Optum Learning: Coding from the Operative Report for ICD-10-CM and PCS

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Third Edition

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Answers and Rationale

Preoperative diagnosis:
Cerebral hemorrhage

Postoperative diagnosis:
Cerebral arteriovenous malformation with hemorrhage[1]

Procedure performed:
Endovascular coil embolization

Indications:
The patient is a 35-year-old male who presented to the ED with severe headache of three-day duration and diplopia. Imaging revealed an arteriovenous malformation with a pin sized hole that was leaking slowly. The patient was brought to the catheterization suite for emergent AVM embolization.

Procedure description:
The patient was sedated using IV Versed. The right thigh area above the femoral artery was prepped and draped in the usual sterile fashion, and the area was infiltrated with 1% lidocaine for local anesthesia. Once it was established that adequate sedation had been achieved, a small incision was made over the femoral artery and a catheter was inserted into the vessel.[2] The catheter was manipulated using fluoroscopic guidance through the vascular system to the site of the AVM. A HydroCoil 14 was then threaded through the catheter and into the AVM. A total of six coils were introduced into the defect until the entire defect was filled[2] and confirmed under fluoroscopy. An injection of contrast was applied and it was ensured that the coiling was successful in blocking the blood flow to the AVM entirely, thereby closing the site of the hemorrhage. The catheter was removed. Pressure was applied to the incision site until hemostasis was obtained. The patient was then taken to the recovery room in hemodynamically stable condition.

Diagnosis Codes

I6Ø.8 Other nontraumatic subarachnoid hemorrhage[1]

Rationale for Diagnosis Codes

The terms "Malformation, arteriovenous, cerebral" in the ICD-10-CM index lead the coder to Q28.2. However, this is not the correct code for reporting a ruptured arteriovenous malformation (AVM), according to the Excludes 1 note under category Q28. The correct code according to the tabular instructional notes is I6Ø.8, which is confirmed by the inclusion note that states "rupture of cerebral arteriovenous malformation."

Procedure Codes

Ø3LG3DZ Occlusion of Intracranial Artery with Intraluminal Device, Percutaneous Approach[2]

Rationale for Procedure Codes

The procedure described completely closed off the AVM from the rest of the vascular system using six coils. This coincides with the ICD-10-PCS root operation *Occlusion*. The intent of endovascular coil embolization is to completely block off the abnormal arterial blood flow into the vein with coils inserted via a catheter guided through the femoral artery into the feeding artery of the brain AVM. This procedure is reported with a code originating from the "Upper Artery" tables. The artery is specified as intracranial, and the procedure is performed percutaneously under fluoroscopic guidance, which is reported using the fifth-character value of 3. HydroCoil endovascular coils are intraluminal devices, but they are not bioactive, making the correct device character value D.

MS-DRG

022 Intracranial Vascular Procedures with Principal Diagnosis of Hemorrhage without CC/MCC RW 4.7113

If the AVM is reported incorrectly using code Q28.2, the MS-DRG groups to lower-weighted MS-DRG 027 Craniotomy and Endovascular Intracranial Procedures without CC/MCC (RW 2.2505).

KEY POINT

ICD-10-CM Official Guidelines for Coding and Reporting Section I.A.12.a:

A type 1 excludes note is a pure excludes note. It means "NOT CODED HERE!" An Excludes 1 note indicates that the code excluded should never be used at the same time as the code above the Excludes 1 note. This note is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

DEFINITIONS

occlusion. ICD-10-PCS root operation value L. Completely closing an orifice or the lumen of a tubular body part. The orifice can be natural or artificially created.

percutaneous. ICD-10-PCS approach value 3. 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.

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Operative Report MDC 8—#5

Preoperative diagnosis:
Posttraumatic osteoarthropathy

Postoperative diagnosis:
Posttraumatic osteoarthropathy

Procedure performed:
Total hip arthroplasty

Indications:
This is a 67-year-old male who sustained a fracture of the right hip five years ago and subsequently developed osteoarthritis at the site. The patient presents for a total hip arthroplasty using a ceramic-on-ceramic prosthetic hip implant.

Procedure description:
After adequate anesthesia was achieved, the patient was prepped and draped in the usual sterile fashion. The patient was placed in a lateral decubitus position, an incision was made along the posterior aspect of the hip. The fascia lata was incised and the muscles around the hip joint were retracted to visualize the capsule. The capsule was incised, and the hip dislocated posteriorly. The femoral head and any osteophytes around the rim of the acetabulum were removed with an osteotome. The acetabulum was reamed out with a power reamer, exposing both subchondral and cancellous bone, and the acetabular component was inserted. The femoral canal was prepared using the power reamer. The stem was secured into the femoral shaft using bone cement. The femoral stem prosthesis was repositioned. The external rotator muscles were reattached. The hip was repositioned, and the external rotator muscles were reattached. The incision was repaired in layers with suction drains. The patient tolerated the procedure well and was transported to the recovery room in stable condition.

Code all relevant ICD-10-CM diagnosis and ICD-10-PCS procedure codes in accordance with official guidelines and coding conventions.

Diagnosis Codes:

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Procedure Codes:

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MS-DRG:

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Answers and Rationale

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This is a 67-year-old male who sustained a fracture of the right hip five years ago and subsequently developed osteoarthritis at the site.[2] The patient presents for a total hip arthroplasty using a ceramic-on-ceramic prosthetic hip implant.[3]

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After adequate anesthesia was achieved, the patient was prepped and draped in the usual sterile fashion. The patient was placed in a lateral decubitus position, an incision was made along the posterior aspect of the hip. The fascia lata was incised and the muscles around the hip joint were retracted to visualize the capsule. The capsule was incised, and the hip dislocated posteriorly. The femoral head and any osteophytes around the rim of the acetabulum were removed with an osteotome. The acetabulum was reamed out with a power reamer,[3] exposing both subchondral and cancellous bone, and the acetabular component was inserted.[3] The femoral canal was prepared using the power reamer. The stem was secured into the femoral shaft using bone cement. The femoral stem prosthesis was repositioned.[3] The external rotator muscles were reattached. The hip was repositioned, and the external rotator muscles were reattached. The incision was repaired in layers with suction drains. The patient tolerated the procedure well and was transported to the recovery room in stable condition.

Diagnosis Codes

M16.51 **Unilateral post-traumatic osteoarthritis, right hip[1]**

S72.ØØ1S **Fracture of unspecified part of neck of right femur, sequela[2]**

Rationale for Diagnosis Codes

"Osteoarthritis, Posttraumatic, Hip" in the ICD-10-CM index lists M16.5-. The documentation notes that the osteoarthritis was caused by a previous fracture, or is "sequela" of a hip fracture. Therefore, the code for the hip fracture, not otherwise specified, should be reported with a seventh character of "S" denoting that the osteoarthritis is a sequela of the fracture.

Procedure Codes

ØSR9Ø39 **Replacement of Right Hip Joint with Synthetic Substitute, Ceramic, Open Approach, Cemented[3]**

Rationale for Procedure Codes

Because the entire hip surface, both the acetabular and femoral, are replaced using ceramic prostheses, the root operation is *Replacement* on the body part is *Right Hip*. The sixth character represents the device used—in this instance, the ceramic prosthesis. As the femoral end of the prosthetic was secured in place using a bone cement, the seventh character is qualifier "9," representing *Cemented*.

MS-DRG

470 **Major Joint Replacement or Reattachment of Lower Extremity without MCC** **RW 2.1463**

Key Point

ICD-10-CM Official Guidelines for Coding and Reporting Section I.C.19.a:

7th character "S," sequela, is for use for complications or conditions that arise as a direct result of a condition, such as scar formation after a burn. The scars are sequelae of the burn. When using 7th character "S," it is necessary to use both the injury code that precipitated the sequela and the code for the sequela itself. The "S" is added only to the injury code, not the sequela code. The 7th character "S" identifies the injury responsible for the sequela. The specific type of sequela (e.g., scar) is sequenced first, followed by the injury code.

Coding Axiom

ICD-10-PCS Coding Guidelines Section B3.1b:

Components of a procedure specified in the root operation definition and explanation are not coded separately. Procedural steps necessary to reach the operative site and close the operative site are also not coded separately.

Example: Resection of a joint as part of a joint replacement procedure is included in the root operation definition of *Replacement* and is not coded separately.

ICD-10-PCS Coding Guidelines Section B6.1b:

Materials such as sutures, ligatures, radiological markers, and temporary postoperative wound drains are considered integral to the performance of a procedure and are not coded as devices.

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