ICD-10 Coding Alert
Your monthly guide to ICD-10 coding, training, and reimbursement.

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Your Coding Manual

Discover How to Navigate Your ICD-10-CM Manual — And Don’t Miss These Subtle Differences

Your Injury/Poisoning codes and E codes completely transform.

Good news! You’ll find that your ICD-10-CM coding manual is similar to your ICD-9-CM one, which means you likely already know how to use it. However, don’t miss these subtle differences in your Alphabetic Index and Tabular List.

Check Out the Alphabetic Index

In the Alphabetic Index, you’ll have chapters divided up by letter with a list of terms and their corresponding code. This is where you’ll find the Index of Diseases and Injury, Index of Eternal Causes of Injury, the Table of Neoplasms, and the Table of Drugs and Chemicals. Here is an example of how hemiatrophy appears in the Alphabetic Index.

Hemiatrophy R68.89
- cerebellar G31.9
- face, facial, progressive (Romberg) G51.8
- tongue K14.8

ICD-10 Differences: Here are a few changes to your Alphabetic index in ICD-10-CM:

> You won’t find morphology codes listed alongside descriptors and standard codes.
> Morphology codes no longer have a separate appendix either.
> The Table of Drugs and Chemicals contains an “under-dosing” column.

Don’t Miss This Big ICD-10 Alphabetic Index Change

One of the biggest changes to your ICD-10-CM Alphabetic Index includes what ICD-9-CM currently terms Injury/Poisoning codes and E codes.

In Chapter 19: Injury, Poisoning And Certain Other Consequences of External Causes, you’ll find your injury codes are organized by body region, starting with the head and ending with the foot. For instance, you’ll find the S75 category for “Injury of blood vessels at hip and thigh level” followed by S76 for “Injury of muscle, fascia and tendon at hip and thigh level.”

In Chapter 20: External Causes of Morbidity contains what ICD-9-CM currently terms E codes (as well as some in Chapter 19). Chapter 20 codes specifically capture:

> what caused the injury or health condition,
> the intent behind it (such as unintentional or intentional),
> the place where an event occurred,
» what the patient was doing at the time, and
» the patient’s status (such as civilian or military).

For instance, check out W21.03xA (Struck by baseball, initial encounter), Y92.320 (Baseball field as the place of occurrence of the external cause), Y93.64 (Activities involving other sports and athletics playing as team or group: baseball), and Y99.8 (Other external cause status [recreation or sport not for income or while a student]).

Now Check Out the Tabular List

In the Tabular List, you’ll find 21 chapters, organized either by body/organ system (such as Diseases of the Circulatory System) or the etiology/nature of the disease process (such as Certain Infectious and Parasitic Diseases).

ICD-10 Differences: Here are some differences to your chapters in ICD-10-CM:

» ICD-9-CM’s chapter for the Diseases of the Nervous System and Sense Organs transforms into three separate chapters in ICD-10-CM.

» ICD-10-CM does not divide up the ICD-9-CM codes for E Codes (External Causes of Injury and Poisonings) and V Codes (Factors Influencing Health Status and Contact with Health Services).

» Some chapters are reordered.

These chapters are full of categories, subcategories, and codes. Remember, characters may be a letter or a number.

How to Decipher Code Categories

All categories are three characters. If a three character category doesn’t have any subdivisions, then this is a complete code.

Subcategories can have either four or five characters. These subcategories have codes listed underneath them that can expand up to seven digits. Some of these codes require a seventh digit and are invalid without them.

Here’s an example of how acute appendicitis appears in the Tabular Index:

<table>
<thead>
<tr>
<th>K 35 Acute appendicitis</th>
</tr>
</thead>
<tbody>
<tr>
<td>K35.2 Acute appendicitis with generalized peritonitis</td>
</tr>
<tr>
<td>Appendicitis (acute) with generalized (diffuse) peritonitis following rupture or perforation of appendix</td>
</tr>
<tr>
<td>Appendicitis with peritonitis NOS</td>
</tr>
<tr>
<td>Perforated appendix NOS</td>
</tr>
<tr>
<td>Ruptured appendix NOS</td>
</tr>
<tr>
<td>K35.3 Acute appendicitis with localized peritonitis</td>
</tr>
<tr>
<td>Acute appendicitis with localized peritonitis with or without rupture or perforation of appendix</td>
</tr>
<tr>
<td>Acute appendicitis with peritoneal abscess</td>
</tr>
<tr>
<td>K35.8 Other and unspecified acute appendicitis</td>
</tr>
<tr>
<td>K35.80 Unspecified acute appendicitis</td>
</tr>
<tr>
<td>Acute appendicitis NOS</td>
</tr>
<tr>
<td>Acute appendicitis without (localized) (generalized) peritonitis</td>
</tr>
<tr>
<td>K35.89 Other acute appendicitis</td>
</tr>
</tbody>
</table>

ICD-10-PCS

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

Hint: If your doc performs two root operations, report two PCS codes.

When you build a PCS code from the “0” section (the largest one), you must first identify the body system — but your second step is to choose the root operation. This 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.

Remember: A PCS code consists of seven characters — and will always include seven characters, unlike ICD-10-CM. Here is a break down of what each character means:

<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>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

Editor’s Note: To start at the beginning, refer to The ICD-10 Coding Alert, Volume 2, Number 3 article entitled, “ICD-10-PCS: Step 1 to Coding Section ‘0’ ICD-10-PCS? Identify the Body System.” That will help you choose your second character.

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

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» Root operations involving cutting or separation only
» 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

Note: If your physician performs multiple root operations with distinct objectives, you should submit multiple PCS codes.

Your root operations are (in alphabetic order):

» Alteration
» Bypass
» Change
» Control
» Creation
» Destruction
» Detachment
» Dilation
» Division
» Drainage
» Excision
» Extirpation
» Extraction
» Fragmentation
» Fusion
» Insertion
» Inspection
» Map
» Occlusion
» Reattachment
» Release
» Removal
» Repair

Watch out: Some of these root operations are similar. For instance, “resection” has a subtle distinction from “excision.” An “excision” means the physician used a sharp instrument to cut out or off a portion of body part without replacement. Examples of “excision” procedures are a breast lumpectomy or liver biopsy.

On the other hand, a “resection” means the physician cut out or off, without replacement, all of a body system. Examples of “resection” procedures are a total mastectomy or a cholecystectomy.

Difference: “Excision” refers to the removal of a portion of a body part, whereas “resection” refers to the removal of all of a body system.

Examine This Example PCS Chart

Suppose your physician performs an insertion of an infusion pump into the patient’s chest. Using a percutaneous approach, he inserts the pump underneath the subcutaneous tissue.

Step 1: First of all, you know this is part of the Medical and Surgical section of the PCS manual. Then, you should identify the body system. This would be the subcutaneous tissue and fascia.

Step 2: The physician inserted the infusion pump. Because this is an insertion, you would use root operation “H” (meaning insertion) as your third character.

Here is what your chart looks like:

<table>
<thead>
<tr>
<th>Section:</th>
<th>0 Medical and Surgical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body System:</td>
<td>J Subcutaneous Tissue and Fascia</td>
</tr>
<tr>
<td>Operations:</td>
<td>H 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.</td>
</tr>
<tr>
<td>Body Part</td>
<td>Approach</td>
</tr>
<tr>
<td>S Subcutaneous Tissue and Fascia, Head and Neck</td>
<td>0 Open</td>
</tr>
<tr>
<td>V Subcutaneous Tissue and Fascia, Upper Extremity</td>
<td>3 Percutaneous</td>
</tr>
<tr>
<td>W Subcutaneous Tissue and Fascia, Lower Extremity</td>
<td>0 Open</td>
</tr>
<tr>
<td>T Subcutaneous Tissue and Fascia, Trunk</td>
<td>3 Percutaneous</td>
</tr>
</tbody>
</table>
N80.2, N83.0 and More: Match the Code to the Female Reproductive Site

Give your coding a boost by tying code digits to actual structures.

When your radiologist interprets imaging of the female reproductive system, your ability to identify the body part involved will sharpen your coding.

Use the anatomic illustration below to locate the site described, and then match that site to the sampling of applicable ICD-9-CM and ICD-10-CM codes in the table. (The table shows only sample codes. You should choose a code for your particular case based on the documentation and the most specific code available in the manual.)

<table>
<thead>
<tr>
<th>Illustration location</th>
<th>Anatomic site</th>
<th>Sample ICD-9 code</th>
<th>ICD-10 crosswalk</th>
<th>Code definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Fallopian tubes</td>
<td>617.2</td>
<td>N80.2</td>
<td>Endometriosis of the fallopian tube</td>
</tr>
<tr>
<td>2</td>
<td>Ovaries</td>
<td>620.0</td>
<td>N83.0</td>
<td>Follicular cyst, ovary</td>
</tr>
<tr>
<td>3</td>
<td>Uterine cavity</td>
<td>752.32</td>
<td>Q51.811</td>
<td>Hypoplasia of uterus</td>
</tr>
<tr>
<td>4</td>
<td>Cervix</td>
<td>233.1</td>
<td>D06.-</td>
<td>Carcinoma in situ of cervix uteri</td>
</tr>
<tr>
<td>5</td>
<td>Vagina</td>
<td>184.0</td>
<td>C52</td>
<td>Malignant neoplasm of vagina</td>
</tr>
</tbody>
</table>
Cardiology:
I11.- Codes Eliminate Malignant/Benign Dilemma

Your documentation no longer needs to distinguish this attribute.

The ICD-10 implementation date has been officially postponed, according to a Feb. 16 statement from the Dept. of Health and Human Services (HHS). Although a new date hasn’t been announced, you can take advantage of the extra time to ensure your practice has all of its preparations in place for the new coding and documentation requirements. Continue your training with this look at coding for hypertensive heart disease.

The diagnosis: In hypertensive heart disease, hypertension leads to heart disease. As the codes indicate, heart failure may or may not be present.

ICD-9 codes:
• 402.0x, Hypertensive heart disease; malignant
• 402.1x, Hypertensive heart disease; benign
• 402.9x, Hypertensive heart disease; unspecified

Fifth digit options:
0, … without heart failure
1, … with heart failure

ICD-10 codes:
I11.0, Hypertensive heart disease with heart failure
I11.9, Hypertensive heart disease without heart failure

ICD-9 coding rules: The terms “benign” and “malignant” in the ICD-9 hypertensive heart disease codes can cause problems. If physicians don’t include those terms in their hypertension documentation, coders are left with an “unspecified” code as the only compliant option.

A second coding requirement for ICD-9 is that you should report the heart failure type (428.x, Heart failure), if applicable and if known.

ICD-10 changes: ICD-10 simplifies coding by eliminating the terms benign and malignant from your choices.

Under ICD-10, your coding will still vary based on heart failure (I11.0) or no mention of heart failure (I11.9). As with ICD-9, you should use an additional code to report the heart failure type, when present.

Documentation: For coding purposes, documentation will no longer need to distinguish between benign and malignant hypertension. But if you’re reporting I11.0, you will need to see the heart failure type so you may code it, as well (I50.-).

Inform providers that for both ICD-9 and ICD-10, hypertensive heart disease codes apply only when documentation states or implies a causal relationship between the two. For example, the documentation may state the heart disease is “due to hypertension” or imply the relationship by calling the heart disease “hypertensive.” For instance, ICD-10 instructs that the issues described by heart disease codes I51.4-I51.9 should be coded to I11.- when due to hypertension. If there’s no documented relationship, you should report the heart disease and hypertension separately.

Coder tips: A note under I11.9 states it’s appropriate for hypertensive heart disease NOS (not otherwise specified), so it is appropriate if there’s no mention of heart failure in the documentation.

You’ll also avoid confusion if you alert everyone involved with coding to expect ICD-10 codes to begin with a letter followed by digits. In this case, the code begins with the letter “I” followed by the number “1.” The similarities between letter “I” and number “1” could cause a mix-up.

Urology:
Combine Kidney Plus Ureter Calculus Under 1 Code in ICD-10

Use 2 examples to master Excludes1 vs. Excludes2 notes.

Kidney stone sufferers number in the millions each year. Because those numbers are on the rise, the diagnosis code for this ailment is sure to still rank among your (Continued on next page)
commonly used codes when the transition to ICD-10 occurs in 2013.

**Good news:** For “calculus of kidney and ureter” codes, you’ll find almost a one-to-one code correspondence between ICD-9 and ICD-10.

As shown above, the major difference is that ICD-10 offers a code (N20.2) that is appropriate when the patient has calculi of both the kidney and the ureter. Under ICD-9, you would report the same diagnosis using two codes (592.0 and 592.1).

**Instructional notes:** The “includes” notes for these codes are nearly identical for ICD-9 and ICD-10. Be sure to take special care in reviewing the “excludes” notes, though, because ICD-10 has two different types of excludes notes that have two different meanings.

ICD-9 guidelines explain that an excludes note under a code indicates that the terms excluded from the code are to be coded using other codes. “The term excludes means ‘DO NOT CODE HERE,’” the guidelines state. For example, an ICD-9 excludes note instructs you to assign 275.49 for nephrocalcinosis rather than using a code in the 592 range (Calculus of kidney and ureter).

In contrast, ICD-10 has both “Excludes1” and “Excludes2” notes. According to ICD-10 guidelines, Excludes1 means “NOT CODED HERE.” In fact, you should never report the excluded code “at the same time as the code above the Excludes1 note,” the guidelines state. Excludes1 means the “two conditions cannot occur together.”

An Excludes2 note instead tells you that the excluded term should be reported using another code, but if the patient has both conditions you may report both codes. In other words, “When an Excludes2 note appears under a code it is acceptable to use both the code and the excluded code together,” ICD-10 guidelines state.

**Excludes1 example:** ICD-10 lists an Excludes1 note directly under N20 (Calculus of kidney and ureter). That means the note applies to the entire N20 range. The excluded terms are “nephrocalcinosis” (E83.5-, Disorders of calcium metabolism) and “that with hydronephrosis” (N13.2, Hydronephrosis with renal and ureteral calculous obstruction).

Because these terms are listed as an Excludes1 note, you should never report N20. with N13.2 or the code for nephrocalcinosis (E83.5).

**Excludes2 example:** Code N21.0 (Calculus in bladder) has an Excludes2 note for staghorn calculus indicating you should use N20.0 rather than N21.0 for that diagnosis. But because this is an Excludes2 note, if the documentation shows both “staghorn calculus” (N20.0) and “calculus in bladder” (N21.0), you may report the codes for each on the same claim.

Keep in mind that some insurers want to know which nostril was bleeding via modifiers such as RT (Right side), LT (Left side), or 50 (Bilateral) applied to the CPT® code that represents treatment of the nosebleed (e.g. 30901, Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method). Therefore, provider documentation should very clearly include this information. In addition, if another cause is discovered for the bloody nose (such as a nasal fracture), you would report the fracture diagnosis code instead of the epistaxis.

**Coding tips:** When the ICD-10 transition gets close, be sure to replace 784.7 on your superbills with code with R04.0.
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30901 Can Pair With E/M Code

Question:
A patient experienced a nosebleed while in the office. The hematologist used packing in the patient’s right nostril for 15 minutes and then used a silver nitrate stick to stop the bleed. May we report this service separately from the E/M? The physician also performed a level-4 established visit to evaluate the patient’s thrombocytopenia.

Answer:
In the case you describe, you may report 30901 (Control nasal hemorrhage, anterior, simple [limited cautery and/or packing], any method) linked to current ICD-9 code 784.7 (Epistaxis). You may report the 30901 service in addition to 99214 (Office or other outpatient visit …) linked to the appropriate thrombocytopenia code (such as 287.30, Primary thrombocytopenia, unspecified). The intervention you describe, which succeeded with the first attempt, meets the requirements for the limited cautery and/or packing code.

If ice packs or pressure had been sufficient to control the bleed, experts advise incorporating the service into the E/M code. On the other hand, if the nosebleed had required complex care, the appropriate code would be 30903 (Control nasal hemorrhage, anterior, complex [extensive cautery and/or packing] any method). Extensive repair may include preformed nasal packs that fill nearly the entire anterior nasal vestibule (nasal tampons), nasal packing with yards of Vaseline gauze, cautery of several areas, or multiple bleeding episodes with several attempts to control the hemorrhage.

ICD-10-CM: When your coding system changes to ICD-10-CM, 784.7 will become R04.0 (Epistaxis) and 287.30 will translate to D47.3 (Essential [hemorrhagic] thrombocythemia).

Double Check Coding for Left and Right Lung

Question:
If the physician documents that the patient has a primary neoplasm of the right lower lobe with metastasis to the left lung. Do both the left and right lungs fall under the primary code? Or should we report both a primary code and a secondary code?

Answer:
When the oncologist documents a primary right lower lobe neoplasm with metastasis to the left lung, you should report:

» Right lobe: 162.5, Malignant neoplasm of lower lobe bronchus or lung
» Left lung: 197.0, Secondary malignant neoplasm of lung.

Support: ICD-9 Coding Clinic (2010, vol. 27, no. 3) addressed a similar question in which the patient had been diagnosed with cancer of the left lower lobe and metastasis to the right lung, peritoneum, and liver. Coding Clinic stated proper coding would include 162.5 (lung primary), 197.0 (lung secondary), 197.6 (Secondary malignant neoplasm of retroperitoneum and peritoneum), and 197.7 (Malignant neoplasm of liver secondary).

Caution: Don’t assume that the presence of a second neoplasm in the same organ system as a primary neoplasm means that you have both primary and secondary neoplasms. A patient may have two primary neoplasms in the same organ system. Let the documentation guide your choice.

ICD-10-CM: When ICD-10-CM becomes effective, 162.5 will be replaced by C34.3- (Malignant neoplasm of lower lobe bronchus or lung) and 197.0 will translate to C78.0- (Secondary malignant neoplasm of … lung). Your final code choice will depend on whether the lung is documented as left, right, or unspecified.

ICD-10 is More Specific for Fibromyalgia

Question:
Is there a specific code for fibromyalgia?

Answer:
Currently, your best option is to report fibromyalgia as 729.1 (Myalgia and myositis, unspecified). There isn’t a specific code for fibromyalgia in ICD-9. However, going further when ICD-10 becomes effective, you will be able to report fibromyalgia using a specific code. The ICD-10 code for fibromyalgia is M79.7 (Fibromyalgia).

You Be the Coder

How to Interpret NEC and NOS in ICD-10

(Question on page 37)

Answer:
Like ICD-9, the NEC (Not Elsewhere Classifiable) abbreviation contains codes for “other” types of specified conditions that haven’t already been classified. An example is H26.8 (Other specified cataract).

When your physician doesn’t clearly specify the condition, you can use a NOS (Not Otherwise Specified) code -- although payers usually frown upon this process. An example is H40.9 (Unspecified glaucoma).
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