ICD-10-CM
General Surgery

WVUPC
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It’s changing everything

One huge change with ICD-10-CM is that there will be more codes to select from. ICD-9 has about 14,000 codes. ICD-10 starts with 68,000 codes and can go higher. ICD-9 did not have a code for a cranialrectal blockage, so you couldn’t code that diagnosis or you had to select an unspecified code, but now you can have a code for a cranialrectal blockage (YOU do know that cranialrectal blockage is not a real disease or injury). ICD-10 is going to change the way YOU do business..
Documentation Importance

Why? It is 100% dependent on medical record documentation. ICD-9 was forgiving to a doctor who is lax on their documentation.

Steve could visit Dr Smith with pain in his right ear.

All Dr Smith had to document was that Steve has OM which is short for otitis media and the coder could select a code for simple OM

That code is 382.9 - Unspecified otitis media, Otitis media: NOS, acute NOS, chronic NOS

ICD-10 will require more work on the provider to document the exact type of diagnosis found with the patient. ICD-10 demands documentation of the anatomical area affected and allows for coding of chronic modalities.

Under ICD-10-CM, you have the following codes for Otitis Media:
- H66.9 Otitis media, unspecified
- H66.90 Otitis media, unspecified, unspecified ear
- H66.91 Otitis media, unspecified, right ear
- H66.92 Otitis media, unspecified, left ear
- H66.93 Otitis media, unspecified, bilateral
“Document the visit as if you had to appear in court to defend your actions."

“Document the visit as if your paycheck and career is on the line.”

Coders will spend a lot of time returning medical records for additional information because the documentation is insufficient to code the visit with 100% truth, accuracy and correctness.
Documentation themes

- Document comorbidities with detail that will show their impact on patient condition even if it is not the primary problem
- Documents the clinical findings/indicators to support the diagnosis documented
- Document a clear LINK between underlying condition and related, secondary or causal illness whenever appropriate
- Partner with the Clinical Documentation Improvement Specialist if you have questions, are queried, are documenting an uncommon diagnosis or procedure
- Document location with as much specificity as possible
- Document related, secondary or causal illness whenever appropriate
Signs and Symptoms

• Signs and symptoms
Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (codes R00.0 - R99) contains many, but not all codes for symptoms.

• 5 Conditions that are an integral part of a disease process
Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

• 6 Conditions that are not an integral part of a disease process
Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.
General Surgery providers are responsible for a wide array of diagnoses and procedures. By identifying those used most frequently and those with high ICD-10 impact, this module will

- Provide specific knowledge for a common core of diagnoses
- Identify concepts of ICD-10 specificity to apply to any diagnoses

**General Surgery Diagnoses Included:**

- Post Operative Complications
- Appendicitis
- Cholecystitis
- Hernia
- Pancreatitis
- Neoplasms
- Diagnoses of the Digestive Track
- Sepsis and Septic Shock
- Respiratory Failure
- Ulcers
  - Ulcers of the digestive tract
  - Ulcerative Colitis
  - Non-pressure skin ulcers
  - Pressure (Decubitus) ulcers
- Anemia
- Blood Loss Anemia
Post Op Complications

Complications with a procedure or a device requires the same specificity of documentation regardless of the initial cause or patient presentation:

• Clearly defining the complication either of procedure or device
• Identifying the complication as causal to the patient presentation
• Clearly identifying if this was an expected or unexpected outcome
Complications cont..

Treatment of a complication resulting from a surgical procedure
When the admission/encounter is for treatment of a complication resulting from a surgical procedure, designate the complication as the principal or first-listed diagnosis if treatment is directed at resolving the complication

Complication from surgical procedure for treatment of a neoplasm
When an encounter is for treatment of a complication resulting from a surgical procedure performed for the treatment of the neoplasm, designate the complication as the principal/first listed diagnosis. See guideline regarding the coding of a current malignancy versus personal history to determine if the code for the neoplasm should also be assigned.
Post Operative Pain

- **Postoperative Pain**
  The provider’s documentation should be used to guide the coding of postoperative pain, as well as Section III. Reporting Additional Diagnoses and Section IV. Diagnostic Coding and Reporting in the Outpatient Setting. The default for post-thoracotomy and other postoperative pain not specified as acute or chronic is the code for the acute form. Routine or expected postoperative pain immediately after surgery should not be coded.

- **Postoperative pain not associated with specific postoperative complication**
  Postoperative pain not associated with a specific postoperative complication is assigned to the appropriate postoperative pain code in category G89.

- **Postoperative pain associated with specific postoperative complication**
  Postoperative pain associated with a specific postoperative complication (such as painful wire sutures) is assigned to the appropriate code(s) found in Chapter 19, Injury, poisoning, and certain other consequences of external causes. If appropriate, use additional code(s) from category G89 to identify acute or chronic pain (G89.18 or G89.28).
Appendicitis

Documenting appendectomy should include two primary indications:

**Character:**
- Acute
- Chronic/Recurrent

**Presence of Peritonitis:**
- Localized
- Generalized

**Examples:**
- Acute appendicitis with localized peritonitis
- Acute appendicitis with generalized peritonitis
Appendicitis Codes

**ICD-9-CM** 540.0 (Acute appendicitis, With generalized peritonitis) or 540.9 (Acute appendicitis, Without mention of peritonitis)

**ICD-10-CM**

**K35.0 Acute appendicitis with generalized peritonitis**
Appendicitis (acute) with perforation
Appendicitis (acute) with peritonitis (generalized) (localized) following rupture or perforation
Appendicitis (acute) with peritonitis with peritoneal abscess
Appendicitis (acute) with rupture
Acute appendicitis

**K35.9 Acute appendicitis, unspecified**
Acute appendicitis NOS
Acute appendicitis with peritonitis, localized without rupture or NOS
Acute appendicitis without generalized peritonitis
Acute appendicitis without perforation
Acute appendicitis without peritoneal abscess
Acute appendicitis without rupture
Gallbladder/Bile duct

Diagnoses of gallbladder and bile duct are characterized by:

**Location**—gallbladder, bile duct, gallbladder and bile duct - identify if calculi are present

**Inflammation**—with/without cholecystitis, with/without cholangitis

**Character of inflammation**—acute, chronic, acute and chronic

**Obstruction**—with/without

**Examples:**

*Calculus of gallbladder with acute cholecystitis, without obstruction*

*Calculus of Bile duct with acute and chronic cholangitis with obstruction*

*Calculus of gall bladder and bile duct with acute cholecystitis, with obstruction*
Hernia

Documentation for coding hernias is consistent with many location specific conditions, requiring the following documentation: location, complication, instance

**Location:** Should contain laterality

Examples:
- Bilateral inguinal hernia
- Unilateral inguinal hernia

**Complication**

Examples:
- Umbilical hernia with gangrene
- Incisional hernia with obstruction, without gangrene

**Instance:** Used to identify recurrence

Examples:
- Bilateral femoral hernia, with gangrene, recurrent
188.9 (Inguinal hernia, without mention of obstruction or gangrene, unspecified) Inguinal hernia NOS

ICD-10 Needs to be more specific:

K40 Inguinal hernia
   Includes:
   - bubonocele direct inguinal hernia
   - double inguinal hernia
   - Indirect inguinal hernia
   - inguinal hernia NOS
   - oblique inguinal hernia scrotal hernia

K40.90 Unilateral inguinal hernia, without obstruction or gangrene, not specified as recurrent Inguinal hernia NOS
Unilateral inguinal hernia NOS
Pancreatitis

Documentation for pancreatitis should include:

- Acute or Chronic
- Cause
- Identity of drug, when applicable

**NOTE:** When documenting Chronic, alcohol-induced pancreatitis, it is important to document alcohol abuse and dependence as a concurrent condition.
Neoplasms will be defined location and behavior - Location specificity should include:

• Laterality
• Specificity
• Any overlapping sites
• Document site, state morphology e.g. benign, in situ, malignant, uncertain behavior, document the stage and any metastatic sites.
• Tobacco use, dependence, past history, or exposure (second hand, occupational, etc.)
• Reason for the patient’s current admission/encounter, or when the patient is admitted for a specific treatment related to the neoplasm, e.g. chemo, surgical removal, radiation therapy

Examples:

*Malignant neoplasm of overlapping sites of bone and cartilage of right limb*

*Malignant melanoma of nose*

*Merkel cell of the left eyelid, including canthus*
Neoplasms cont..

Primary vs. Metastatic Sites

Coding for treatment of primary sites differs from that of treatment directed at secondary or other sites.
- Document primary site
- Document malignancies
- Identification of direction of treatment

Documenting histology of neoplasms

The documentation of a specific histology helps to direct coding of neoplasm diagnosis.
- Document that a neoplasm cannot be determined after histology study to be Malignant, benign, or uncertain behavior.
- Clinical information by acknowledging the cytology, pathology or histology findings in the notes.
- When histology is known, document clearly.

Neoplasm complication:

These are conditions that complicates the neoplasm, they are either adverse reaction to neoplastic treatment or the progression of neoplastic disease e.g. neoplastic anemia, pathological fracture due to a neoplastic process, vomiting secondary to chemo.
- Clearly document the reason for the encounter, the conditions that requires treatment e.g. dehydration, anemia.
- Specify any drug causing adverse effects and the adverse effects of treatments e.g. anemia secondary to anemia.
Neoplasm Complications

Episode of care involves surgical removal of neoplasm

- When an episode of care involves the surgical removal of a neoplasm, primary or secondary site, followed by adjunct chemotherapy or radiation treatment during the same episode of care, the neoplasm code should be assigned as principal or first-listed diagnosis, using codes in the C00-D49 series or where appropriate in the C83-C90 series.

Complication from surgical procedure for treatment of a neoplasm

- When an encounter is for treatment of a complication resulting from a surgical procedure performed for the treatment of the neoplasm, designate the complication as the principal/first listed diagnosis. See guideline regarding the coding of a current malignancy versus personal history to determine if the code for the neoplasm should also be assigned.

Current malignancy versus personal history of malignancy

- When a primary malignancy has been excised but further treatment, such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed.
Neoplasm Codes

ICD-9-CM
• 153.9 Malignant neoplasm of colon

ICD-10-CM Needs to be more specific
• C18 Malignant neoplasm of colon
• C18.0 Malignant neoplasm of cecum
• C18.2 Malignant neoplasm of ascending colon
• C18.4 Malignant neoplasm of transverse colon
• C18.6 Malignant neoplasm of descending colon
• C18.7 Malignant neoplasm of sigmoid colon

ICD-9-CM
• 550.90 (Malignant neoplasm of other and ill-defined sites, (Abdomen)

ICD-10
• C76.2 Malignant neoplasm of abdomen
  (Needs more info on anatomical body within abdomen affected with neoplasm)
ICD-9-CM

174.9 (Malignant neoplasm of female breast, Breast (female), unspecified)

ICD 10-CM

C43.52 Malignant melanoma of skin of breast
C50 Malignant neoplasm of breast
- Includes: connective tissue of breast, Paget's disease of breast, Paget's disease of nipple.
- Use additional code to identify estrogen receptor status (Z17.0, Z17.1)
- Excludes1: skin of breast (C43.5, C44.5)

C50.0 Malignant neoplasm of nipple and areola
C50.01 Malignant neoplasm of nipple and areola, female
C50.011 Malignant neoplasm of nipple and areola, right female breast
C50.012 Malignant neoplasm of nipple and areola, left female breast
C50.019 Malignant neoplasm of nipple and areola, unspecified female breast
C50.11 Malignant neoplasm of central portion of breast, female
C50.111 Malignant neoplasm of central portion of right female breast
C50.112 Malignant neoplasm of central portion of left female breast
C50.119 Malignant neoplasm of central portion of unspecified female breast
C50.21 Malignant neoplasm of upper-inner quadrant of breast, female
C50.211 Malignant neoplasm of upper-inner quadrant of right female breast
C50.212 Malignant neoplasm of upper-inner quadrant of left female breast
C50.219 Malignant neoplasm of upper-inner quadrant of unspecified female breast
C50.31 Malignant neoplasm of lower-inner quadrant of breast, female
C50.311 Malignant neoplasm of lower-inner quadrant of right female breast

C50.312 Malignant neoplasm of lower-inner quadrant of left female breast
C50.319 Malignant neoplasm of lower-inner quadrant of unspecified female breast
C50.41 Malignant neoplasm of upper-outer quadrant of breast, female
C50.411 Malignant neoplasm of upper-outer quadrant of right female breast
C50.412 Malignant neoplasm of upper-outer quadrant of left female breast
C50.419 Malignant neoplasm of upper-outer quadrant of unspecified female breast
C50.51 Malignant neoplasm of lower-outer quadrant of breast, female
C50.511 Malignant neoplasm of lower-outer quadrant of right female breast
C50.512 Malignant neoplasm of lower-outer quadrant of left female breast
C50.519 Malignant neoplasm of lower-outer quadrant of unspecified female breast
C50.61 Malignant neoplasm of axillary tail of breast, female
C50.611 Malignant neoplasm of axillary tail of right female breast
C50.612 Malignant neoplasm of axillary tail of left female breast
C50.619 Malignant neoplasm of axillary tail of unspecified female breast
C50.81 Malignant neoplasm of overlapping sites of breast, female
C50.811 Malignant neoplasm of overlapping sites of right female breast
C50.812 Malignant neoplasm of overlapping sites of left female breast
C50.819 Malignant neoplasm of overlapping
C50.91 Malignant neoplasm of breast of unspecified site, female
C50.911 Malignant neoplasm of unspecified site of right female breast
C50.912 Malignant neoplasm of unspecified site of left female breast
Digestive Diagnoses of the small and large intestines follow the same principles of documentation:

1. Location - Small intestine, large intestine, peritoneum, retroperitoneum
2. Character - Acute, Chronic, Acute and Chronic
3. Cause - Identify the underlying cause or document unknown e.g. alcoholic cirrhosis, Crohn’s disease, ulcerative colitis, diverticulitis
4. Complication - Obstruction, bleeding, perforation, with abscess, without perforation, with diarrhea, state abnormal test/lab findings or link them to a related diagnosis e.g. positive guaiac stool due to internal hemorrhoids
5. Identify the site of bleeding that is visualized or suspected
6. Document medications used e.g. NSAID
7. Tobacco use, dependence, past history, or exposure (second hand, occupational, etc.)
8. Alcohol use, abuse, dependence

Examples:
- Diverticulosis of the small intestine without perforation or abscess
- Allergic gastroenteritis and colitis
- Crohn’s disease of the small intestine with fistula
- IBS with diarrhea
- Postprocedural peritoneal adhesion
Sepsis documentation requires the documentation of:

1. Document if treating a localized or systemic infection (or both)
2. Designation of Sepsis, Severe Sepsis, Septic Shock
3. Identification of underlying infection or causal organism

**SEPSIS:**
- Identify cause of infection or causal organism
- Document the sepsis onset e.g. at admission (POA) or during admission
- **Urosepsis** is not an acceptable term and will result in query

**SEVERE SEPSIS:**
- Identify cause or causal organism
- Identify acute organ dysfunction

**SEPTIC SHOCK:**
- Identify cause or casual organism
- Identify circulatory failure
- Identify any additional acute organ dysfunction

Bacteremia- is defines as bacteria in the blood (i.e. positive blood culture), it does not constitute sepsis. More clarification will be needed when Bacteremia is documented.
Sepsis/SIRS

Sepsis/ SIRS - Special Situations to Document:

• Any non-infectious process that results in septic shock—trauma, burn, post-procedural—the connection between the event and shock must be very clearly documented

The same documentation requirements for shock apply to SIRS:

• Causal agent
• Presence of SIRS
• Any acute organ dysfunction

There is no longer a code for SIRS occurring due to an infectious process in ICD-10 CM. If a patient presents with a localized infection, SIRS, and a clinical picture of sepsis, clearly document sepsis as a diagnosis.
Sepsis Code Sequencing

Sepsis due to a post-procedural infection
Sepsis resulting from a post-procedural infection is a complication of medical care. For such cases, the post-procedural infection code, such as,

- T80.2, Infections following infusion, transfusion, and therapeutic injection.
- T81.4, Infection following a procedure.
- T88.0, Infection following immunization.
- O86.0, Infection of obstetric surgical wound, should be coded first, followed by the code for the specific infection.

If the patient has severe sepsis the appropriate code from subcategory R65.2 should also be assigned with the additional code(s) for any acute organ dysfunction.
Respiratory Failure

Respiratory Failure *never* a single diagnosis—always an associated cause

**Documenting Respiratory Failure:**
1. Diagnosis *does not* require mechanical ventilation
2. Must document as *acute, chronic, or acute and chronic*
3. Must be defined as *hypercapnic* or *hypoxic*
4. If respiratory failure is *post-procedural*, specify if this is a *complication* or an *expected outcome* of the surgery and specify the etiology (aspiration, radiation, pneumonia, etc.)
5. Document any *tobacco use, dependence, past history, or exposure* (second hand, occupational, etc.)

Documentation of cause and sequence of events vital to assigning the correct codes:

Is respiratory failure the reason the patient was admitted secondary to another cause?

*Patient with myasthenia gravis presents to the ED with acute exacerbation and respiratory failure.*

Did the patient present with a problem that after the admission resulted in respiratory failure?

*Patient with acute on chronic combined heart failure required mechanical ventilation following hospitalization for sepsis and aggressive fluid resuscitation that resulted in respiratory failure.*
Ulcers

Ulcers of the Digestive Tract
- Document the anatomical location and site
- Identify if acute, chronic, or acute ON chronic
- Document id with or without:
  - Perforation
  - Abscess
  - Hemorrhage
- Document the causal relation between the ulcer complications
- Document other related diagnosis e.g. H. Pylori
- Document any associated medication or drugs use and the purpose of its usage e.g. ibuprofen for headache
- Document alcohol use, abuse or dependence

Ulcerative Colitis
- Document the anatomic location/site
- Document the site of bleeding e.g. rectal
- Document the presence of any complication e.g.:
  - Intestinal obstruction
  - Bleeding
  - Fistula
  - Abscess
  - Other complications
- LINK the complication with the underlying condition

Non-pressure skin ulcers
- Document site and laterality
- Document the type:
  - Atherosclerosis
  - Diabetic ulcer
  - Stasis edema
  - Varicose veins with ulcers
  - Ischemic
  - Other type
- Document any underlying conditions
Pressure/Decubitus Ulcers

- Document the site, location of a pressure ulcer, and laterality
- Document gangrene if present
- Document any associated condition, the causal relation and manifestation e.g. diabetes mellitus, PVD
- Document the stages of ulcer
  - Stage I: Non-blanching erythema of the skin (redness that does not turn pale when pressed and released with a fingertip) with intact skin (no dermal ulceration).
  - Stage II: Partial thickness ulceration and loss of epidermis with abrasion, blister, or shallow ulcer.
  - Stage III: Full-thickness ulceration into subcutaneous fat; may extend up to but not through deep fascia.
  - Stage IV: Deep ulceration to muscle, tendons, joint, and/or bone (often with osteomyelitis); extensive tissue necrosis/destruction.
- Unstageable: A scab or eschar forming on the surface may obscure the true extent of the ulcer, which is considered “unstageable”. These must be debrided promptly for correct staging and treatment.
- Deep tissue injury (DTI): Deep tissue injury involves necrosis of subcutaneous fat and/or deep fascia/muscle while the skin still remains intact (is not yet “ulcerated”). With DTI, necrosis of the skin is inevitable and this condition requires extensive deep excisional debridement of all necrotic tissue.
# Anemia

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<thead>
<tr>
<th>Anemia</th>
<th>Blood Loss Anemia</th>
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<tbody>
<tr>
<td>• Document the type of anemia e.g. aplastic, blood loss, hemolytic, etc.</td>
<td>• Document if acute or chronic</td>
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<tr>
<td>• Specify the acuity of the disease e.g. acute, chronic</td>
<td>• Document the underlying cause of the blood loss e.g. trauma, surgery</td>
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<tr>
<td>• Specify the hemolytic anemia as being hereditary, acquired, enzyme disorder, autoimmune, non-autoimmune</td>
<td>• Document the etiology when anemia is identified in the post-operative period e.g. dilutional anemia</td>
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<tr>
<td>• Document any vitamin/mineral deficiencies for nutritional anemia</td>
<td>• When related to a surgical procedure, document if the blood loss was an expected outcome e.g. ruptured abdominal aortic aneurysm, or secondary to a surgical complication e.g. accidental artery puncture.</td>
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<tr>
<td>• Document the underlying cause or if unknown cause e.g. CKD, ulcer, chemotherapy, etc.</td>
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<tr>
<td>• List the name and purpose of substances or medications causing the anemia</td>
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<td>• Link the lab findings to a related diagnosis e.g. leukocytosis to hereditary hemolytic anemia</td>
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<td>• Document blood transfusion</td>
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**OP Surgery ICD 10 Sequencing Rule**

**Outpatient Surgery**

When a patient presents for outpatient surgery (same day surgery)

1. Code the reason for the surgery as the first-listed diagnosis (reason for the encounter), even if the surgery is not performed due to a contraindication

**Ambulatory surgery**

1. For ambulatory surgery, code the diagnosis for which the surgery was performed.
2. If the postoperative diagnosis is known to be different from the preoperative diagnosis at the time the diagnosis is confirmed, select the postoperative diagnosis for coding, since it is the most definitive.
Admission from Outpatient Surgery

When a patient receives surgery in the hospital's outpatient surgery department and is subsequently admitted for continuing inpatient care at the same hospital, the following guidelines should be followed in selecting the principal diagnosis for the inpatient admission:

- If the reason for the inpatient admission is a complication, assign the complication as the principal diagnosis.

- If no complication, or other condition, is documented as the reason for the inpatient admission, assign the reason for the outpatient surgery as the principal diagnosis.

- If the reason for the inpatient admission is another condition unrelated to the surgery, assign the unrelated condition as the principal diagnosis.
Contact

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