WELCOME TO CODING ROUND TABLE WEBINAR 146: Decoding Debridement and other Complex Procedures

The webinar will begin shortly

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Round Table 146

Decoding Debridement and other Complex Procedures
May 10, 2022

Agenda

- Decoding Debridement
- Left frontal encephalocele/skull base defect repair
- Excision vs. Resection of the colon

Decoding Debridement

INDICATIONS (not all inclusive):

- ✓ Pressure Ulcers/Decubitus ulcers

- ✓ Other ulcer types (infected, diabetic, ischemic, venous)

  Reminder: We can assume that a foot ulcer is diabetic related if no other cause is stated, see the “with” guideline and Coding Clinic, 2nd quarter, 2016, p 36-37, ICD-10 CM Tabular

- ✓ Non-healing (surgical) (traumatic) (burns) wounds

- ✓ Infection: Cellulitis/Abscess, Osteomyelitis, Fasciitis, gangrene

  Reminder: We can assume that osteomyelitis and gangrene are diabetic related if no other cause is stated, see the “with” guideline in FY 2017, Coding Clinic 2nd
  Quarter, 2016, p 36-37, and Coding Clinic, 4th Quarter 2016, p 141-142

  Reminder: We can’t assume that cellulitis is related to diabetes, Per Diabetes and cellulitis, ICD-10-CM/PCS Coding Clinic, Fourth Quarter ICD-10 2017 Pages: 100-101 Effective with discharges: October 1, 2017, "Diabetes with skin complication NEC," is indexed, but "diabetes with cellulitis" is not specifically indexed. The "with" guideline does not apply to "not elsewhere classified (NEC)" index entries that cover broad categories of c onditions. Specific conditions must be linked by the terms "with," "due to" or "associated with". Coding professionals should not assume a causal relationship when the diabetic complication is "NEC.”

What is debridement?

Debridement is the removal of foreign material, contaminated or devitalized tissue, necrosis, or slough using either non-excisional (brushing, irrigating, scrubbing, or washing using tools such as Versajet, ultrasound, etc.) or excisional (cutting away the dead and necrotic tissue) from a traumatic or infected lesion until surrounding healthy tissue is exposed

- **Surgical (Excisional)**: involves cutting away dead tissue
- **Mechanical (Nonexcisional)**: Loosens and removes wound debris using a pressurized irrigation device, ultrasound, pulsed lavage
- **Autolytic debridement (Nonexcisional/Wound Management)**: Special dressing that enhances the body's natural process of using enzymes to break down dead tissue
- **Enzymatic debridement (Nonexcisional/Wound Management)**: Application of chemical enzymes and dressings to break down dead tissue
- **Maggot therapy (Wound Management)**

Introduction of New Therapeutic Substances (2022)

Bromelain-enriched Proteolytic Enzyme

NexoBrid™ is a mixture of proteolytic enzymes (enriched in bromelain) used for eschar removal in adults with deep partial thickness and/or full thickness thermal burns. The proteolytic enzymes can be applied at bedside to selectively remove eschar and denatured collagen while sparing healthy tissue. New ICD-10-PCS codes have been created for the external application to skin or subcutaneous tissue.

XW00X27 Introduction of Bromelain-enriched Proteolytic Enzyme into Skin, External Approach, New Technology Group 7
XW01X27 Introduction of Bromelain-enriched Proteolytic Enzyme into Subcutaneous Tissue, External Approach, New Technology Group 7

Excisional and nonexcisional debridement, ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2015 Page: 3 Effective with discharges: October 7, 2015

VERICEL

Application of Topical Agent for Non-Excisional Eschar Removal

- **NEXOBRID** is an Enzymatic Treatment for Eschar Removal in Hospitalized Burn Patients
- NexoBrid is a novel, non-surgical option for eschar removal. Eschar is the dead tissue and dried secretions following a burn, and removal is essential for wound healing
- It is a botanical and biologic product for topical use and is comprised of 2 components: the NexoBrid Powder, containing a concentrate of proteolytic enzymes enriched in bromelain extracted from pineapple stems, and a Gel Vehicle
- NexoBrid has been developed for patients with deep partial thickness (DPT) and/or full thickness (FT) thermal burns

Section	**X** New Technology		
Body System	**W** Anatomical Regions		
Operation	**0** Introduction: Putting in or on a therapeutic, diagnostic, nutritional, physiological, or prophylactic substance except blood or blood products		
Body Part	*Approach*	*Device / Substance / Technology*	*Qualifier*
0 Skin **1** Subcutaneous Tissue	**X** External	**ADD 2** Bromelain-enriched Proteolytic Enzyme	**7** New Technology Group 7

Administration:

NexoBrid is applied topically at the patient's bedside:

- Apply sterile gauze soaked with antibacterial solution to the wound bed for 2 hours
- Mix NexoBrid powder and gel and apply topically to wound within 15 minutes of mixing, maintaining a moist environment during application
- Maintain appropriate pain control throughout the procedure, particularly during NexoBrid application and removal
- Cover with an occlusive dressing and leave on for 4 hours
- Remove NexoBrid with a blunt instrument, such as a sterile tongue depressor
- Apply a dressing soaked with antibacterial solution for 2 hours to remove remnants of the dissolved eschar and cool the treatment area
- NexoBrid can be applied to an area of up to 15% TBSA in one session

Coding prior to October 1, 2021 : There are no unique ICD-10-PCS codes to describe the application of bromelain-enriched proteolytic enzyme for non-excisional eschar removal. Facilities can report the application of bromelain-enriched proteolytic enzyme using the following code:
3E00XGC Introduction of other therapeutic substance into skin and mucous membranes, external approach

WHEN TO CODE DEBRIDEMENTS

- ✓ Debridement that is preparatory to further surgery, should not be code separately
  - ✓ Such as that performed during reduction of an open fracture
  - ✓ or minimal debridement in addition to a drainage procedure
- ✓ Non-excisional debridement may be done at bedside and documentation found in the progress notes.
- ✓ Excisional debridement is usually done in an operating room with anesthesia but not always

LOOK SHARP

- ✓ The term “sharp” and excisional” are not interchangeable/synonymous
- ✓ As stated in Coding Clinic, Third Quarter 2015, page 3, “The use of a sharp instrument does not always indicate that an excisional debridement was performed”
- ✓ A query to the provider would be needed to determine whether the debridement was excisional or non-excisional

WHO CAN PERFORM A DEBRIDEMENT

According to a 2004 Coding Clinic, “Excisional debridement of wound, infection, or burn should be assigned when a provider such as a physical therapist documents ‘excisional debridement’, in the health record. It is appropriate to assign a procedure code based on documentation by a non-physician when that professional provides the service”.

As also substantiated in a 2014 Coding Clinic It would be appropriate to assign a procedure code based on a non-physician professional that provides a service such as “infusions may be carried out by a nurse, mechanical ventilation may be provided by a respiratory therapist, or a drug may be ordered by the physician and administered by a nurse. Please note this only applies to procedure coding where there is documentation to substantiate the code. This advice does not apply to diagnosis coding”.

For clarification:
“It would be appropriate to use the health record documentation of other providers, such as nurse practitioners and physician assistants as the basis for code assignment to report new diagnoses, if they are considered legally accountable for establishing a diagnosis within the regulations governing the provider and the facility. The Official Guidelines for Coding and Reporting define a provider as the individual legally accountable for establishing a diagnosis.”

Coding Clinic, 4th quarter, 2004
Documentation Issues from Coding Clinic, ICD-10-CM/PCS Coding Clinic, First Quarter ICD-10 2014 Pages: 11-13 Effective with discharges: March 31, 2014

Debridement Coding Thought Process

What is the condition requiring debridement? Intent of procedure?
Body System: Skin, Subq and fascia, muscle, bursa/ligament, joint, tendon, bone, etc.?
Method used to remove tissue (excision vs. nonexcisional)?
Extent and depth of debridement: What was the deepest layer debrided? Where multiple sites debrided?
Site/Location (and laterality) of debridement?
Approach
Critical Thinking Questions:

1. What body system value should be used or excisional debridement of skin and sub-q? Fascia and Muscle?

1. Excisional Debridement of dermis? Epidermis?

1. Excisional Debridement of soft tissue?

1. Versajet Debridement of necrotic fat?

Pertinent Coding Guidelines

ICD-10-PCS coding guideline A10 states the word “and” when used in a code description, means “and/or.”

Root Operation

B3.2 (Multiple Procedures) during the same operative episode, multiple procedures are coded if:

a. The same root operation is performed on different body parts as defined by distinct values pf the body part character
b. The same root operation is repeated in multiple body parts, and those body parts are separate and distinct body parts classified to a single ICD-10-PCS body part value
c. Multiple root operations with distinct objectives are performed on the same body part

B3.5 Overlapping Body Layers

Overlapping body layers B3.5 If root operations such as Excision, Extraction, Repair or Inspection are performed on overlapping layers of the musculoskeletal system, the body part specifying the deepest layer is coded. Example: Excisional debridement that includes skin and subcutaneous tissue and muscle is coded to the muscle body part.

Excision/Resection followed by replacement

B3.18

If an excision or resection of a body part is followed by a replacement procedure, code both procedures to identify each distinct objective, except when the excision or resection is considered integral and preparatory for the replacement procedure. Examples: Mastectomy followed by reconstruction, both resection and replacement of the breast are coded to fully capture the distinct objectives of the procedures performed. Maxillectomy with obturator reconstruction, both excision and replacement of the maxilla are coded to fully capture the distinct objectives of the procedures performed. Excisional debridement of tendon with skin graft, both the excision of the tendon and the replacement of the skin with a graft are coded to fully capture the distinct objectives of the procedures performed. Esophagectomy followed by reconstruction with colonic interposition, both the resection and the transfer of the large intestine to function as the esophagus are coded to fully capture the distinct objectives of the procedures performed. Examples: Resection of a joint as part of a joint replacement procedure is considered integral and preparatory for the replacement of the joint and the resection is not coded separately. Resection of a valve as part of a valve replacement procedure is considered integral and preparatory for the valve replacement and the resection is not coded separately.

Pertinent Coding Guidelines

Other helpful guidelines:

Body Part

B4.1b “Peri”

If the prefix “peri” is combined with a body part to identify the site of the procedure, and the site of the procedure is not further specified, then the procedure is coded to the body part named. This guideline applies only when a more specific body part value is not available.

Examples: A procedure site identified as perirenal is coded to the kidney body part when the site of the procedure is not further specified.

A procedure site described in the documentation as peri-urethral, and the documentation also indicates that it is the vulvar tissue and not the urethral tissue that is the site of the procedure, then the procedure is coded to the vulva body part.

A procedure site documented as involving the periosteum is coded to the corresponding bone body part.

Pertinent Coding Guidelines

Other helpful guidelines:

B4.3 Bilateral body parts

Bilateral body part values are available for a limited number of body parts. If the identical procedure is performed on contralateral body parts, and a bilateral body part value exists for that body part, a single procedure is coded using the bilateral body part value. If no bilateral body part value exists, each procedure is coded separately using the appropriate body part value. Examples: The identical procedure performed on both fallopian tubes is coded once using the body part value Fallopian Tube, Bilateral. 12The identical procedure performed on both knee joints is coded twice using the body part values Knee Joint, Right and Knee Joint, Left.

B4.5 Tendons, ligaments, bursa and fascia near a joint

Tendons, ligaments, bursae and fascia near a joint B4.5 Procedures performed on tendons, ligaments, bursae and fascia supporting a joint are coded to the body part in the respective body system that is the focus of the procedure. Procedures performed on joint structures themselves are coded to the body part in the joint body systems. Examples: Repair of the anterior cruciate ligament of the knee is coded to the knee bursa and ligament body part in the bursae and ligaments body system. Knee arthroscopy with shaving of articular cartilage is coded to the knee joint body part in the Lower Joints body system

B4.6 Skin, subcutaneous tissue and fascia overlying a joint

If a procedure is performed on the skin, subcutaneous tissue or fascia overlying a joint, the procedure is coded to the following body part:

- Shoulder is coded to Upper Arm
- Elbow is coded to Lower Arm
- Wrist is coded to Lower Arm
- Hip is coded to Upper Leg
- Knee is coded to Lower Leg
- Ankle is coded to Foot

Pertinent Coding Guidelines
Other helpful guidelines:

B4.7 Fingers and Toes
If a body system does not contain a separate body part value for fingers, procedures performed on the fingers are coded to the body part value for the hand. If a body system does not contain a separate body part value for toes, procedures performed on the toes are coded to the body part value for the foot. Example: Excision of finger muscle is coded to one of the hand muscle body part values in the Muscles body system.

Approach
B5.3a External approach
Procedures performed within an orifice on structures that are visible without the aid of any instrumentation are coded to the approach External. Example: Resection of tonsils is coded to the approach External.

B5.3b
Procedures performed indirectly by the application of external force through the intervening body layers are coded to the approach External. Example: Closed reduction of fracture is coded to the approach External. Percutaneous procedure via device

Percutaneous procedure via device
B5.4 Procedures performed percutaneously via a device placed for the procedure are coded to the approach Percutaneous. Example: Fragmentation of kidney stone performed via percutaneous nephrostomy is coded to the approach Percutaneous

Pertinent Coding Guidelines

Other helpful guidelines:

B6. Device

B6.1b

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

Dermis—which body System?

Skin Layer	Description
Epidermis	the outermost layer of skin, provides a waterproof barrier and creates our skin tone
Dermis	The dermis, beneath the epidermis, contains tough connective tissue, hair follicles, and sweat glands

Subcutaneous Tissue-Which body system?

Layer	Description
Subcutaneous tissue	Is also known as the hypodermis or subcutis, is the innermost layer of skin. It's made up of fat (adipose tissue) and connective tissues. In contains superficial blood vessels and cutaneous nerves.

Soft tissue-Which Body System?

Layer	Description
Tendons	A flexible but inelastic cord of strong fibrous collagen tissue attaching a muscle to a bone
Ligaments and bursa	Ligaments are bands of tough elastic tissue around joints. They connect bone to bone, and give joints support, and limit their movement. Bursa is a fluid filled sac that creates a cushion and gliding surface between bone surfaces and soft tissue
Fascia	Fascia is connective tissue that is classified three ways: ● Superficial fascia is the deepest layer of subcutaneous tissue; the galea is the superficial fascia that attaches the scalp to the skull. ● Deep fascia is dense fibrous connective tissue also known as muscle fascia; this is the layer that covers, separates, and binds the muscles, bones, nerves, blood vessels, and internal organs. Visceral or parietal fascia is the connective tissue membrane that surrounds and suspends organs within their cavities.
Muscles	Muscle is soft tissue and has three classifications: • Skeletal muscle is “voluntary” meaning it is under conscious control and responsible for movement and maintaining posture. ● Cardiac muscle is “involuntary” meaning it is not under conscious control and found only in the heart and surrounding the pulmonary vein and superior vena cava. ● Smooth muscle is “involuntary” meaning it is not under conscious control and is within the walls of visceral organs (hollow tube organs), blood vessels, and some other structures.

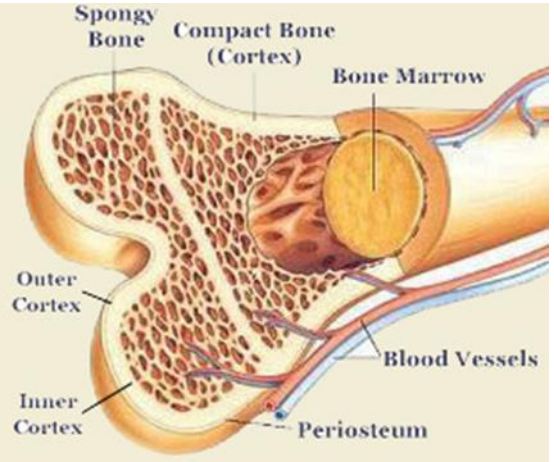
Periosteum- which body system?

4 layers of bone

Periosteum
Soft outer covering over the surface of the bone that contains nerves and blood vessels that nourish the bone
Cortical bone/compact bone
This is solid hard outside covering of a bone

Cancellous Bone (spongy)
Located inside the compact bone. It looks like a sponge and bone marrow fills in the spaces

Bone Marrow
Soft bone marrow is found inside many bones that makes red blood cells, white bloods cells and platelets for the body



Most Common Approach Values

Keep in mind that we are using the Excision and Extraction root operations there may or may not be options for approaches/body (I,e joint extraction) that we do have for debridement

Body System	Most Common Root operations	Approach Definition/Comments
Skin / Skin Breast =Chest	External	Procedures performed directly on the skin or mucous membrane
Breast	Open	Cutting through the skin or mucous membrane and any other body layers necessary to expose the site of the procedure
Subq and Fascia Muscle Bursa and Ligaments Tendons Joints Bone Brain	Open	Cutting through the skin or mucous membrane and any other body layers necessary to expose the site of the procedure
Joints	Percutaneous Endoscopic	Entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to reach the site of the procedure

Excisional Debridement

Root Operation: Excision

Definition: Cutting out or off, without replacement, a portion of a body part

- ✓ The documentation standard did not change from ICD-9 to ICD-10
- ✓ Documentation of debridement should be very specific regarding the type of debridement
  - Documentation should state “excisional”
- ✓ Description of “sharp instrument” is not enough to code the root operation Excision
- ✓ Review procedure note for the presence of an excisional debridement (definite cutting away of tissue, not the minor removal of loose fragments)
- ✓ A code for excisional debridement can be assigned based on documentation of “excisional debridement and/or the documentation meets the root operation definition of “excision”
- ✓ If the documentation is not clear other there is any question about the procedure, the provider should be queried for clarification
  - Knife dissection is insufficient language to code the root operation excision as it can be referring to the means used to reach the operative site and not necessarily what was done at the site
- ✓ Debridement of bone, fascia, tendon or muscle should not be assumed to be excisional
- ✓ If a debridement is performed to clean the open wound as part of an open reduction internal fixation (ORIF), it would not be coded separately
  - If a separate excisional debridement was done then it would be appropriate to code
- ✓ An excisional debridement is coded separately when performed on a deeper level (fascia, muscle) than a skin graft
- ✓ When multiple layers of the same site are debrided, only a assign a code for the deepest layer of the excisional debridement
  - Guideline B5.3
    - If the root operation Excision, Repair, or Inspection are performed on overlapping layers of the musculoskeletal system, the body part specifying the deepest layer is coded

Debridement using knife dissection, ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2015 Page: 4 Effective with discharges: October 7, 2015
Open reduction internal fixation of fracture with debridement, ICD-10-CM/PCS Coding Clinic, Fourth Quarter ICD-10 2014 Pages: 32-33 Effective with discharges: December 31, 2014
Application of TheraSkin® and excisional debridement ,ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2014 Pages: 14-15 Effective with discharges: September 15, 2014
Placement of reverse sural fasciocutaneous pedicle flap
ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2014 Pages: 18-19 Effective with discharges: September 15, 2014

Excisional Debridement

- Example:
  - Excisional debridement that includes skin, subcutaneous tissue and muscle is coded to the muscle body part
- Documentation: “down to and including {Insert Layer}”

✓ If an excisional and non-excisional debridement are performed at the same site , only the excisional debridement is reported

✓ If excisional muscle debridement of sacrum does not specify laterality, then assign codes for both right and left hip excision

✓ The periosteum is part of the bone and therefore is coded as bone. ICD-10-PCS does not separately classify periosteal tissue as a body part value; therefore, assign a code for the debridement of the underlying bone

✓ We should look for additional procedures performed with additional objectives

Excisional debridement of sacrum, ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2016 Page: 20 Effective with discharges: September 23, 2016
Excisional debridement of periosteum, ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2018 Pages: 17-18 Effective with discharges: September 24, 2018
Sacral pressure ulcer with excisional and nonexcisional debridement of same site
ICD-10-CM/PCS Coding Clinic, Second Quarter ICD-10 2020 Page: 26 Effective with discharges: May 29, 2020

Nonexcisional Debridement

Root Operation: Extraction

Definition: Pulling or stripping out or off all or a portion of a body part by the use of force

Examples:

High Pressure Irrigation
Mechanical Irrigation
Peeling off infectious material in the dura
Pulsed lavage
Tenex ultrasound device
VersaJet

Nonexcisional Debridement

- ✓ Nonexcisional debridement of the skin is the nonoperative brushing, irrigating, scrubbing, or washing of devitalized tissue, necrosis, slough, or foreign material.
- ✓ Most nonexcisional debridement procedures are classified to the root operation "Extraction" (pulling or stripping out or off all or a portion of a body part by the use of force).
- ✓ When multiple layers of the same site are debrided, only a assign a code for the deepest layer of the non-excisional debridement
- ✓ Code to the body part that is the closest available equivalent when coding excisional debridement of deeper tissues (bone, muscle, tendon)
- ✓ Non-excisional debridement may be done at bedside and documentation found in the progress notes.
- ✓ Documentation should be clarified, for example, if the depth and type (excisional vs. nonexcisional) of debridement is not clear.

Coding Question

How would you code excisional debridement of bioburden right lower extremity?

Patient has been followed at the wound center for continued management of this wound. Last visit was started on p.o. antibiotics for infection, presents today with increased cellulitis and pain along with maceration and extensive edema of right lower extremity. Patient was sent to ED for further evaluation and admission. Requiring intravenous antibiotics. Will review for possible bedside debridement.

LOS 2 Pt debrided at bedside again this a.m. with lidocaine cream. Excisional debridement of bioburden, using 15 blade scalpel. Wound size measurements post debridement 7 x 5 x 0.2. Patient tolerated procedure at bedside without complication.

Coding Question

Would you code the non-excisional debridement (leg and toe) as open?

Procedures :
1. DEBRIDE SUBCUTANEOUS TISSUE

Tissue level: subcutaneous
Excisional or Non-excisional: non-excisional
Tissue type: hyperkeratosis and slough
Tools utilized: curette 4mm and moistened gauze
Response: minimal bleeding and no pain
Hemostasis obtained: direct pressure
Wound #1:Lower leg, left
Post-debridement measurements(cm): 0.9 L x 0.7 W = 0.63 sqcm
Wound #2: 2nd toe, right distal
Post-debridement measurements(cm): 0.7 L x 1.0 W = 0.7 sqcm
Debrided: 100% = 1.33 sqcm total debrided
Post Procedure Treatment: dressing
Patient tolerated procedure well

Coding Question

With the buttock wound tracking down through the perineum do I consider this a single excisional debridement to the deepest layer? I'm reading this as the perineum muscle with debridement of the scrotum as well. I am also seeing counter incisions with nothing done to them so would this just code to the exploration as I have it?

PROCEDURE: Excisional debridement of scrotum and perineum.
Total excised area 15cm x 5cm (skin and subcutaneous tissue to muscle)
FINDINGS: Significant nonviable tissue in the right scrotum requiring debridement. Minor nonviable tissue in the right buttock requiring debridement. Counter incisions made in the anterior right perineum, right groin, and inner right thigh with healthier appearing tissue
INDICATIONS FOR PROCEDURE:
The patient is a xxx admitted xxx early morning 1/30/22 for rapidly progressive infection of his perineum concerning for necrotizing soft tissue infection. He had had symptoms for approximately one week, which rapidly progressed in the time immediately prior to his presentation. He was hemodynamically within normal limits and was taken urgently to the OR for debridement on 1/30. He now returns to the OR for further debridement.

DESCRIPTION OF PROCEDURE:
The patient was brought to the operating room. He was positioned he was transferred to the operating room table. General anesthesia was induced and he was intubated without issue. The patient was then positioned in lithotomy with yellowfin stirrups and all pressure points were padded. Appropriate preoperative antibiotics were given. The buttocks perineum and bilateral lower abdomen were prepped and draped in the usual sterile fashion. A timeout was called according to hospital policies and procedures.
We started with exploration of the scrotum, and noted significant devitalized and nonviable tissue around the right scrotum which was debrided until appropriate bleeding was encountered. The tissue surrounding the left scrotum appeared healthier. The testicular sacs were noted to be intact and overall uninvolved.
We then turned our attention to the right buttock and noted a moderate amount of devitalized tissue which was excised sharply with scissors and electrocautery. Excised area - 15cm x 5cm (skin and subcutaneous tissue to muscle) The wound tracked anteriorly towards the groin, and **a counterincision was made in the anterior right perineum, along with a second counterincision over the right groin. There was notably no significant devitalized tissue requiring devitalization at the sites of these counterincisions**. We also explored the wound along the **inner right thigh creating 1 additional counterincision. This tunnel however did not communicate with the perineal region as it was separated by the expected fascial planes.**
There was also no devitalized tissue in this right medial thigh wound requiring debridement. When no further necrotic tissue was noted all wounds were irrigated and dried. Hemostasis was achieved with electrocautery. The right buttock wound and tunnel to the right perineum was packed with Dakin soaked Kerlix, including one end of the Kerlix through the right perineal wound. The wound required multiple Kerlix rolls which were tied at each end creating 1 long packing strip. The scrotum was also packed with Dakin soaked Kerlix. Finally the counterincisions were loosely packed with Dakin soaked Kerlix. The wounds were cleaned and dried and dressed with ABDs, tape, and mesh briefs

Coding Question

I have a question on the procedure done on this patient. Here is the operative report. I had coded it as Excision of Scrotum 0VB50ZZ. The CDI coded it as Excision of subcutaneous tissue pelvic region 0JBC0ZZ and Drainage of scrotum 0V950ZZ. A query was done on the debridement type and depth and was answered "the upper right scrotal tissue excision debridement was preformed
with removal of affected skin and subcutaneous necrotic tissue". Which excision code would be appropriate in this case? Also since debridement was done, would the drainage need to be coded? I know normally it is not, but CDI felt it needed to be coded separately. Thank you.

Pre-Operative Diagnosis:
1.Right upper scrotal abscess with small area of ischemic / necrotic tissue - concerning for gangrene.
2.Accompanying right scrotal cellulitis.
3.Right orchitis / epididymitis.
Post-Operative Diagnosis:
1.Right upper scrotal abscess with small area of ischemic / necrotic tissue - concerning for gangrene.
2.Accompanying right scrotal cellulitis.
3.Right orchitis / epididymitis

After discussing with patient his current urological condition and the different treatment options he agreed to proceed with incision and drainage of right scrotal abscess and tissue debridement of upper right scrotal tissue. Discussed with patient the urological procedure and all of the potential risks including but not limited to: bleeding, infection, sepsis, need for repeated surgeries and debridement, scarring and pain at the site, recurrence of other abscess sites, need for long term wound care.Patient understands all these and has agreed to proceed with the procedure as above.A signed consent was obtained and placed into patient's chart.Patient was taken to the OR and placed on a dorsal lithotomy position.A timeout was called recognizing patient's name, date of birth, allergies, site of the procedure and the type of procedure being performed as well as he received IV abx prior while admitted on the floor.The lower abdominal area and the genitalia area was prepped and draped in a surgical sterile fashion.The upper right scrotal abscess site was incised with a 15 blade scalpel with a 3 cm incision.Small amount of purulent drainage was expressed from the site and aerobic and anaerobic cultures were then sent to microbiology.Small amount of necrotic tissue was noted tracking towards the right inguinal canal that was successfully debrided and tissue was sent to microbiology and tissue to pathology.Any of the small bleeding vessels were then carefully pin-point cautery was used and hemostasis was obtained.The wound then was irrigated with copious amount of sterile water and then packed with a 1/2 inch packing strip.The scrotum was then supported with cotton fluffs and ABD and supportive scrotal underwear.Patient tolerated the procedure well and returned to PACU in stable condition.All the instrument and sharps count was correct at the end of the surgery

Coding Question

I have a question about the procedure code to use on this case. The patient had septic right hip joint and debridement was done. A query was sent to the physician for the debridement type and it was answered that it was excisional and the capsule was excised. The CDI on the case and I are having a hard time figuring out the body part to use. I used hip joint and coded 0SB90ZZ. CDI used Bursa and Ligament and coded 0MBL0ZZ. Please help us decide which one is appropriate. Here is a copy of the operative report. Thank you.

Procedure Performed
Irrigation and debridement right septic hip joint (open lavage)

Indication for Surgery
is a pleasant XX-year-old female with acute onset right hip pain and inflammatory markers and aspiration suggestive of septic right hip acute hematogenous. Presents now for the aforementioned procedure. Risks benefits alternatives of surgery discussed. All questions answered.

Pre-Operative Diagnosis

Right septic hip joint

Post-Operative Diagnosis
Same

Operative Summary

Operative report in detail: was brought to the operating placed in the supine position on the OR table. After adequate anesthesia was obtained they were carefully positioned on the OR table with the right lower extremity prepped and draped in normal sterile fashion. A timeout procedure was performed. All were in agreement. I began the case by fashioning a standard anterior approach to the right hip using Bovie electrocautery to gain hemostasis.

I fashioned a longitudinal incision distal lateral to the ASIS. Dissected down to the level of the tensor fascia lata. Divided the overlying fascia. Retracted the muscle belly laterally so that it could be carefully protected. Extracapsular retractors were placed. Anterior and inferior capsulotomy completed and the capsule tagged. Intracapsular retractors placed.

There is a fair amount of thickened fluid with joint debridement knee which I collected for culture and analysis. I elevated the capsule and lavage the entire hip joint proper. I completed a small anterior capsulectomy as well. With this the entire wound was irrigated and closed in standard layer fashion. Sterile dry dressing. Patient awake and taken to postanesthesia care in stable condition there were no complications.

Reference Page

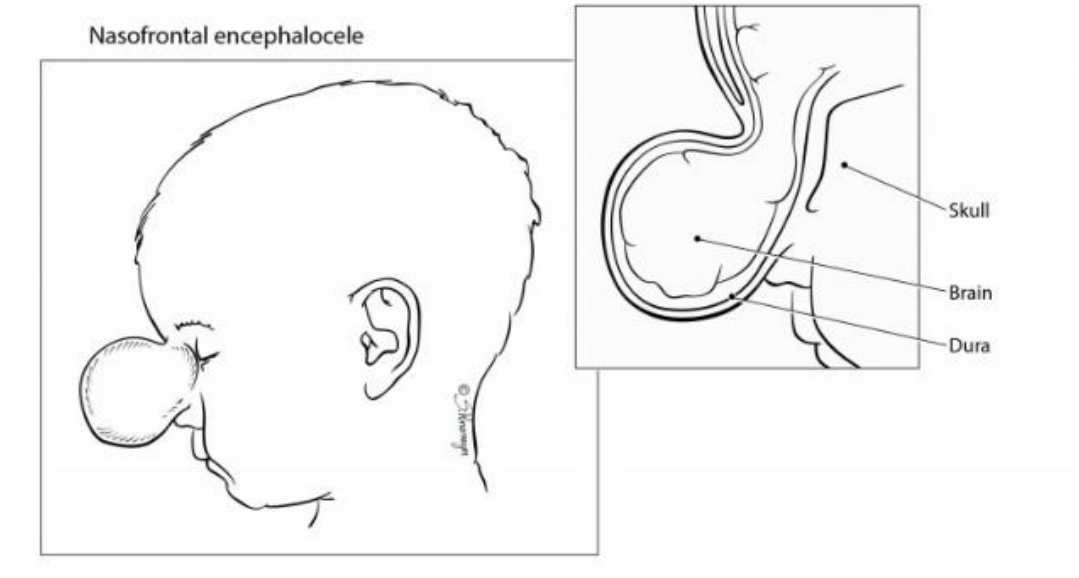
Removal of fat necrosis from retroperitoneum and space of Retzius
ICD-10-CM/PCS Coding Clinic, First Quarter ICD-10 2022 Pages: 42-43 Effective with discharges: March 18, 2022
Antibiotic-eluting bone void filler
ICD-10-CM/PCS Coding Clinic, Fourth Quarter ICD-10 2021 Pages: 74-75 Effective with discharges: October 1, 2021
Application of bioabsorbable wound dressing
ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2021 Pages: 13-14 Effective with discharges: September 20, 2021
Evolving deep tissue injury
ICD-10-CM/PCS Coding Clinic, First Quarter ICD-10 2021 Page: 24 Effective with discharges: March 10, 2021
Changes to the ICD-10-PCS Official Guidelines for Coding and Reporting 10/01/2020
ICD-10-CM/PCS Coding Clinic, Fourth Quarter ICD-10 2020 Page: 93,94 Effective with discharges: October 1, 2020
Arthroscopic manipulation and nonexcisional debridement of knee joint
ICD-10-CM/PCS Coding Clinic, Second Quarter ICD-10 2020 Pages: 26-27 Effective with discharges: May 29, 2020
Excisional debridement of breast tissue and skin
ICD-10-CM/PCS Coding Clinic, First Quarter ICD-10 2018 Pages: 14-15 Effective with discharges: February 18, 2018
Excisional debridement definition, ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2015 Pages: 4-5 Effective with discharges: October 7, 2015
Debridement using knife dissection, ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2015 Page: 4 Effective with discharges: October 7, 2015
Open reduction internal fixation of fracture with debridement, ICD-10-CM/PCS Coding Clinic, Fourth Quarter ICD-10 2014 Pages: 32-33 Effective with discharges: December 31, 2014
Application of TheraSkin® and excisional debridement ,ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2014 Pages: 14-15 Effective with discharges: September 15, 2014
Placement of reverse sural fasciocutaneous pedicle flap, ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2014 Pages: 18-19 Effective with discharges: September 15, 2014
Coding Clinic, 4th quarter, 2004
Documentation Issues from Coding Clinic, ICD-10-CM/PCS Coding Clinic, First Quarter ICD-10 2014 Pages: 11-13 Effective with discharges: March 31, 2014
Excisional and nonexcisional debridement, ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2015 Page: 3 Effective with discharges: October 7, 2015
Excisional debridement of periosteum
ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2018 Pages: 17-18 Effective with discharges: September 24, 2018

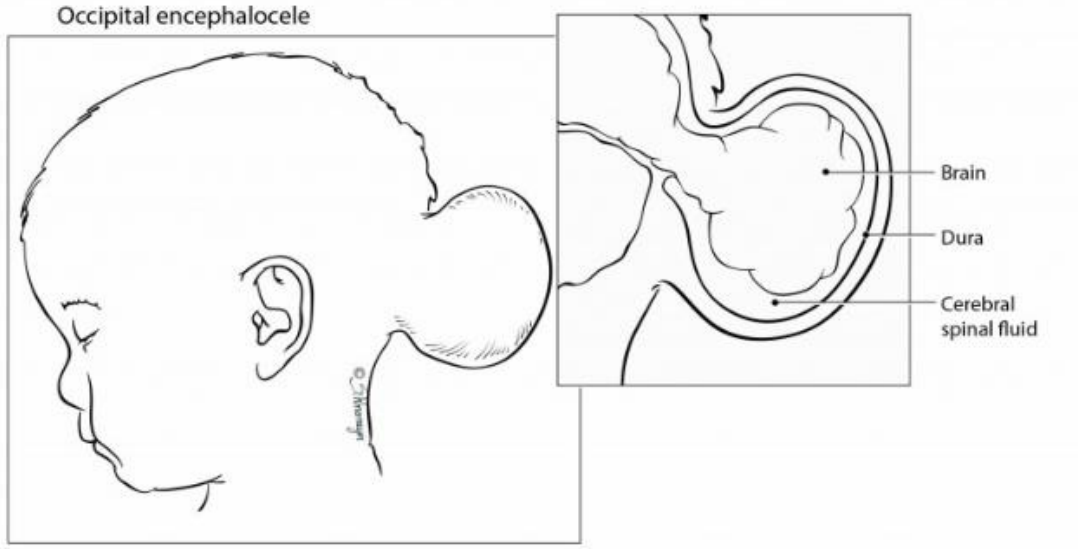
Reference Page

Necrotic pressure ulcer of heel with diabetic peripheral vascular disease and neuropathy
Excisional debridement of sacrum, ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2016 Page: 20 Effective with discharges: September 23, 2016
Arthroscopic drainage of knee and nonexcisional debridement, ICD-10-CM/PCS Coding Clinic, First Quarter ICD-10 2018 Pages: 14-15 Effective with discharges: February 18, 2018
Excisional debridement of skin of buttock documented, ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2015 Pages: 3-4 Effective with discharges: October 7, 2015
Excisional debridement of coccyx including bone, ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2015 Pages: 3-4 Effective with discharges: October 7, 2015
Extensively excised necrotic infection of buttock, ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2015 Pages: 6-7 Effective with discharges: October 7, 2015
Debridement of bone, fascia or muscle, ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2015 Pages: 7-8 Effective with discharges: October 7, 2015
Extraction procedures, ICD-10-CM/PCS Coding Clinic, Fourth Quarter ICD-10 2017 PageS: 41-42 Effective with discharges: October 1, 2017
Exchange of intramedullary antibiotic impregnated spacer, ICD-10-CM/PCS Coding Clinic, Second Quarter ICD-10 2017 Pages: 20-21 Effective with discharges: May 17, 2017
Epifix® allograft, ICD-10-CM/PCS Coding Clinic, First Quarter ICD-10 2017 Pages: 35-36 Effective with discharges: March 13, 2017
Non-excisional debridement with lavage of wound, ICD-10-CM/PCS Coding Clinic, First Quarter ICD-10 2015 Page: 23 Effective with discharges: March 16, 2015
Pulsed lavage digressive debridement, ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2015 Pages: 5-6 Effective with discharges: October 7, 2015
VersaJet debridement, ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2015 Page: 5 Effective with discharges: October 7, 2015
Correction: VersaJet debridement ICD-10-CM/PCS Coding Clinic, First Quarter ICD-10 2016 Page: 41
Debridement of bone and tendon using Tenex ultrasound device, ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2016 Page: 22 Effective with discharges: September 23, 2016
Nonexcisional debridement of infected lumbar wound, ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2016 Page: 21 Effective with discharges: September 23, 2016
Nonexcisional pulsed lavage debridement, ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2016 Pages: 21-22 Effective with discharges: September 23, 2016
VersaJet™ nonexcisional debridement of leg muscle
ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2016 Pages: 20-21 Effective with discharges: September 23, 2016
Nonexcisional debridement of cranial wound with removal and replacement of hardware
ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2015 Pages: 13-14 Effective with discharges: October 7, 2015

Left frontal encephalocele/skull base defect repair

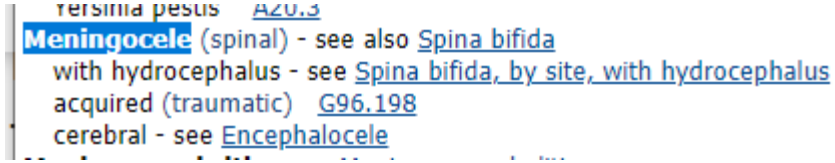
Left frontal encephalocele/skull base defect repair





Reference: http://ohiofetalmedicine.org/conditions-we-treat/encephalocele/

➢ Left frontal encephalocele acquired vs congenital



G96.198 **Other disorders of meninges, not elsewhere classified**

G93.89 **Other specified disorders of brain**

Postradiation encephalopathy

Q01 **Encephalocele**

INCLUDES

Arnold-Chiari syndrome, type III
encephalocystocele
encephalomyelocele
hydroencephalocele
hydromeningocele, cranial
meningocele, cerebral
meningoencephalocele

EXCLUDES 1

Meckel-Gruber syndrome (Q61.9)

Q01.0 **Frontal encephalocele**

Q01.1 **Nasofrontal encephalocele**

Q01.2 **Occipital encephalocele**

Q01.8 **Encephalocele of other sites**

Q01.9 **Encephalocele, unspecified**

Left frontal craniotomy for repair of encephalocele and skull base defect

PREOPERATIVE DIAGNOSIS:
Left frontal encephalocele/skull base defect.

POSTOPERATIVE DIAGNOSIS:
Left frontal encephalocele/skull base defect.

OPERATION (COMPLEX):
1. Left frontal craniotomy for repair of encephalocele and skull base defect.
2. Successful washout and repair of encephalocele/mucocele and skull base defect.
3. Decompression of left orbit from mucocele.
4. Successful removal of mucosa and packing and closure of left frontal sinus.
5. Use of intraoperative microscope.
6. Use of pedicled pericranial flap and bioglue for reconstruction

INDICATION FOR PROCEDURE:
The patient who presents with proptosis of left orbit, and was found on MRI imaging to have a mucocele over the left orbit as well as encephalocele through the anterior skull base in the frontal sinus.

Left frontal craniotomy for repair of encephalocele and skull base defect

DESCRIPTION OF PROCEDURE:
The patient was met in the preoperative area by Nursing and Anesthesia Teams. These teams brought the patient to the operative theater were an appropriate time-out was performed with Anesthesia and Surgical staff all present. The patient was intubated using general anesthetic by the anesthesiologist. The patient was positioned supine with head turned towards the right to expose the left side of the head. The patient was placed in Mayfield headholder. SCDs were used at the begin and throughout the entire duration of the case. A Foley catheter placed by the surgical nurse. All pressure points were appropriately padded to avoid peripheral neuropathy. Next, the left side of the head was then prepped and draped in the usual sterile fashion.

Using a skin knife, a pterional-type incision was created. The temporalis muscle was left down and the cutaneous skin flap was elevated and reflected anteriorly, held in place using the fishhook**. A large pedicalized pericranial graft was then harvested and reflected anteriorly as well**. We then used a perforator to perform 3 bur holes in the left frontal region. The dura was stripped using the dental Penfield 3. The remainder of the craniotomy was performed with a B1 footplate drill. Hemostasis with bipolar electrocautery and Gelfoam slurry was applied to the dura.

The dura was left closed and we dissected along the anterior fossa floor down to the roof of the orbit and the obvious encephalocele**. At this point, we found an obvious dural defect with encephalocele eroding through the skull base into the frontal sinus. This was carefully circumferentially dissected and the defect was truncated and the dura and brain retracted posteriorly**

At this point, we then evacuated this encephalocele defect in the skull base and made our way into the frontal sinus. The frontal sinus was then carefully curetted and stripped of all its mucosa. Turning laterally and in the frontal sinus, we found a defect that was leading directly into the left orbit. **There was a very large mucocele extending into the left orbit carefully. In order to better remove this, we did drill a very small amount carefully of the anterior skull base for the roof of the orbit. This allowed us to better access this and remove this. All this mucus as well as the mucosal lining was all removed without complication**. We could obviously identify the periorbit without complication. Luckily the periorbit was left completely intact**. At this point, we continued to do mucosa stripping from the left frontal sinus.** Once this was all completed, we felt that we had successfully performed our mucocele and encephalocele resection and decompression. At this point, antibiotic soaked Gelfoam was then packed into the left frontal sinus. Once this was completed, we then sprayed bio glue over top of this defect. We did leave the orbit completely open given that his underlying symptom was proptosis. **At this point, we then carefully repaired the dural defect as best we could with 4-0 Nurolon suture.** We then copiously irrigated with antibiotic irrigation.

The pedicalized pericranial flap was then carefully laid over top of this entire defect and this was also packed with Gelfoam. At this point, the bone was replaced using the KLS Martin plating system. Vancomycin powder was placed in the wound. Copious amounts of antibiotic irrigation were used. The wound was ultimately closed using 2-0 Vicryl suture for the galea followed by a running Monocryl for skin. The wound was dressed and clean. The patient was awoken from anesthesia without complication and taken to the PACU in stable condition. All counts were correct at the end of the case x2.

Suggested PCS codes

ONBQ0ZZ Excision of left orbit, open approach for the the release/decompression of the orbit by excision for the drilling and removal of the mucocele tissue extending into the orbit causing proptosis

Turning laterally and in the frontal sinus, we found a defect that was leading directly into the left orbit. ***There was a very large mucocele extending into the left orbit carefully. In order to better remove this, we did drill a very small amount carefully of the anterior skull base for the roof of the orbit. This allowed us to better access this and remove this. All this mucus as well as the mucosal lining was all removed without complication****. We could obviously identify the periorbit without complication. Luckily the periorbit was left completely intact****.***

00Q10ZZ Repair Cerebral Meninges, Open Approach for the repair of dural defect created by the encephalocele

*The dura was left closed and we dissected along the anterior fossa floor down to the roof of the orbit and the obvious encephalocele****. At this point, we found an obvious dural defect with encephalocele eroding through the skull base into the frontal sinus. This was carefully circumferentially dissected and the defect was truncated and the dura and brain retracted posteriorly…. At this point, we then carefully repaired the dural defect as best we could with 4-0 Nurolon suture.***

0JX10ZZ Transfer Face Subcutaneous Tissue and Fascia, Open Approach for closure of the defect

*The temporalis muscle was left down and the cutaneous skin flap was elevated and reflected anteriorly, held in place using the fishhook****. A large pedicalized pericranial graft was then harvested and reflected anteriorly as well****…. The pedicalized pericranial flap was then carefully laid over top of this entire defect and this was also packed with Gelfoam***

09CT0ZZ Extirpation of Matter from Left Frontal Sinus, Open Approach for stripping of the mucocele from frontal sinus

At this point, we then evacuated this encephalocele defect in the skull base and made our way into the frontal sinus. The frontal sinus was then carefully curetted and stripped of all its mucosa

Decompression of Chiari malformation by excision

ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2021 Pages: 16-17 Effective with discharges: September 20, 2021

Question
The patient was admitted for suboccipital craniectomy with C1 laminectomy for Chiari decompression with duraplasty and bilateral tonsillar bipolar coagulation for reduction of the tonsillar size. A dissection was made down to the C1 and C2 spinous processes and the occipital bone. A suboccipital craniectomy was performed. A C1 laminectomy was performed, the dura was opened and the bilateral cerebellar tonsils herniating past the foramen magnum as well as the spinal accessory nerves 9, 10 and 11 complex were visualized. Decompression of the nerves was achieved by shrinking the tonsils on the left side using bipolar suction. A portion of the left tonsil was resected as well. Then on the right side the tonsil was shrunken down using bipolar electrocautery. After confirming tonsillar reduction and being able to visualize the fourth ventricular outflow, an AlloDerm® dural patch was placed and the site was closed. What are the ICD-10-PCS codes for this procedure?

Answer:

Assign the following ICD-10-PCS codes:

00BC0ZZ
Excision of cerebellum, open approach, for the excision of the cerebellar tonsil on the left side;

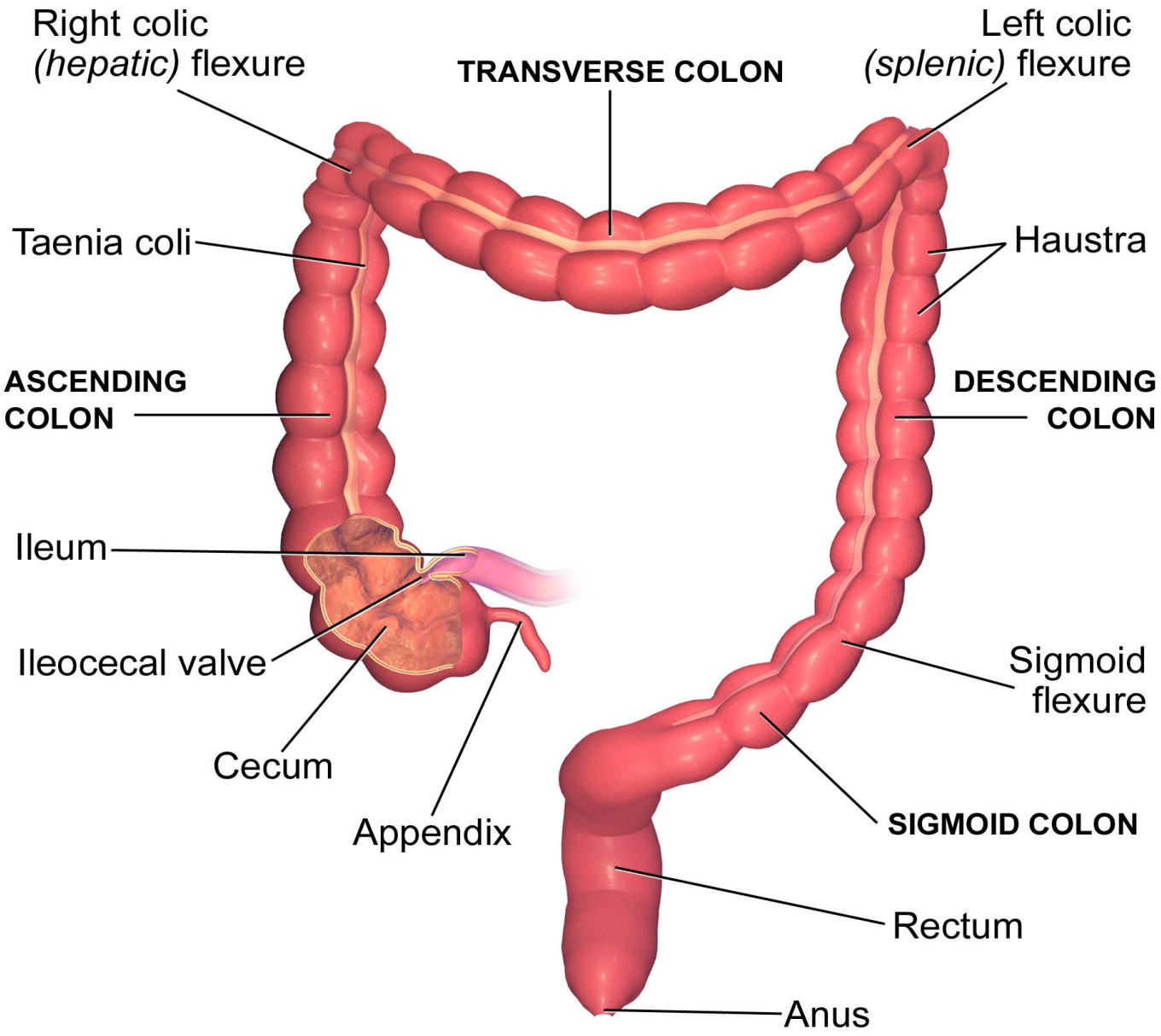
005C0ZZ
Destruction of cerebellum, open approach, for shrinking the cerebellar tonsil on the right side with bipolar coagulation; and

00U20KZ
Supplement dura mater with nonautologous tissue substitute, open approach, for the AlloDerm® dural patch.

Body Part

COLON ANATOMY

Revise 0DBF0ZZ Excision of Right Large Intestine, Open Approach to 0DTF0ZZ Resection of Right Large Intestine, Open Approach. The right colon was removed through the mid-transverse colon that is considered removal of the entire body part and thus Root Operation of Resection is more appropriate. PCS: Delete 0D1B0ZL Bypass of Ileum to Transverse Colon, Open Approach. The physician indicates side to side anastomosis that is required to complete the procedure and therefore not assigned



The Large Intestine

Operation: Hand-assisted laparoscopic partial ileocolectomy

Assistants: None

Anesthesia: General endotracheal anesthesia

Procedure Details
Description of Procedure: After adequate general endotracheal anesthesia The patient was placed in the supine position. A Foley catheter was placed and the patient was prepared and draped in the usual sterile fashion. A 6 cm upper midline incision was made just above the umbilicus . The abdomen was entered and the mentioned findings were noted. With one hand in the abdomen 11 mm noncutting trochars were placed in the epigastrium and suprapubic region. The GelPort was placed and pneumoperitoneum established the usual fashion. The terminal ileum and cecum were mobilized. The ascending colon was mobilized by incising along the white line of Toldt. The incision had to be extended 6 cm in the cephalad direction through the epigastric trocar site to take down the hepatic flexure. An Alexis wound protector was placed. The hepatic flexure was taken down and the lesser sac entered. The omentum was separated from the transverse colon. The mid transverse colon just proximal to the middle colic vessels was transected using the linear stapler. The terminal ileum was transected using the linear stapler. The ileocolic and right colic vessels were clamped, transected, and ligated using 0 Vicryl suture. Mesentery to the terminal ileum was clamped transected and ligated using 0 Vicryl suture. Mesentery to the mid transverse colon was clamped transected and ligated using 0 Vicryl suture. The specimen consisting of right colon and terminal ileum was opened on a back table and sent to pathology for permanent section. A side-to-side anastomosis was created in the usual fashion between the terminal ileum and midtransverse colon in the usual fashion using the linear stapler. There was no tension on the anastomosis. Bowel on both sides of the anastomosis were pink in color and there were no leaks seen. The abdomen was irrigated with 3 L of saline solution and hemostasis was complete. Gowns and gloves were changed and the patient was redraped. The closing tray was then used. The linea alba was approximated using figure-of-eight #1 PDS suture. Subcutaneous tissues was irrigated with saline and skin approximated using skin clips. The suprapubic trocar site was irrigated with saline and approximated using skin clips. A sterile dressing was applied. Laparotomy pads count was incorrect and x-rays revealed no retained laparotomy pads. Needle and instrument counts were correct and the patient was sent to the recovery room in good condition.

Findings:
4 cm sessile polyp in the proximal ascending colon with adjacent India ink tattoo.

Estimated blood loss: 50 mL

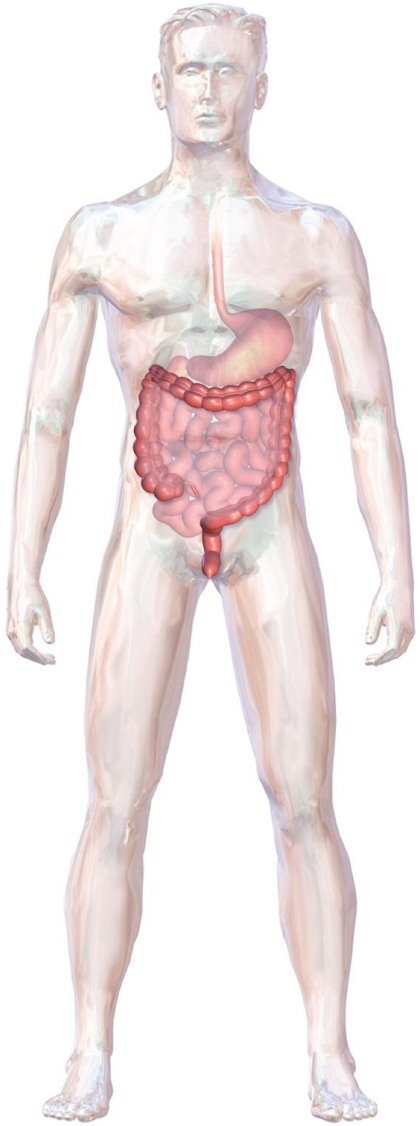
Specimens: Right colon and terminal ileum

Complications: None; patient tolerated the procedure well.

ILEOCOLECTOMY

R

L



Right colic
(hepatic) flexure

TRANSVERSE COLON

Left colic
(splenic) flexure

Taenia coli

Haustra

ASCENDING
COLON

DESCENDING
COLON

Ileum

Ileocecal valve

Cecum

Appendix

Sigmoid
flexure

SIGMOID COLON

Rectum

Anus

The Large Intestine

COLON ANATOMY

The left colon consists of the left half of the transverse colon (to the left of middle colic vessels), splenic flexure, descending colon, and sigmoid

The right colon consists of the cecum, ascending colon, hepatic flexure and the right half of the transverse colon.

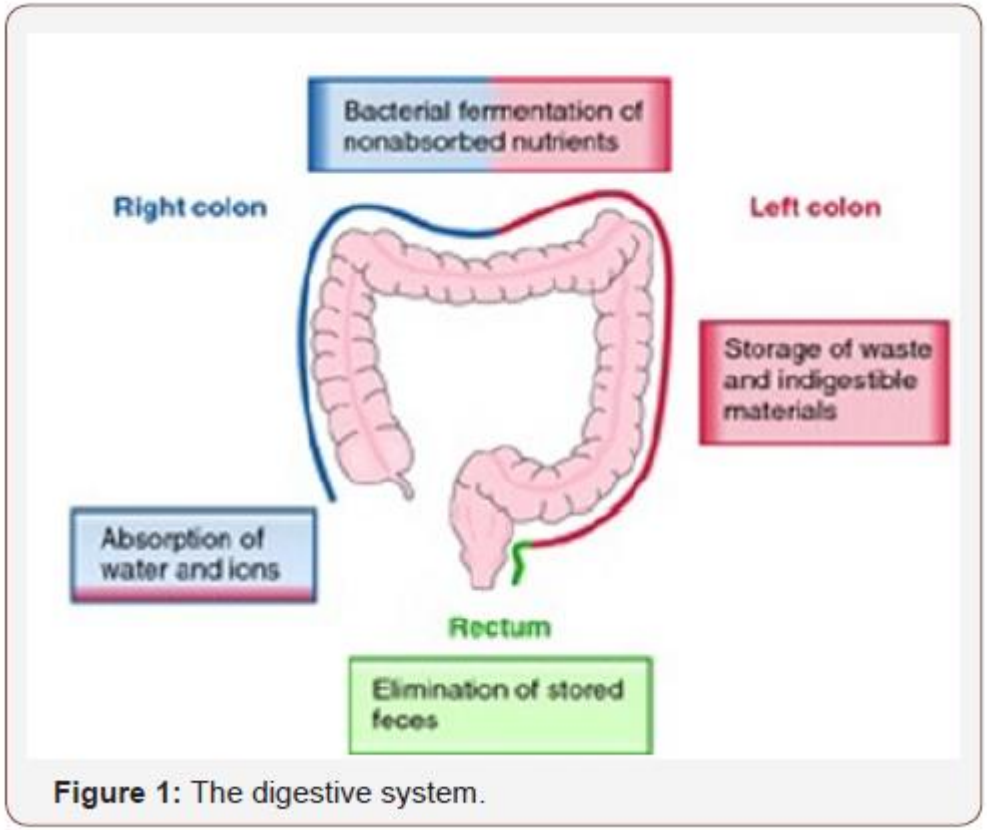


Figure 1: The digestive system.

B3.1b
Components of a procedure specified in the root operation definition or explanation as integral to that root operation are not coded separately. Procedural steps necessary to reach the operative site and close the operative site, including anastomosis of a tubular body part, are also not coded separately.

Examples: 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.

Laparotomy performed to reach the site of an open liver biopsy is not coded separately. **In a resection of sigmoid colon with anastomosis of descending colon to rectum, the anastomosis is not coded separately**

ICD-10-PCS Official Guidelines for Coding and Reporting 2022

General guidelines

B3. Root Operation

Laparoscopic Hand-Assisted is coded to the OPEN approach per the ICD-10-PCS guidelines

An approach value for any operative procedure may not be obvious when reading the brief description of the procedure note. The operative report should be gleaned in entirety when assigning PCS codes. We have noticed a trend of coders missing "hand assisted" or "Laparoscopic assisted" in the documentation. In addition, be on the lookout for laparoscopic procedures being converted to open.

Hand-assisted laparoscopy (HAL) allows surgeons direct hand contact with the operative field, maximizing tactile feedback and minimizing surgical injury to the patient.

Hand-assisted laparoscopy (HAL) utilizes all the principles of standard transperitoneal laparoscopy. A pneumoperitoneum is created to insufflate the abdomen, increasing the working space. A laparoscope is introduced to provide magnified visualization of the operative field, and laparoscopic instruments are utilized to perform the surgery. The only difference between standard laparoscopy and HAL is that the surgeons are also able to introduce their hand into the operative field.

The hand may be introduced through variously placed incisions in the anterior abdominal wall, depending upon the procedure to be performed and the surgeon’s preference.

This technique is being utilized for colon resections, splenectomy, hysterectomy, distal pancreatectomy, partial hepatectomy and other complex laparoscopic procedures

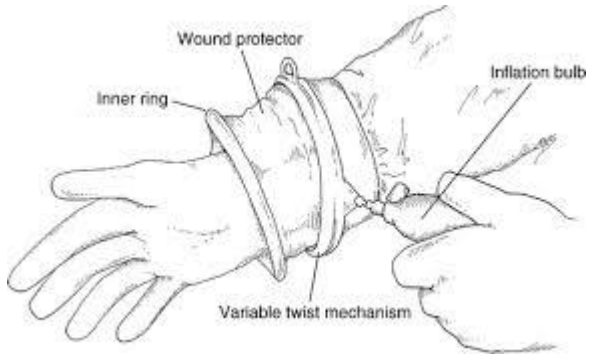
Guideline Reference

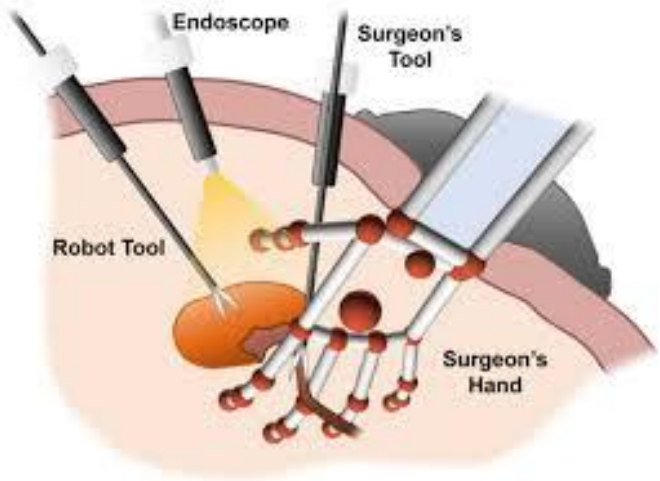
B5.2 Procedures performed using the open approach with percutaneous endoscopic assistance are coded to the approach Open. Example: Laparoscopic-assisted sigmoidectomy is coded to the approach
Open.

Hand assisted Laparoscopic surgeries

HAND ASSISTED LAPAROSCOPY

Hand-assisted laparoscopic surgery is an alternative laparoscopic approach in which a minilaparotomy is planned and performed to enable the surgeon to introduce his or her hand while the pneumoperitoneum is maintained and the dissection maneuvers are performed under videoendoscopic control





B5.2a
Procedures performed using the open approach with percutaneous endoscopic assistance are coded to the approach Open.
Example: Laparoscopic-assisted sigmoidectomy is coded to the approach Open

Open approach with percutaneous endoscopic assistance
ICD-10-PCS Official Guidelines for Coding and Reporting 2022
B5.2a

LAPAROSCOPIC PROCEDURES WITH EXTENSION OF INCISION

- Guideline B5.2b was added to the FY 2021 guidelines of the Medical and Surgical section.

- The guideline was added for the percutaneous endoscopic approach with extension of incision. This guideline is described in more detail as procedures performed using the percutaneous endoscopic approach made with incision or requiring an extension of the incision to assist in the removal of all or a portion of a body part or to anastomose a tubular body part to complete the procedure.

- These procedures should be coded to the approach value percutaneous endoscopic. For example, this new approach coding guideline would apply when a laparoscopic nephrectomy with midline incision to remove the kidney.

- Another example where this coding guideline can be applied is a robotic laparoscopic prostatectomy requiring an extension of the incision to remove the patient's prostate. This should be coded to the Percutaneous Endoscopic approach value.

Percutaneous endoscopic approach with extension of incision
B5.2b
Procedures performed using the percutaneous endoscopic approach, with incision or extension of an incision to assist in the removal of all or a portion of a body part or to anastomose a tubular body part to complete the procedure, are coded to the approach value Percutaneous Endoscopic. Examples: Laparoscopic sigmoid colectomy with extension of stapling port for removal of specimen and direct anastomosis is coded to the approach value percutaneous endoscopic. Laparoscopic nephrectomy with midline incision for removing the resected kidney is coded to the approach value percutaneous endoscopic. Robotic-assisted laparoscopic prostatectomy with extension of incision for removal of the resected prostate is coded to the approach value percutaneous endoscopic.

Question:
A patient underwent a complete left nephroureterectomy. The kidney and proximal ureter were removed via "hand-assisted" laparoscopy and the distal ureter was removed from the bladder via an incision. What is the appropriate ICD-10-PCS code assignment for a left nephroureterectomy when two planned approaches are used to completely remove the ureter?

Answer:
The left kidney and proximal ureter were excised using a "hand port" laparoscopic-assisted approach. At surgery, an 8-cm incision was made to gain access to the distal ureter site. This is considered an open approach. For the left nephroureterectomy assign the following ICD-10-PCS procedure codes:

0TT10ZZ Resection of left kidney, open approach

0TT70ZZ Resection of left ureter, open approach

Hand-assisted laparoscopy nephroureterectomy

ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2014 Page: 16 Effective with discharges: September 15, 2014

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*Ciox Employees please refer to the Yammer group for guidelines.

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