device values
* addition of bifurcation as a qualifier
Revised Cardiovascular PCS Codes

Revised Cardiovascular System codes, related to:
• changing the number of coronary artery sites to the number of vessels
• specification of the descending thoracic aorta
Other New PCS Codes - Ortho

New Orthopedic PCS codes, related to:

• addition of unicompartmental knee replacement
• expansion of the body part detail in Removal and Revision of lower joints
New Section of ICD-10-PCS Codebook
X = New Technology

• Place for unique procedure codes requested through New Technology Application process.
• Effective Oct 1, 2015
• Four new technology drugs
  – Ceftazidime-Avibactam
  – Idarucizumab Dabigatran
  – Isavuconazole
  – Blinatumomab
• Two new values describe new equipment
  – Orbital Atherectomy Technology
  – Intraoperative Knee Replacement Sensor
## Section X Structure

<table>
<thead>
<tr>
<th>1&lt;sup&gt;st&lt;/sup&gt; Character</th>
<th>2&lt;sup&gt;nd&lt;/sup&gt; Character</th>
<th>3&lt;sup&gt;rd&lt;/sup&gt; Character</th>
<th>4&lt;sup&gt;th&lt;/sup&gt; Character</th>
<th>5&lt;sup&gt;th&lt;/sup&gt; Character</th>
<th>6&lt;sup&gt;th&lt;/sup&gt; Character</th>
<th>7&lt;sup&gt;th&lt;/sup&gt; Character</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section X</td>
<td>Body System</td>
<td>Operation</td>
<td>Body Part</td>
<td>Approach</td>
<td>Device Substance Technology</td>
<td>Qualifier</td>
</tr>
</tbody>
</table>
How Does Section X Compare with Category III Codes?

• Section X not intended to be used for experimental or investigational

• Allow new technologies to be used for a variety of clinical, research and new technology add-on payment policies
Coding Guideline – Section X

“Section X does not introduce any new coding concepts or unusual guidelines for correct coding. Section X codes are standalone codes. They are not supplemental codes. Section X codes fully represent the specific procedure code described in the code title, and do not require any additional codes from other sections of ICD-10-PCS. When section X contains a code title which describes a specific new technology procedure, only that X code is reported for the procedure. There is no need to report a broader, non-specific code in another section of ICD-10-PCS.”
Coding Scenario – Resection of Spleen

70 year old patient presented to ER with acute abdomen and suspected internal bleeding after falling off roof onto patio furniture. Patient had been on Lovenox for DVT prophylaxis. To reverse anticoagulation, a bolus infusion of idarucizumab was administered via PICC line and patient was taken to the OR for open resection of spleen, total.

Test Your Knowledge: What are the ICD-10-PCS procedure code(s) for this scenario?
How to Build the Code

Key Word: Resection –
  - Total
  - Lymphatic & Hemic
  - Spleen
  - Open

07TP0ZZ – Resection of Spleen, Open Approach
How to Build the Code

Key Word: Infusion
- Substance
- Idarucizumab, Dabigatran reversal agent
- central vein
- percutaneous

XW04331 Introduction of Idarucizumab Dabigatran Reversal Agent into Central Vein, Percutaneous Approach, New Technology
Group 1
Loop Recorder: Indication for Procedure

Indication for Procedure includes

1) Patients with clinical syndromes or situations at increased risk for cardiac arrhythmias; and

2) Patients who experience transient symptoms such as dizziness, palpitation, syncope and chest pain, that may suggest a cardiac arrhythmia.
**Loop Recorder Description**

*About 1/3 the size of a triple A battery, the device is capable of wireless communication to a cellular-based home bedside monitor.*

*This technology allows for daily downloads of alerts that have been triggered by the device.*

*These alerts are programmed by the implanting physician and may be tailored to the individual patient’s needs.*

*Alert notification allows physicians to be notified when an alert has been triggered, instead of waiting until the patient has symptoms or at the time of a monthly interrogation, as was the practice in previous generations of the device.*
Coding Scenario – Loop Recorder

- PREOPERATIVE DIAGNOSIS: History of recurrent rapid palpitations, rates to 180s beats per minute with nondiagnostic noninvasive evaluation.
- POSTOPERATIVE DIAGNOSIS: Same.
- OPERATIVE PROCEDURE: Loop recorder implantation.
- ANESTHESIA: Local with Xylocaine.
- COMPLICATIONS: None.
- BLOOD LOSS: Negligible.
- SPECIMENS: None.
- PROCEDURE: The left chest was prepped and draped in standard manner. Local Xylocaine anesthesia was used. 0.5” incision was made in the left chest. Loop recorder was placed in the left chest subcutaneous tissue in a standard manner without complications.
Loop Recorder

Implantable cardiac monitor (ICD-9 code 37.79) classified as OR procedure

Current ICD-10-PCS (also classified as OR procedures)

0JWT0PZ open
0JWT3PZ percutaneous

Codes for implantation into chest, and procedures for revision were non-OR
Loop Recorder – New Codes FY17

• 0JH602Z: Insertion of monitoring device into chest subcutaneous tissue and fascia, open approach
• 0JH632Z: Insertion of monitoring device into chest subcutaneous tissue and fascia, percutaneous approach
• 0JWT02Z: Revision of monitoring device in trunk subcutaneous tissue and fascia, open approach
• 0JWT32Z: Revision of monitoring device in trunk subcutaneous tissue and fascia, percutaneous approach
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Pacemakers

A table in the federal register shows columns which expand the list of ICD-10-PCS codes for pacemakers and leads

- MS-DRGs 242, 243, and 244 (permanent cardiac pacemaker implant with MCC, with CC, and without CC/MCC) had some procedure code combinations excluded.
- CMS’ initial approach used specific procedure code combinations.
- Now CMS is taking a more generic approach, compiling a list of all codes describing procedures involving pacemakers and leads, and will modify the DRG logic.
Watch for Corrections

Scenario – Versajet Debridement

Using a Versajet debrider, the physician performed debridement of the skin and subcutaneous tissue of a nonhealing necrotic ulcer of the right thigh.

Test Your Knowledge: How would this procedure be coded?
Coding Scenario: Arterial Line Insertion

Arterial Line Insertion: Indications for this procedure included hemodynamic monitoring. The procedure was performed in the left radial artery. A 20 gauge 1 3/8 inch catheter was used. Catheter secured with sutures, adhesive securement device and sterile tape. Antimicrobial disk was placed around catheter at insertion site and covered with transparent, occlusive dressing. Ultrasound with sterile sleeve was used during procedure. The procedure required 1 attempt.

Test Your Knowledge: How would this procedure be coded? What root operation would you use?
Coding Scenario – TAVR

Patient was prepped and draped...The left femoral artery was selected as primary access for the insertion of the valve delivery system. Using micropuncture technique bilateral femoral vascular access was established as follows: 6 Fr. x 11 cm sheath into the left femoral artery, 6 Fr. x 11 cm sheath into the right femoral artery, 6 Fr. x 45 cm sheath into the right femoral vein. Next, a screw-in pacemaker electrode lead was advanced via the right femoral vein sheath into the right ventricle and attached to a temporary pacing generator. Excellent capture threshold was confirmed. Heparin IV was administered and ACT was confirmed > 300 secs. A 6 Fr angled pigtail catheter then was advanced over a 0.035mm J-wire via the 6 Fr. arterial sheath and placed in the ascending aorta for monitoring of central blood pressure and angiography.

**Transfemoral Delivery System Placement**

A guide wire was advanced up the aorta via the primary access femoral sheath. Then over this wire, a Prostar percutaneous suture closure device was advanced for “pre-close technique” and deployed. The sutures were recovered and placed in wet packing for later closure at the end of the procedure. The access sheath was replaced with an 11 Fr sidearm sheath. Then a pigtail catheter was advanced over a J-wire to the level of the aortic arch through which a 0.035" Lunderquist wire was then advanced and placed at the level of the aortic arch. The catheter was then removed and the Lunderquist wire was left in place. Multiple dilators were advanced through the pelvic course of the ilio-femoral artery over this Lunderquist guidewire followed by passage of the Edwards delivery sheath to the level of the abdominal aorta.

**Left Heart Catheterization**

A 6 Fr AL-1 catheter was then advanced over the wire through the Edwards delivery sheath up to the aortic root. The wire was then removed and exchanged for a .035" straight wire that was then advanced across the native aortic valve. The AL-1 catheter was then advanced over the wire across the valve and into the left ventricle. The straight wire was removed and simultaneous aortic and LV pressures were recorded. The transvalvular peak gradient was estimated at 32 mmHg. The pre-formed primary access wire was then placed distally into the ventricular apex through the AL-1 catheter, and the catheter was removed leaving this primary access wire in place.
Edwards Transcatheter Heart Valve (ETCHV) Deployment

The ETCHV was then advanced over the primary access wire into the Edwards delivery sheath using the loader device, then advanced to the descending thoracic aorta where, using the delivery catheter mechanisms, the crimped valve was advanced from its mounting segment to a position centered on the delivery balloon. The delivery catheter was then advanced to the root of the aorta and subsequently across the aortic valve. Position was confirmed by fluoroscopy and angiography. Rapid ventricular pacing was initiated at 180 bpm and contrast aortogram was conducted confirming stable position of the valve astride the annulus. When pacing capture and decline of the BP to 40 mmHg was confirmed the ETCHV was deployed by slow, then complete inflation of the delivery balloon. The balloon was held at full volume for about 3 seconds and then rapidly deflated. Rapid pacing was then terminated, and recovery of the arterial pressure was observed. The delivery balloon segment of the system was withdrawn from the annulus leaving the primary access wire in place in the LV.
Coding Scenario – TAVR, Continued

Post Deployment Findings
The transthoracic echocardiogram confirmed the appropriate position of the ETCHV with no paravalvular regurgitation. TTE and angiography then confirmed excellent results and unobstructed coronary artery ostia. No pericardial effusion was present. The implantation phase of the procedure was then terminated with the patient in a hemodynamically stable condition. The delivery system was withdrawn from the aorta then removed from the body leaving the primary access guidewire in place in the LV. The AL1 catheter was then advanced over the wire into the LV and the guidewire was then removed. LV pressure was recorded with simultaneous aortic pressure confirming near complete resolution of the transvalvular gradient and an LV EDP of about 0-10 mmHg. This catheter was removed from the LV then from the aorta over the Lunderquist wire that was left in place in the thoracic aorta for the closure phase of the procedure.

Closure Procedure
A 5 Fr Omniflush catheter was advanced through the secondary/contralateral access 6 Fr arterial sheath and was maneuvered into the primary access side common iliac artery over a 0.035" glide wire. Angiography of the primary side common and external iliac artery was then performed from this contralateral approach as the Edwards sheath was retrieved, confirming that there was no evidence of dissection or perforation. The Prostar sutures were retrieved from their packing and sliding knots were tied. The sheath was then removed over a glide wire, as the primary access arteriotomy was closed by cinching the sutures. Hemostasis was achieved after a brief period of added local compression. The small skin incision was closed with 2-0 Vicryl and 3-0 Monocryl. The secondary contralateral common femoral artery access was closed by Proglide closure device achieving good hemostasis. Manual Compression held over the right groin for a few minutes.
Discussion

ETCHV – Edwards Transcatheter Heart Valve
(Note: Edwards-Sapien is bovine pericardial tissue with a radiopaque stainless steel stent frame. If CoreValve Transcatheter, CoreValve is made from porcine pericardium over a metallic framework.)

Would you code the heart cath separately?

Approach is:

What about the type of valve?
Regulatory Notes

• Comments on the 2017 IPPS proposed changes were due to CMS by June 16.
• CMS expects to issue a final rule by August 1, which will go into effect October 1, 2016.
• CMS will continue to refine the MS-DRGS for FY18. Comments can be sent to MSDRGClassificationchanges@cms.hhs.gov through December 7.