Banner Health

Banner Health Provider ICD-10 Education
General Surgery

TRUVEN HEALTH ANALYTICS 15 TOP HEALTH SYSTEMS 2013

HIMSS ANALYTICS STAGE 7 AWARD RECIPIENT

Documentation Specificity

- **Laterality** – Right/left
- **Acuity** – severe, acute, chronic
- **Site** - lobe of lung; upper, mid, lower
- **Manifestations** – link to disease process:

  HTN with CKD
- **Episode of Care:**

  Initial

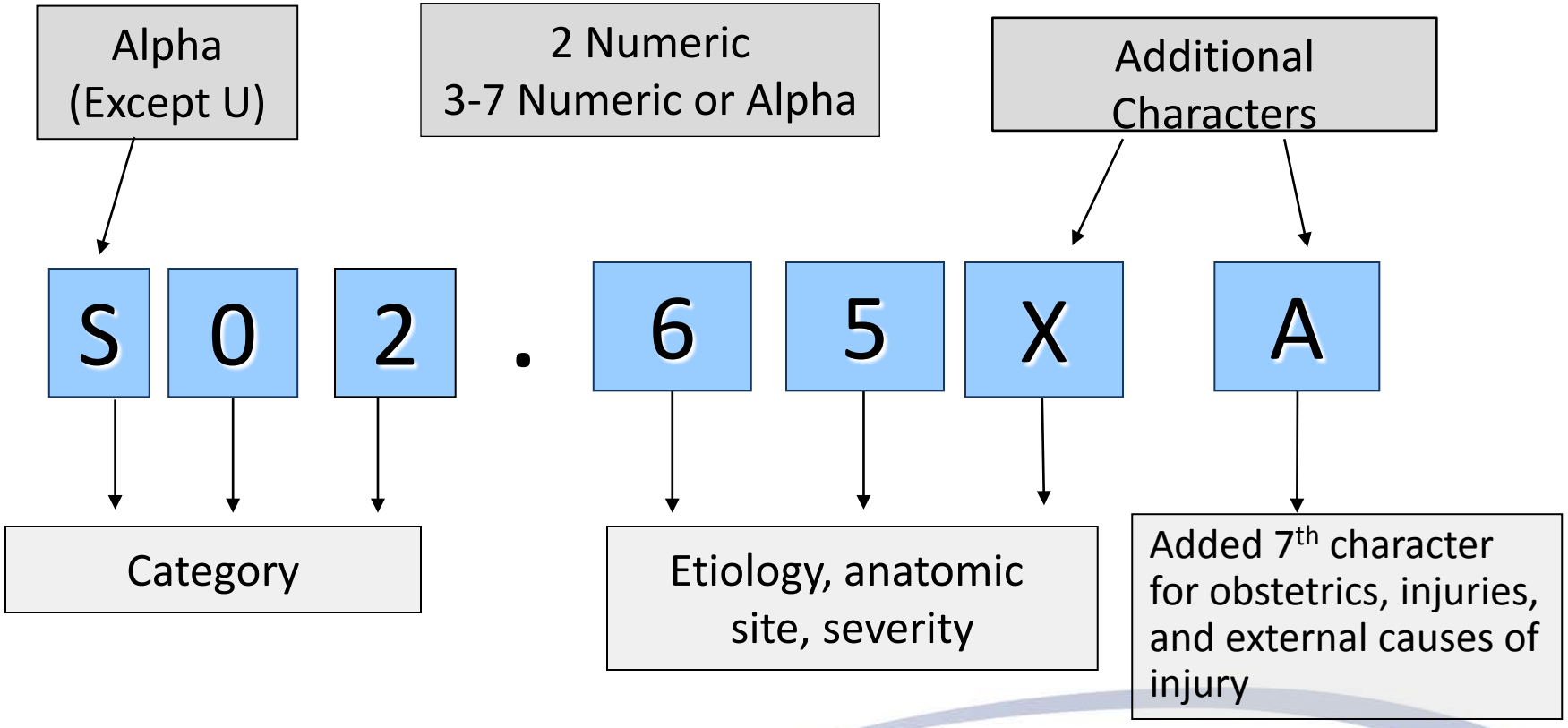
  Subsequent

  Sequela

ICD-9-CM & ICD-10-CM COMPARISON

ICD-9-CM	ICD-10-CM
Three to five characters	Three to seven characters
First digits is numeric but can be alpha (E or V)	First character is always alpha, (except U is not used)
2-5 are numeric	Character 2 is always numeric: 3-7 can be alpha or numeric
Always at least three digits	Always at least three digits
Decimal Placed after the first three characters (With E codes, placed after the first four characters	Decimal placed after the first three characters
Alpha Characters – not case sensitive	Alpha characters are not case sensitive

ICD-10-CM CODE STRUCTURE



Place holder X

- Where a placeholder exists, the X must be used in order for the code to be considered a valid code.
- Certain ICD-10-CM categories have applicable 7th characters. The applicable 7th character is required for all codes within the category.
- The 7th character must always be the 7th character in the data field.
- Codes that require a 7th character but no 6th, a placeholder X must be used to fill in the empty 6th place character.
  - Fall down Escalator, initial encounter
    - W100XXA

NEC and NOS

- NEC “Not elsewhere classifiable”
  - Used when no specific code is available to represent the condition

- NOS “Not otherwise specified”
  - Used when there isn’t enough documentation to assign a more specific code

Excludes Notes

The ICD-10-CM has two types of excludes notes:

Excludes1

- "NOT CODED HERE" - indicates that the code excluded should **never** be used at the same time as the code above the Excludes1 note.
- Indicates that two conditions **cannot** occur together, such as a congenital form vs an acquired form of the same condition.

Excludes2

- "NOT INCLUDED HERE" – Indicates that a patient may have both conditions at the same time. Indicates it is **acceptable** to **report both** the codes together, when appropriate.

Inclusion Notes

Inclusion notes contain terms that are the condition for which that code number is to be used.

The terms may be:

- Synonyms of the code title, or
- in the case of “other specified” codes, the terms are a list of various conditions assigned to that code.
- The inclusion terms are **not** necessarily exhaustive.

Seventh Characters A, D and S

- A - **initial** encounter:
  - patient is receiving active treatment for the condition
- D - **subsequent** encounter:
  - the patient has received active treatment for the condition and is receiving routine care for the condition during the healing or recovery phase
- S – **sequela**:
  - complications or conditions that arise as a direct result of a condition

Code Also, Code First, Use Additional Code

- A “code also” note instructs that:
  - two codes may be required to fully describe a condition
  - this note does not provide sequencing direction.

- The “code first” and “use additional code” notes provide sequencing order of the codes.

Place of Occurrence and Activity Codes

Regardless of the number of external cause codes assigned on a particular record, there should only be one place of occurrence Code and one activity code assigned to a record.

Y92, Place of occurrence of the external cause,

- Report once, at the initial encounter for treatment with only one code from Y92 category being recorded on the medical record.

Y93, Activity Code

- Report once, at the initial encounter for treatment with only one code from Y93 category being recorded on a medical record.

Colitis

- ICD-10 code identifies the level of intestine
- Combination codes in ICD-10 for complications, such as GI bleed, obstruction, fistula, abscess
- Diagnosis: Left-sided colitis with abscess - K515.14

Esophagitis

GERD now has a combination code for with or without esophagitis

- Diagnosis: Gastroesophageal reflux with esophagitis - K21.0

Esophageal Varices

- Code identifies with or without bleeding
- Document the underlying cause (e.g., cirrhosis, portal hypertension)
- Document anemia if present (e.g., acute blood loss anemia)

Crohn's Disease

- Documentation should include site - large or small intestine
- Complications, such as abscess, fistula, obstruction, bleeding
- Manifestations, such as pyoderma gangrenosum

Crohn's Disease

ICD-10-CM provides combination codes under subcategory K50.XXX for complications commonly associated with Crohn's disease.

- Diagnosis: Crohn's disease of large intestine with obstruction - K50.112

Barrett's Esophagus

Barrett's Esophagus

- Include with or without ulcer, with or without dysplasia and low grade/high grade
- Diagnosis: Barrett's esophagus with low grade dysplasia – K22.710

Diaphragmatic Hernia

- Document congenital vs. acquired, with or without gangrene, with or without obstruction
- Diagnosis: Diaphragmatic hernia with obstruction without gangrene – K44.0

Abdominal Hernia

- Document laterality, with or without obstruction, with or without gangrene, due to adhesions and whether initial or recurrent
- Diagnosis: Unilateral inguinal hernia, with obstruction and gangrene, recurrent – K404.1

Anemia

- Specify acute / chronic
- Known or suspected cause: Post-hemorrhagic anemia, iron deficient, folate deficiency, anemia of chronic disease, aplastic anemia
- ICD-10 Guidelines state the neoplasm should be the first listed code, even if treatment is for the anemia
- Diagnosis: Anemia due to left breast cancer – C50.912 Carcinoma of left breast, D63.0 Anemia due to neoplasm

Surgical Conditions

Adhesions

- Specificity due to PID, endometriosis, post-surgery
- Specify process that caused adhesions, known or suspected
- Specify in operative report what organ(s) / body part involved
- Degree of lysis (e.g., extensive)

Abdominal/Pelvic Pain

- Location
- Duration
- Character

Diverticulitis

- Document the location (i.e. large/ small intestine) and associated conditions, such as abscess, perforation or peritonitis
- Specific with or without bleeding
- Diagnosis: Diverticulitis of the small intestine with abscess K57.00

Cholelithiasis

- Specific location of the stone: gallbladder, bile duct
- Associated with (acute and/or chronic) cholecystitis or cholangitis
- With or without obstruction
- Diagnosis: Cholelithiasis with acute cholecystitis without obstruction - K80.00

Malnutrition and Obesity

Malnutrition

- Specify type (i.e. protein calorie, marasmus)
- Severity/ Degree (mild, moderate, severe, first, second, third)
- BMI (i.e. emaciated with BMI of 15)

Obesity

- Type – morbid, drug induced, overweight, excessive calories, etc.
- BMI
- Surgery status
- Complications (i.e. Pickwickian syndrome)

Diabetes Mellitus

- New combination codes in ICD10
- No longer classified as controlled or uncontrolled
- Inadequately, out of control or poorly controlled coded by type with hyperglycemia

Diabetes Mellitus

Five updated Diabetes Mellitus categories to reflect the current clinical classification and manifestations:

- E08.XX Diabetes Mellitus due to an underlying condition
  - E08.22, Diabetes mellitus due to an underlying condition with diabetic chronic kidney disease

- E09.XX Drug or chemical induced diabetes mellitus
  - E09.52, Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy with gangrene

Documentation Specificity - Endocrine

- E10.XX Type 1 DM
  - E10.11, Type 1 diabetes mellitus with ketoacidosis with coma
- E11.XX Type 2 DM
  - E11.41, Type 2 diabetes mellitus with diabetic mono-neuropathy
- E13.XX Other specified DM
  - E13.341 Other specified DM with sever non-proliferative diabetic retinopathy with macular edema
- Note: No longer use controlled and uncontrolled. Now classifies inadequately controlled, out of control, and poorly controlled DM by type with hyperglycemia.

Documentation Specificity – Skin Ulcers

Pressure or Other specified type

- Specific location including laterality
- Pressure ulcer specific stage: 1-4, unspecified, or unstageable
  - Specify skin only, muscle necrosis, exposed fat layer, or bone necrosis
- Unstageable cannot be clinically determined (covered by eschar or treated with graft)
- Etiology (i.e. pressure, vascular, diabetic PVD, diabetic neuropathy
- Combination codes in ICD-10 to report ulcer and stage
- Diagnosis: Stage 2 pressure ulcer of the sacrum – L89.152

Documentation Specificity - Oncology

- Benign, In-Situ or Malignant
- Specified Primary and Secondary Sites
- Tissue type (i.e. lymphatic, connective)
- Cell type (i.e. carcinoma, melanoma)
- Acuity (i.e. in remission, relapse, recurrent, history of)

Procedural Specificity

Always document in operative reports:

- Specific anatomical location(s)
- Laterality
- How much of the body part was removed (all, partial)
- Approach (i.e. open, percutaneous)

Procedural Specificity

Major Bowel

- Location of lesion
- Specify partial or total excision of specific body parts
  - Cecum, Appendix, Ascending colon, Transverse colon, Descending colon, Sigmoid colon, or Rectum

Procedural Specificity

Colostomy creation

- Specify which segment of the bowel was used to create the colostomy

Procedural Specificity

Debridement: Always document

- Location, laterality, size and depth of wound
- Excisional or non-excisional
- Type of instrument used to remove any tissue
- Type and amount of tissue removed (i.e. skin, muscle, bone)
- Nature of tissue removed (i.e. necrotic, non-viable)
- Specify if the debridement extended outside the wound margins

Email questions to BHICD-10@bannerhealth.com