These codes may be used even if treatment is begun for a suspected condition that is ruled out.

Chapter 17, Congenital Malformations, Deformations, and Chromosomal Abnormalities, also has some additional codes, including:

- Q20.4 Double inlet left ventricle

ICD-10-PCS coding of congenital heart repair has been problematic due to lack of codes to capture some of the appropriate procedures. Luckily, the AHA Coding Clinic for ICD-10-CM/PCS, Third Quarter 2014, addresses some of the issues relating to the repair of congenital heart defects, including:

- Blalock-Taussig shunt
- Fontan completion procedure, stage II
- Repair of tetralogy of Fallot

Additional issues of Coding Clinic have been released to address other congenital problems, including:

- Vascular ring and double aortic arch
- Congenital hyperbilirubinemia versus transient hyperbilirubinemia
- Craniosynostosis with cranial vault reconstruction

The Official Guidelines for Coding and Reporting state that the Z38 codes may only be assigned once to a newborn at the time of birth. This differs from physician billing as the physician may assign the Z38 code for each visit during the birth admission.

As ICD-10-CM/PCS evolves, CDI specialists need to stay up to date on the official coding advice offered to ensure that we are capturing the most appropriate codes and procedures.

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CODING CLINIC FOR CDI

Reassessing debridement documentation

The AHA’s Coding Clinic for ICD-10-CM/PCS, Third Quarter 2015, opens with a discussion of the differences between excisional and non-excisional debridement—diagnoses with a long history of causing coding and clinical documentation confusion.

The new code set hasn’t made it any easier, as this edition of Coding Clinic includes eight questions on the matter on pp. 3–8, and an additional question regarding non-excisional debridement of cranial wound with removal and replacement of hardware.

The bottom line, really, is that just because a physician documents use of a sharp instrument to remove devitalized tissue does not necessarily mean that an excisional debridement was performed.

There are times when a physician may need to clean an area for a procedure or perform an excisional debridement that is not integral to the procedure itself. In such cases, the documentation in the medical record needs to be as clear as possible regarding what the physician did and why he or she did it. If a cleaning was performed as part of an overall procedure, it may not be coded separately. However, if a provider performs a true excisional debridement, it could require separate code assignment.

This issue of Coding Clinic emphasizes that a code is assigned for excisional debridement when the provider documents “excisional debridement” and/or the documentation meets the definition of the Excision root operation.

Excision is defined in ICD-10-PCS as cutting out or off, without replacement, a portion of a body part. Excisional debridement is considered a surgical procedure that results in a surgical MS-DRG and a higher relative weight, which translates into a higher reimbursement.
Root operations that employ cutting to accomplish the objective allow the use of any sharp instrument, including but not limited to scalpel, wire, scissors, bone saw, and electrocautery tip.

Elements that must be documented in the medical record to support an excisional debridement include:

- Technique used by the provider (cutting, scrubbing, trimming)
- Instruments used (scissors, scalpel, pulse lavage, or curette)
- Nature of the tissue removed (slough or necrosis, devitalized tissue, or non-viable tissue)
- Appearance and size of the wound (fresh bleeding tissue or viable tissue)

Last but not least, the physician needs to document the depth of the debridement. Teaching providers and non-providers to use the verbiage “down to and including” removes any uncertainty as to the exact depth of the excision.

I often teach new CDI specialists to think of the mnemonic device “TINA D.,” which stands for technique, instrument, nature of tissue, appearance, and depth. This makes remembering all the information needed for appropriate code assignment a little easier.

Excisional debridements can be performed by nurses, therapists, physician assistants, or physicians, and must be documented as such by the person who performed the debridement. An excisional debridement can be performed in many areas in a facility. The location of where the procedure is performed has no bearing on whether it is considered excisional or non-excisonal. External auditors require explicit documentation to support an excisonal debridement, so CDI professionals need to make sure they have all the proper documentation in the chart.

Non-excisonal debridement is the non-operative brushing, irrigation, scrubbing, or washing of devitalized tissue, necrosis, slough, or foreign material. Non-excisonal debridement does not result in a surgical DRG payment. If the documentation indicates a non-excisonal debridement was performed, it will be classified to the root operation Extraction, defined as pulling or stripping out or off all or a portion of a body part by the use of force.

The ICD-10-PCS Official Guidelines for Coding and Reporting (A11) state, “[M]any of the terms used to construct PCS codes are defined within the system. It is the coder’s responsibility to determine what the documentation equates to in the PCS definitions.”

The provider is not expected to use the terms used in PCS code descriptions, nor is the coder required to query the provider when the correlation between the documentation and the defined PCS term is clear.

When multiple layers of the same site are debrided, only a code for the deepest layer will be assigned. Coders cannot assume that the debridement of bone, fascia, or muscle is always excisional. ICD-10-CM/PCS does not provide a default if the debridement is not specified as excisional or non-excisonal; for this reason, provider education should include use of verbiage such as “down to and including” so the subject is not left open to interpretation.

As mentioned, it is the coder’s responsibility to determine what the documentation equates to in ICD-10-PCS to determine code assignment for a procedure. It is also important for the CDI specialist to have knowledge of the different definitions used in ICD-10-PCS, including root operations, surgical approaches, devices, and qualifiers, so coders have all the information needed for proper code assignment.

Per the ICD-10-PCS Official Guidelines for Coding and Reporting (B3.3), “If a procedure is discontinued before any other root operation is performed, [assign] the code for the root operation of ‘inspection’ for the body part or anatomical region inspected.”

If, for any reason, the documentation in the medical record is unclear about what was done, a query should be generated to clarify the procedure with the physician. As coders and CDI specialists, we cannot assume anything—the documentation needs to clearly reflect what actually happened to the patient.

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