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**Are You Ready for ICD-10-PCS? Expert Tips, Tools,
and Guidance
to Make the Transition Simple**

**By Amy Crenshaw Pritchett
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Agenda

In this webinar:

- **Expand your understanding of ICD-10-PCS with can't miss ICD-10-PCS coding conventions & guidelines.**
- **Understand the basic differences between ICD-9-CM Volume 3 and ICD-10-PCS.**
- **Learn code structure, organization, & characters:**
 - Step 1 to coding section “0” ICD-10-PCS? Pinpoint the body system.
 - To build your ICD-10-PCS code, you must identify the root operation.
 - Study 7 options when assigning your PCS code’s 5th character.
 - Master how to determine the device value for your PCS code’s character.
- **Raise your awareness of unique ICD-10-PCS challenges pertaining to documentation and specificity:**
 - Prepare physicians now for more detailed transfusion notes under ICD-10-PCS.
 - Discover why writing “Right Carotid Endarterectomy” won’t be enough.
- **Know where to find ICD-10-PCS tools, techniques, and best practices.**

Understanding ICD-10-PCS

ICD-10-PCS is a major departure from ICD-9-CM procedure coding, requiring you to know which root word applies.

Effective October 1, 2014, this procedure coding system will be used to collect data, determine payment, and support the electronic health record for all inpatient procedures performed in the US.

Gear Up for ICD-10-PCS

This procedure coding system is starkly different from ICD-9-CM procedure coding:

Every ICD-10-PCS code has seven characters, each character defining one aspect of the procedure performed.

For instance, not correctly identifying your physician's approach – the fifth character – and not being able to distinguish between similar root operations can throw off your claims accuracy!

Converting to ICD-10-PCS

Have your inpatient coders and clinical documentation specialists begun preparing for ICD-10-PCS yet?

That's why we're here today ... to ease your transition from ICD-9-CM procedure coding to ICD-10-PCS.



Basic Differences

- **ICD-9-CM Volume 3**
 - Follows ICD structure (designed for diagnosis coding)
 - Codes available as a fixed/finite set in list form
 - Codes are numeric
 - Codes are 3 to 4 digits long
- **ICD-10-PCS**
 - Designed/developed to meet healthcare needs for a procedure code system
 - Codes constructed from flexible code components (values) using tables
 - Codes are alphanumeric
 - All codes are seven characters long



**Expand your understanding of
ICD-10-PCS:**

**Can't miss ICD-10-PCS coding
conventions & guidelines ...**



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How to Prepare

- Focus should be on quality clinical documentation
- Sufficient documentation to support code assignment is key
- Clinicians should document in clinical, not coding, terms
- Cooperation between coders, clinicians, and clinical documentation professionals is essential
- Facilities should focus on areas that need improvement
- On identifying gaps, specific training can be provided



Each procedural code in ICD-10-PCS has seven alphanumeric characters

Each character defines one aspect of the procedure performed to paint a complete picture:

- **Character 1: Section**

The first character in the code determines the broad procedure where the code is found. For instance, the section for **Medical and Surgical** is assigned 0.

- **Character 2: Body System**

The second character in the code defines the body system – the general physiological or anatomical region.

ICD-10-PCS Characters

- **Character 3: Root Operation**

The third character in the code defines the root operation or the objective of the procedure.

- **Character 4: Body Part**

The fourth character in the code defines the body part or specific anatomical site where the procedure was performed.

- **Character 5: Approach**

The fifth character in the code defines the approach or the technique used to reach the procedure site.

- **Character 6: Device**

The sixth character in the code defines the device.

- **Character 7: Qualifier**

The seventh character in the code defines the qualifier or an additional attribute of the procedure.

Study 7 Options When Assigning Your PCS Code's 5th Character

As hospital staff and coders prepare for ICD-10-PCS implementation, learning what each character of a PCS code represents can be tricky.

This is especially true for character 5 if coders don't fully understand the difference between surgical approaches.

Let's go over the latest on ICD-10-PCS options and how to select the best approach for each case.

Identify the approach to ace PCS coding

As already mentioned, every ICD-10-PCS code has seven characters, each character defining one aspect of the procedure performed.

Not correctly identifying your physician's approach — the fifth digit — can throw off your claims accuracy. Keep the following list and accompanying chart handy to clarify your fifth-digit questions.



Approach

Definition: “Approach” refers to the technique a physician uses to reach the site of the procedure. ICD-10-PCS offers the following options for identifying the approach. Here is how you should define each of these approaches:

- **Open:** The physician cuts through the skin or mucous membrane and any other body layers necessary to expose the site of the procedure.
- **Percutaneous:** The physician gains entry, by puncture or minor incision, with instrumentation through the skin or mucous membrane and any other body layers necessary to reach the site of the procedure.



Approach

- **Percutaneous endoscopic:** The physician gains entry, by puncture or minor incision, with endoscopic instrumentation through the skin or mucous membrane and any other body layers necessary to reach and visualize the site of the procedure.
- **Via natural or artificial opening:** The physician will use a natural or artificial opening to access the site of the procedure.
- **Via natural or artificial opening endoscopic:** Instrumentation enters through a natural or artificial external opening to reach and visualize the site of the procedure.

Approach

- **Via natural or artificial opening with percutaneous endoscopic assistance:** Like above, this involves instrumentation entering through a natural or artificial external opening, but it also involves puncture or minor incisions through the skin or mucous membrane and any other body layers necessary to aid in the performance of the procedure.
- **External:** The physician will perform a procedure directly on the skin or mucous membrane or indirectly by application of external force through the skin or mucous membrane.

Take a look at the summary below for fifth digit characters you'll assign for each approach

Approach	Fifth Character
Percutaneous	0
Percutaneous Endoscopic	4
Via natural or artificial opening	7
Via natural or artificial opening endoscopic	8
Via natural or artificial opening with Percutaneous endoscopic assistance	F
External	X

Practice Choosing the Approach

Example: With that knowledge in mind, consider how you would select the correct digit for Character 5 in some real-life examples.

- *Suppose the physician performs liposuction on the patient's left upper arm. This procedure involves a small tube-like instrument called a cannula that is inserted through tiny incisions to surgically remove fat cells. Therefore, the approach is percutaneous. You should use a fifth character of "3."*
- **Coding:** *In this case, you would report 0JDF3ZZ. The fifth character is "3" because the surgeon used a percutaneous approach.*



Step 1 to Coding Section “0” ICD-10-PCS? Identify the Body System

Familiarize yourself with the 28 possible numbers and letters.

- The "Medical and Surgical" or "0" section of the ICD-10-PCS manual is the largest section.
- When you choose the appropriate PCS code from this section, you have to look for the *body system* to get to your code's second digit.

You will find 28 body systems and 3 general anatomical regions.

Example

Suppose your surgeon performs a lysis of adhesions of the large intestine. You know that this code will come from the "0" section of your PCS manual. Your next step is to identify the second digit.

Medical and Surgical

00	Central Nervous System
01	Peripheral Nervous System
02	Heart and Great Vessels
03	Upper Arteries
04	Lower Arteries
05	Upper Veins
06	Lower Veins
07	Lymphatic and Hemic Systems
08	Eye
09	Ear, Nose, Sinus
0B	Respiratory System
0C	Mouth and Throat
0D	Gastrointestinal System
0E	Hepatobiliary System and Pancreas



Example

Solution: Because the procedure took place in the large intestine, you should choose "D," the gastrointestinal system, from the list of options PCS provides. Your full code is 0DNE0ZZ.



Root Operations:

- ❑ Inpatient coders and clinical documentation specialists:
 - *Should be well-versed in ICD-10-PCS root operation definitions*
 - *Should be able to apply the correct root operations for procedures carried out within their facilities.*
- ❑ By starting this practice now, gaps in documentation should be identified and corrected before the transition
- ❑ Working with clinicians during this period is pivotal to ensuring that documentation is ready

Clarify How ICD-10-PCS Works by Observing the Obstetrics Section 1

If you're looking for a succinct ICD-10-PCS section to examine, then check out the Obstetrics Section 1. Because this section includes only procedures performed on a pregnant female, it's small — and therefore perfect for using as an example for the rest of ICD-10-PCS.



Highlight These 2 Guidelines for Obstetrics

In this section, you'll find two guidelines:

- (1) a single guideline related to products of conception, and
- (2) a single guideline related to procedures following delivery or abortion.

They state:

C.1. *Products of Conception*

- Procedures performed on the products of conception are coded to the Obstetrics section. Procedures performed on the pregnant female other than the products of conception are coded to the appropriate root operation in the Medical and Surgical section.
- *Example:* Amniocentesis is coded to the products of conception body part in the Obstetrics section. Repair of obstetric urethral laceration is coded to the urethra body part in the Medical and Surgical section.

C.2. Procedures following delivery or abortion

Procedures performed following a delivery or abortion for curettage of the endometrium or evacuation of retained products of conception are all coded in the Obstetrics section, to the root operation Extraction and the body part Products of Conception, Retained. Diagnostic or therapeutic dilation and curettage performed during times other than the postpartum or post-abortion period are all coded in the Medical and Surgical section, to the root operation Extraction and the body part Endometrium.

Source: Printed verbatim from the *ICD-10-PSC Official Guidelines for Coding and Reporting*.



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The Root Operations Limit PCS Tables

The Obstetrics section contains a single body system value — pregnancy (0) — along with

12 root operation values and three body part values:

- Products of Conception (0),
- Products of Conception, Retained (1), and
- Products of Conception, Ectopic (2).

Because you have only one body system and 12 root operations, you will find only 12 tables available in the Obstetrics section from which to construct procedure codes.

Benefit:

While there are two root operations that apply only to Obstetrics, the other 10 root operations also are used in:

- Medical and Surgical section.

Tip: Learn the definitions of those 10 root operations common to both sections, and learn how these definitions are applied in the Obstetrics section. This will help you understand how the root operations are used and applied in the Medical and Surgical section, as well.

To Build Your ICD-10-PCS Code, You Must Identify the Root Operation

Tip: If your physician performs two root operations, report two PCS codes

Back to Medical & Surgical ...

- When you build a PCS code from the "0" section, you must first identify the body system — but your second step is to choose the root operation.
- This root operation will be the third character of your PCS code, but be aware: your selection can be tricky because you need to distinguish between similar root operation attributes.

Take a Broad Overview of 3rd Character

You will find 31 root operations in the medical and surgical section, and they are arranged into the following groupings:

- Root operations that take out some/all of a body part
- Root operations that take out solids/fluids/gasses from a body part
- Root operations involving cutting or separation only

(Continued ...)

- Root operations that put in/put back or move some/all of a body part
- Root operations that alter the diameter/route of a tubular body part
- Root operations that always involve a device
- Root operations involving examination only
- Root operations that include other repairs
- Root operations that include other objectives

Now that we've gone over some of the broader ICD-10-PCS concepts, let's look more closely at some coding examples...



Prepare Physicians Now for More Detailed Transfusion Notes Under ICD-10-PCS

Physician notes describing a simple red blood cell transfusion might send you to a single code under ICD-9.

But that will change when you begin using ICD-10-PCS codes in October 2014. If you don't have sufficient details describing the procedure, you'll have dozens of potential ICD-10-PCS options.



ICD-10-PCS Transfusion

Example: A transfusion record indicates the “transfusion of red blood cells, leukocyte reduced” and indicates the patient has received treatment for myelodysplastic syndrome pancytopenia secondary to anemia. The discharge summary and progress notes document the transfusion of blood.

- **ICD-9:** The ICD-9 code system provides codes for transfusion of blood and blood components (99.0x series) with respect to type of transfusion (e.g., Transfusion of packed cells, platelets, coagulation factors, other serum, etc.). This is the clinical indicator you need to know to choose the accurate code.
 - 99.04 - Transfusion of packed cells

ICD-10-PCS Transfusion

The transfusion/administration PCS codes require specific details per ICD-10 PCS guidelines. Transfusion related codes require specific details as follows:

- Section (type of procedure): Administration
- Body System (general body system): Circulatory
- Root Operation (objective of procedure): Transfusion or putting in blood or blood products
- Body Part/Region (specific part of body system): Peripheral Vein, Central Vein, Peripheral Artery, Central Artery
- Approach (technique used to reach site): Open, Percutaneous

ICD-10-PCS Transfusion

- Substance: Red Blood Cells, Frozen Red Blood Cells
- Qualifier (provides additional information about procedure): Autologous, Non-Autologous

Current Documentation Shows:	Needs to add:
<p>Section: Administration Body System: Circulatory Root Operation: Transfusion or putting in blood or blood products</p>	<p>Body Part/Region Approach Substance Qualifier</p>

Next steps:

Begin educating providers now about the importance of including details to support every component of ICD-10-PCS codes.

Otherwise, you'll spend unnecessary time asking physicians to amend patient charts before you can submit claims.



How to Determine the Device Value for Your PCS Code's Character 6

To complete your seven character **ICD-10-PCS code**, your sixth character relies on the device. Not only do you have to decide if the physician had to use a device, but you have to know the *type* of device. That sometimes involves untangling tricky terminology.

Follow these steps to understanding what device character you should apply.

Step 1: Break Down Device Types and Values

When you choose your device digit or letter (the sixth character), you may have to decipher whether the procedure involved four types of devices:

- Grafts or prostheses
- Implants
- Simple or mechanical appliances
- Electronic appliances
- If the procedure does not involve a device, then you will use the no device character value of "Z."

Also, the devices must remain after the procedure. Materials that incidental to the procedure, such as clips and sutures, are not considered devices.

Step 2: Make the Extraluminal, Transluminal Distinction

To understand "extraluminal" versus "intraluminal," you need to know what lumen means. The lumen is the inside space of a tubular structure, such as an artery or intestine.

- **Extraluminal:** This device works on the outside of the lumen, such as the clipping of a cerebral aneurysm.
- **Intraluminal:** An intraluminal device means that the device is within the lumen, such as within a blood vessel.

Step 3: Define Autologous, Nonautologous

"Autologous" means that the cell source comes from the patient. For instance, a patient scheduled for a non-emergency surgery may donate blood for herself that will be stored for the surgery. In that way, she is both the donor and the recipient.

On the other hand, "nonautologous" means the cell source is not from the patient. The donor and the recipient are not the same person. For instance, if the patient has an emergency surgery and requires a blood from a blood bank, then this blood is "nonautologous." You would use the ICD-10-PCS value of "K."

Step 4: Tackle This Combination Scenario

- Physicians sometimes use combinations of devices and materials on a vertebral joint to render the joint immobile. When the physician uses combinations of devices on the same vertebral joint, you would code the device value as follows:
- If the physician uses an interbody fusion device to render the joint immobile (alone or containing other material like bone graft), you would code the procedure with the device value "Interbody Fusion Device" (A).

Step 4

- If the physician uses the bone graft as the *only* device to render the joint immobile, you should code the procedure with the device value "Nonautologous Tissue Substitute" (K) or "Autologous Tissue Substitute" (7).
- If the physician uses a mixture of autologous and nonautologous bone graft (with or without biological or synthetic extenders or binders) to render the joint immobile, you should code the procedure with the device value "Autologous Tissue Substitute" (7).



Documentation Example: Discover Why Writing “Right Carotid Endarterectomy” Won’t Be Enough

If the physician documents a "right carotid endarterectomy," you can easily report your ICD-9 procedure code — but your potential selections become a little more complicated in ICD-10-PCS.

If you want to avoid having to scramble to educate physicians, start improving your documentation *now*.



The Simplicity of ICD-9 Will Be Gone

Suppose you have a patient claim on your desk with documentation that describes a “right carotid endarterectomy for a critical right internal carotid artery stenosis.”

Right now, you can report the right carotid endarterectomy procedure with 38.12 (*Endarterectomy of other vessels of head and neck*).

However, when you look at your ICD-10-PCS equivalents, you have to have more specific documentation.



Here's What You Need

ICD-10-PCS requires specific information in terms of the type of procedure, the anatomic location/body part, the approach, and the device.

Type of procedure: You need to know whether the right carotid endarterectomy was a "dilation" or "extirpation."

A "dilation" means that the procedure expanded an orifice or lumen of a tubular body part.

An "extirpation" means that the procedure took or cut out solid matter from a body part.

Taking these extra steps in documentation will mean fewer headaches in the future

- **Anatomic location/body part:** Through the "critical right internal carotid artery stenosis" notation, you know that this procedure took place on the right internal carotid artery. That is one area of documentation you don't need to update.
- **Approach:** You do need to know what approach the physician used. Was this open, percutaneous, or percutaneous endoscopic?
- **Device:** Similarly, you need to know what sort of device the physician used — or if she didn't use a device at all. Your options are:
 - Intraluminal Device, Drug-Eluting
 - Intraluminal Device
 - No Device

ICD-10-PCS Help: Where to Turn

Learn ICD-10-PCS with complete code details tied to GEMs, reimbursement maps, & more

To ease your transition from ICD-9-CM procedure coding to **ICD-10-PCS**, **SuperCoder** has added **ICD-10-PCS Search** to its inpatient coding resource, **DRG Coder**.

The ICD-10-PCS search will get you:

- **Index with incomplete codes links** that instantly take you to the right table



ICD-10-PCS Codes at Your Fingertips

- **Info from Official Conventions and Section Guidelines** shown at code level so you don't need to flip from a code to the front of a book or hunt through online PDFs to locate applicable chapter and block specific guidelines
- **Color-Coded Body Part** for fast identification when connecting from index's incomplete code to table
- **ICD-10-PCS GEMs Crosswalk** from or to ICD-9-CM Vol 3 codes in a snap with Medicare's General Equivalency Mappings (GEMs) for procedure codes
- **Reimbursement Mapping Crosswalk** keeps your coding budget neutral with Medicare's reimbursement mapping of each ICD-10-PCS code to a similar priced ICD-9-CM Volume 3 code or code combination.
- **Device and Body Part Handy References** linked to each code to increase coding accuracy.



Start Searching for Codes

Keyword(s), code(s), or code range with - between codes

[Search](#)

Official Long Descriptor

open

Drainage of Brain, Open Approach, Diagnostic

Character Definition

Section(0)	Medical and Surgical
Body System(0)	Central Nervous System
Operation(9)	Drainage
Body Part(0)	Brain
Approach(0)	Open
Device(Z)	No Device
Qualifier(X)	Diagnostic

Official Guidelines for Coding and Reporting

Conventions

A1. ICD-10-PCS codes are composed of seven characters. Each character is an axis of classification that specifies information about the procedure performed. Within a defined code range, a character specifies the same type of information in that axis of classification.

Example: The fifth axis of classification specifies the approach in sections 0 through 4 and 7 through 9 of the system.

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ICD 9 Vol3

Code Description

01.14

Open biopsy of brain



Character Definition

Character Definition	
Section(0)	Medical and Surgical
Body System(0)	Central Nervous System
Operation(9)	Drainage
Body Part(0)	Brain
Approach(0)	Open
Device(Z)	No Device
Qualifier(X)	Diagnostic

This box gives you a complete description of the 7 characters of the searched **ICD-10-PCS** code.

You'll immediately know which section the code belongs to, which body system has been addressed, whether there is any qualifier with this code, and more.

ICD-10-PCS Coverage

DRG Coder also includes a monthly newsletter – ***Inpatient Facility Coding and Compliance Alert*** – that provides you with ‘how-to’ ICD-10-PCS advice in every issue.

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ICD-10-PCS: HERE'S YOUR GUIDE TO ENDOVASCULAR EMBOLIZATION CODING UNDER PCS

- Published on Fri, Nov 08, 2013

Tip: *Don't overlook additional guidelines.*

Endovascular embolization involves inserting a catheter into an artery (usually in the groin) and threading a device into the aneurysm to disrupt the blood flow and cause the blood to clot. This procedure seals off the aneurysm from the artery.

The most common type of device used to treat brain aneurysms are coils. Currently, there are two types of coils used: bare platinum coils (BPCs) and bioactive coils. Your code assignment is based on the type of coil the surgeon uses.

Coil coding options: Endovascular embolization of a brain aneurysm using BPCs is classified to code 39.75 (*Endovascular embolization or occlusion of vessel[s] of head or neck using bare coils*) and includes bare metal coils. Endovascular embolization of a brain aneurysm using bioactive coils is assigned to code 39.76 (*Endovascular embolization or occlusion of vessel[s] of head or neck using bioactive coils*) and includes biodegradable inner luminal polymer coils and coils containing polyglycolic acid.



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