ICD-10 Documentation Training for General Surgery
Objectives

At the completion of this lesson the learner will be able to:

• Identify frequently utilized general surgery diagnoses and procedures
• Identify the ICD-10 changes associated with frequently utilized general surgery diagnoses and procedures
• Define documentation recommendations for each diagnosis and procedure
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ICD-10 Diagnosis Documentation Recommendations

ICD-10 Procedure Documentation Recommendations
Diagnostic and Procedure Documentation Overview

• Documentation of most diagnoses related to general surgical procedures consists of four elements: **Cause, Acuity, Location, Character, and Complication**

• The number of general surgery procedure codes has increased. Structure and function of coding has improved to better represent the diagnosis and acuity of general surgery patients and procedures performed.

• This training will:
  – Identify specific diagnoses with ICD-10 changes
  – Present common principles that can be applied to many diagnoses
  – Cover the major documentation and procedural the themes across general surgery documentation such as:
General Surgery Documentation Themes

• Document a clear LINK between **underlying condition**
• Document **comorbidities** with detail that will show their impact on patient condition even if it is not the primary problem
• Document **location** with as much specificity as possible
• Documents the **clinical findings/indicators** to support the diagnosis documented
• Document **related, secondary or causal illness** whenever appropriate
• Recall the **procedure code characters** and ensure documentation is present to support specificity

*Partner with the Clinical Documentation Improvement Specialist if you have questions, are queried, are documenting an uncommon diagnosis*
Assessment

• Question: What resource is available to help ensure proper documentation with complicated, hard to code cases?
Assessment

• **Answer:** Guidance on tips and recommendations for proper documentation from a Clinical Documentation Improvement Specialist is available.
Helpful Hint

To determine how to calculate the new ICD-10 code documentation requirements, think of the acronym “CALCS” (See below). While not all 5 types of documentation will be needed in each case, remembering this acronym will help you to think through the new specifications required and document the case appropriately.

- **C** - Document *causal* agents as clearly as possible
- **A** - Document the condition as *acute* or chronic
- **L** - Document *location* with as much specificity as possible
- **C** - Document the *clinical findings*/indicators to support the diagnosis documented
- **S** - Document related, *secondary* or causal illness whenever appropriate
Assessment

• **Question:** To remember what information is required for proper documentation, recall what the 5 letters in CALCS stand for?
Assessment

• **Answer:** Cause, Acuity, Location, Clinical Findings, Secondary Illnesses
Section 1: ICD-10 Diagnosis Documentation Recommendations

ICD-10 Diagnosis Documentation Recommendations

ICD-10 Procedure Documentation Recommendations
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

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Documenting Post-Operative Complications

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

1. Clearly defining the complication either of procedure or device
2. Identifying the complication as causal to the patient presentation
3. Clearly identifying if this was an expected or unexpected outcome
Appendicitis

Documentation
• Cause
• Acuity
• Location
• Clinical Findings
• Secondary illnesses

Examples and Specifications
• Acuity: acute, chronic/recurrent
• Secondary Illnesses: Presence of peritonitis and if the peritonitis is localized or generalized

Examples
Acute appendicitis with localized peritonitis
Acute appendicitis with generalized peritonitis
Assessment

• **Question**: If a case of appendicitis is accompanied with peritonitis, what descriptors need to be included in the documentation?
Assessment

- **Answer**: Documentation defining the peritonitis as localized or generalized is required to accurately code the appendicitis case.
Disease of the Gallbladder/Bile Duct

Examples and Specifications

- **Acuity:** inflammation  chronic, acute, acute and chronic inflammation
- **Location:** gallbladder, bile duct, gallbladder and bile duct - identify if calculi are present
- **Clinical Findings:** with/without cholecystitis, with/without cholangitis, with/without Obstruction

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
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

**Encounter:** Used to identify recurrence

Examples:
- Bilateral femoral hernia, with gangrene, recurrent
Assessment

• **Question:** Two of the documentation requirements for hernias, location and secondary illness/complications, are captured by the “CALCS” acronym. What additional information needs to be included in the documentation to accurately code the case?
Assessment

- **Answer:** The encounter of the hernia needs to be recorded.
Pancreatitis

**Documentation:**

- **Cause** of pancreatitis
- **Acuity**: Distinction of acute or Chronic
- **Clinical Findings**: Identification of drug, where appropriate

*NOTE: When documenting chronic, alcohol-induced pancreatitis, it is important to document alcohol abuse and dependence as a concurrent condition*
Neoplasms

The documentation requirements for neoplasms includes cause, location, clinical findings, and secondary illnesses.

Examples and Specifications

• **Cause:**
  - 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

• **Location:**
  - Laterality
  - Specificity
  - Any overlapping sites
  - Document site, state morphology e.g. benign, in situ, malignant, uncertain behavior, document the stage and any metastatic sites.
Neoplasms

Examples and Specifications

• Location (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
      • Identify which site the current treatment is directed towards

• Clinical Findings:
  • 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
Neoplasms

Examples and Specifications

- **Secondary Illnesses:**
  - There are conditions that complicate the neoplasm that are either adverse reactions 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.

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
Diagnoses of the Digestive Track

- **Cause:**
  - Identify the underlying cause or document unknown e.g. alcoholic cirrhosis, Crohn’s disease, ulcerative colitis, diverticulitis
  - Tobacco use, dependence, past history, or exposure (second hand, occupational, etc.)
  - Alcohol use, abuse, dependence
- **Acuity:** Acute, Chronic, Acute and Chronic
- **Location:** Small intestine, large intestine, peritoneum, retroperitoneum
  - Identify the site of bleeding that is visualized or suspected
- **Clinical Findings:** Document medications used e.g. NSAID
- **Secondary Illnesses:** 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

**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

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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

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:**
- 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
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:
  – **Cause:** causal agent
  – **Acuity:** any acute organ dysfunction
  – **Clinical Findings:** presence of SIRS

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.
Respiratory Failure

- Respiratory failure is never a single diagnosis—always an associated cause
- 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

**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.)
# Ulcers

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<th>Ulcerative Colitis</th>
<th>Non-pressure skin ulcers</th>
</tr>
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</table>
| **Cause**     | • The causal relation between any ulcer complications  
                         • Alcohol use, abuse or dependence |
|               | LINK the complication with the underlying condition |
|               | • Document any underlying conditions  
                         • Document the type:  
                          • Atherosclerosis  
                          • Diabetic ulcer  
                          • Stasis edema  
                          • Varicose veins with ulcers  
                          • Ischemic  
                          • Other type |
| **Acuity**    | Identify if acute, chronic, or acute ON chronic |
| **Location**  | Document the anatomical location and site |
|               | Document the anatomic location/site |
|               | Document site and laterality |
# Ulcers

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| **Clinical Findings** | • Any associated medication or drugs use and the purpose of its usage e.g. ibuprofen for headache  
• Document id with or without:  
• Perforation  
• Abscess  
• Hemorrhage | | |
| **Secondary Illnesses** | Document other related diagnosis e.g. H. Pylori | The presence of any complication e.g.:  
Intestinal obstruction  
Bleeding  
Fistula  
Abscess  
Other complications | | |
Pressure (Decubitus) Ulcers

- **Cause:** Document any associated condition, the causal relation and manifestation e.g. diabetes mellitus, PVD
- **Location:** Document the site, location of a pressure ulcer, and laterality
- **Clinical Findings:**
  - Document gangrene if present
  - **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
Assessment

**Question**: Which clinical finding for pressure ulcers needs to be documented in order to accurately define and code a patient’s condition?
Assessment

- **Answer:** The stage of the ulcer needs to be included in the documentation to accurately code the patient’s case.
### Anemia

**Cause:**
- Document the type of anemia e.g. aplastic, blood loss, hemolytic, etc.
- Specify the hemolytic anemia as being hereditary, acquired, enzyme disorder, autoimmune, non-autoimmune
- Document any vitamin/mineral deficiencies for nutritional anemia
- Document the underlying cause or if unknown cause e.g. CKD, ulcer, chemotherapy, etc.
- List the name and purpose of substances or medications causing the anemia

**Acuity:** Specify the acuity of the disease e.g. acute, chronic

**Clinical Findings:** Link the lab findings to a related diagnosis e.g. leukocytosis to hereditary hemolytic anemia

- Document blood transfusion

### Blood Loss Anemia

**Cause:**
- Document the underlying cause of the blood loss e.g. trauma, surgery
- 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.

**Acuity:** Document if acute or chronic

**Clinical Findings:** Document the etiology when anemia is identified in the post-operative period e.g. dilutional anemia
Section 2: ICD-10 Procedure Documentation Recommendations

- ICD-10 Diagnosis Documentation Recommendations
- ICD-10 Procedure Documentation Recommendations
Review of ICD-10 Procedure Code Structure

ICD-10 Procedure documentation: More granular and precise

Focus for Providers: Understand concepts related to coding capture rather than memorize every detail

- Procedure documentation can be thought of on multiple characters
- Each character captures an increased amount of provider documentation in respect to the service or procedure performed
Section: Starting point for coding procedures.
- Provides the coder with the initial criteria to class information and narrows available codes

General surgery procedures are located in highlighted sections

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General Surgery Examples of Section:
- Medical and Surgical—appendectomy, splenectomy, cholecystectomy
- Placement—Percutaneous PEG tube placement, vas cath placement, Trach tube placement
- Extracorporeal—induced hypothermia, mechanical ventilation, hemodialysis
Body System:
As the character increases so does the specificity of documentation and coding.

Depending on the section identified the character may be:

- Body System
- Physiologic System
- Anatomic Region

General Surgery Examples of Body System:
- Liver
- Liver, right lobe
- Liver, left lobe
- Hepatic Duct, Right
- Hepatic Duct, left
- Cystic Duct
- Common Bile Duct
Root Operation determines the purpose of a procedure. There are 31 specific types of root operations that are in 9 groups:

1. Procedures that take out some or all of a body part
2. Procedures that take out solids/fluids/gases from a body part
3. Procedures involving cutting or separating only
4. Procedures that put in/put back or move some/all of a body part
5. Procedures that alter the diameter/route of a tubular body part – can be performed only on tubular body parts
6. Procedures that always involve a device
7. Procedures involving examination only
8. Procedures that define other repairs
9. Procedures that define other objectives
Documenting for Root Operation:

- Don’t attempt to memorize the coding verbiage for each root operation
- Ensure that documentation of each procedure has a clear objective/purpose
- Ensure that one of the 9 groupings of operations can be identified

General surgery Examples of Root Operation:

- Resection—total nephrectomy
- Inspection—exploratory laparotomy
- Drainage—incision and drainage of abscess, drainage of ascites
- Excision—partial nephrectomy, liver biopsy
Body Part: Very specific and detailed.

The type of procedure dictates the specificity of documentation:

- A body part
- Some of a body part
- Area around a body part
- In or On a body Part
- Conduction mechanism (brain or heart)

General Surgery Examples of Body Part:
Hand
Right Hand
Thumb
Proximal phalanx of right thumb
Distal phalanx of right thumb
Approach: Defined based on access location, method and types of instrumentation used:

- **Open**—Cutting through skin or mucous membrane and other body layers necessary to expose procedure site
- **Percutaneous**—Entry, by puncture or incision, of instrumentation through skin or mucous membrane and other body layers necessary to reach procedure site
- **Percutaneous endoscopic**—Entry, by puncture or minor incision, of instrumentation through skin or mucous membrane and other body layers necessary to reach and visualize procedure site
- **Via natural or artificial opening**—Entry of instrumentation through natural or artificial external opening to reach procedure site
- **Via natural or artificial opening endoscopic**—Entry of instrumentation through natural or artificial external opening to reach and visualize procedure site
- **Open with percutaneous endoscopic assistance**—Cutting through skin or mucous membrane and other body layers necessary to expose procedure site, and entry, by puncture or minor incision, of instrumentation through skin or mucous membrane and other body layers necessary to aid in performance of the procedure.
- **External**—Procedures performed directly on skin or mucous membrane and procedures performed indirectly by application of external force through skin or mucous membrane
Assessment

• **Question:** What are the 3 determinants for coding an “approach”?
Assessment

- **Answer:** Location, method, instrumentation
• Devices left in place at the completion of a procedure are coded
• Devices describing how a procedure is performed are not equal to this device character
• Instruments for visualization are specified in the approach character
• Materials incidental to a procedure such as clips and sutures are not considered devices

General Surgery Examples of Devices:
– Non-Autologous Tissue
– Autologous Tissue
– Synthetic Substitutes
– Drainage Devices
– Enteral feeding devices
Assessment

• **Question:** What devices require documentation to accurately code the surgical procedure under ICD-10?
Assessment

• **Answer:** Devices that are left in the body after the procedure require documentation.
**Qualifier**: defines the “qualifier” or an additional attribute of the procedure, when appropriate

- Not all procedure codes require qualifiers
- Data adds specific, clarifying information that is not contained in another character

**General Surgery Examples of Qualifiers:**
- Type of transplant
- Second site for a bypass
- Diagnostic excision (biopsy)
Blood Transfusions

The single data point captured in ICD-9 for blood transfusion was the occurrence of the transfusion. With ICD-10 there are multiple data points that will be captured:

1. Type of cells transfused (RBC or Frozen RBC)
2. Document location or infusion site (Peripheral artery, Peripheral vein, Central Vein, Central Artery)
3. Document the approach
4. Specify if Autologous or non-Autologous

Important Note:
The receipt of transfusions has to be acknowledged by the provider
Debridement

- Document type of debridement e.g. excisional or non-excisional
- Condition requiring debridement e.g. ulcer, fracture, etc.
- Depth of debridement (deepest layer)
- Document the body part, and the laterality
- Document size, and specific tissue removed
- Method(s) used to remove tissue
- Instruments used to remove tissue e.g. scalpel, scissors, etc.
Biopsy

• Document the root operation e.g. excision, resection, etc.
• Document specific site and laterality (if applicable)
• Document approach e.g. open, percutaneous endoscopic, etc.
I&D/ Venous catheterization

**I&D**
- Specify if skin, subcutaneous tissue or fascia
- Laterality
- Document approach e.g. open, percutaneous endoscopic, etc.
- Document location e.g. femoral region

**Venous Catheterization**
- Document Anatomic specificity, site and laterality
- Document approach
New Concepts for Mechanical Ventilation in ICD-10:

1. Respiratory Assistance vs. Respiratory Performance
   - Assistance is respiratory support delivered via mask or non-invasive device (CPAP, BiPAP)
   - Performance is respiratory support delivered via invasive ETT device (nasal, oral, trach)

2. Duration of Ventilator support
   - less than 24 hours
   - 24-96 hours
   - more than 96 hours

3. Capture of detail of support
   - Continuous Positive Airway Pressure
   - Intermittent Positive Airway Pressure
   - Continuous Negative Airway Pressure
   - Intermittent Negative Airway Pressure

**Respiratory Arrest:**
- Is not a diagnosis
- Is a clinical finding for which a more definitive diagnosis should be determined
- Is appropriate to describe an initial finding
Putting It All Together

Coding Descriptions for Appendectomy

0DTJ Appendix >
  0DTJ0 Open >
    0DTJ0ZZ Resection of Appendix, Open Approach
  0DTJ4 Percutaneous Endoscopic >
    0DTJ4ZZ Resection of Appendix, Percutaneous Endoscopic Approach
  0DTJ7 Via Natural or Artificial Opening >
    0DTJ7ZZ Resection of Appendix, Via Natural or Artificial Opening
  0DTJ8 Via Natural or Artificial Opening Endoscopic >
    0DTJ8ZZ Resection of Appendix, Via Natural or Artificial Opening Endoscopic