2013 Coding, Documentation, and Compliance Update
Orthopaedic Trauma – Inpatient Facility and Physician

2013 CODING, DOCUMENTATION, AND COMPLIANCE UPDATE
Orthopaedic Trauma – Inpatient Facility and Physician

Presented by:
Sheila Sylvan
IMPACT!
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Faculty and Planner Disclosure

Laura Driscoll
Sheila Sylvan
IMPACT Medical Consulting

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INPATIENT REIMBURSEMENT
OVERVIEW
Inpatient DRG Determination

- Principal diagnosis
- Secondary diagnoses
- Procedure codes
- Gender
- Age
- Discharge Disposition

Not always a factor

Chief Complaint vs. Principal Diagnosis

- The **CHIEF COMPLAINT** can be defined as the ‘presenting problem’ for which the patient presents to the hospital or other site for care.

- The **PRINCIPAL DIAGNOSIS** is defined in the Uniform Hospital Discharge Data Set (UHDDS) as “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”
Guidelines for Reporting Diagnoses

- Report all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay.

- Conditions documented at discharge as uncertain (e.g., rule out, possible, probable or suspected) are coded as if they exist, in anticipation that further diagnostic studies may be performed.

- Report conditions affecting patient care
  - clinical evaluation
  - therapeutic treatment
  - diagnostic procedures
  - extended LOS
  - increased nursing care or monitoring

Inpatient “CC’s” -- Complications & Comorbidities

- Complication – A condition that arises during the hospital stay that extends the length of stay by at least one day in 75% of the cases.

- Comorbidity – Pre-existing condition that will extend the length of stay by at least one day in 75% of the cases because it coexists with the principal diagnosis.

- The MS-DRG system recognizes both CC and major CC (MCC).
Inpatient “CC’s” -- Complications & Comorbidities

<table>
<thead>
<tr>
<th>Examples of Vague Language</th>
<th>More Specific Documentation Which May Affect DRG Assignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes poorly controlled</td>
<td>Uncontrolled diabetes, specific manifestations</td>
</tr>
<tr>
<td>Anemia</td>
<td>Specific type of anemia (eg, acute blood loss)</td>
</tr>
<tr>
<td>Respiratory insufficiency</td>
<td>Respiratory failure, and acute vs. chronic</td>
</tr>
<tr>
<td>NA = 120</td>
<td>Hyponatremia, and cause if known</td>
</tr>
<tr>
<td>Renal insufficiency</td>
<td>Severity of chronic kidney disease</td>
</tr>
<tr>
<td>Tachycardia</td>
<td>Specific type of tachycardia</td>
</tr>
<tr>
<td>Pressure ulcer</td>
<td>Pressure ulcer stage, site, and if pre-existing</td>
</tr>
<tr>
<td>Obesity</td>
<td>Morbid obesity, and Body mass index</td>
</tr>
</tbody>
</table>

CMS Focus on Patient Safety

- Hospital Acquired Conditions (HAC) -- Secondary diagnoses must be reported with an appropriate POA (Present on Admission) indicator. Relevant HACs to orthopaedic care include:
  - pressure ulcer stages III and IV;
  - surgical site infection following certain orthopedic procedures;
  - deep vein thrombosis and pulmonary embolism following certain orthopaedic procedures.

- "Never Events"

<table>
<thead>
<tr>
<th>Type of Error</th>
<th>Inpatient Remarks Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wrong Surgery on Patient</td>
<td>MX</td>
</tr>
<tr>
<td>Surgery on Wrong Body Part</td>
<td>MY</td>
</tr>
<tr>
<td>Surgery on Wrong Patient</td>
<td>MZ</td>
</tr>
</tbody>
</table>
MS-DRG Assignment

• The relationships between principal diagnosis, secondary diagnoses, and valid O.R. procedures drive MS-DRG assignment.

• The MS-DRG titles do not necessarily reflect all of the elements of an individual patient’s course of care.

• Code according to the documented facts and coding guidelines.

New Coverage Criteria Trends

• Healthcare payor entities have been adopting increasingly stringent coverage criteria.

• These guidelines may be more conservative than the clinical standards of care developed by specialty medical societies.

• While trauma cases are typically less open to challenges of medical necessity, the stricter criteria lead to a need for more specific documentation of patient history and other findings to support medical necessity.
Facility / Physician Coding Issues

Facilities may report procedures using one of two different coding systems:
- For inpatient services -- ICD-9-CM Volume III
- For outpatient services -- CPT® / HCPCS Codes

Physicians report procedures in all settings with CPT®.

These two coding systems do not directly “translate” on a code by code basis.

The payment methodologies and bundling issues are not the same, even when both facility and physician report with CPT® codes.
Procedural Coding Concepts

- HCPCS Coding Family
- Symbols of CPT
- Bundling Issues:
  - CPT Definitions
  - The Correct Coding Initiative (CCI)
  - Private Software
  - Multiple Procedures
  - Surgical Package Concepts
  - Groupers / APC Packaging
- Payor Coverage Criteria

Case Scenario

A question was posed whether a provider would receive separate payment for a combination of procedures and, if so, whether that payment would be at a reduced amount.

This question is not as "simple" as it originally appeared.
Case Scenario – Issues to Consider

- Some procedure codes are paid separately at full rate.
- Some are subject to the multiple procedure payment reduction.
- Some are ancillary or packaged into other services, either always, or in combination only with specific other codes.
- Some services are clearly not separately reimbursed, based upon the CPT code definitions and/or notes.
- It may vary for open surgery vs. arthroscopic procedures.
- It will almost certainly vary by payor type / contract.

Documentation Drives Coding

In all circumstances, documentation indicates the services which may be reported. **The importance of consistent, complete documentation in the medical record cannot be overemphasized.**

Coding is case and patient specific. It is important for the coder and physician to communicate to ensure accurate documentation and coding.

Continued monitoring of complex cases which may arise will help ensure accurate coding.
Injury Diagnosis Coding

- Crushing Injury
- Fractures
- Dislocations
- Intracranial Injuries
- Internal Injury of Thorax, Abdomen and Pelvis
- Open Wounds
- Sprains and Strains
- Burns
- Injury to Nerves and Spinal Cord
- Injury to Blood Vessels
- Contusion with Intact Skin Surface
- Superficial Injury
- Certain Traumatic Complications and Unspecified Injuries

Basic ICD-9-CM Procedure Coding

- If the descriptor for the procedure code does not include “bilateral,” the service may be coded twice to designate both left and right.
- In most circumstances, the operative approach is not reported separately from the procedure. There is usually an instructional note of “omit code.”
- When a procedure is initiated, but not fully completed, code only to the extent of services provided.
- The Principal procedure is that performed for definitive treatment rather than one performed for diagnostic or exploratory purposes, or necessary to take care of a complication, according to sequencing hierarchy.
Injury Procedure Coding

- ICD-9-CM codes for reductions of fractures and dislocations are primarily reported with code 79.xx. Code also any:
  - Application of external fixator device
  - Type of external fixator device, if known

- Alternative coding options to 79.xx include:
  - External fixation alone for immobilization of fracture
  - Internal fixation without reduction of fracture
  - Traction alone for reduction of fracture
  - Specific categories for operations on facial bones, nasal bones, orbit, skull, or vertebrae

- Additional codes for bone grafts, repairs to tendons/lIGaments/muscles, and other structures would be reported in combination, sequentially according to severity or primary injury repair.

Case #1 – Femoral Neck Fracture

PREOPERATIVE DIAGNOSIS(ES): Right valgus impacted femoral neck fracture.

POSTOPERATIVE DIAGNOSIS(ES): Same.  820.02

PROCEDURE(S) PERFORMED:
1. Stress radiograph under anesthesia.
2. Closed reduction and percutaneous pinning of right hip.

TYPE OF ANESTHESIA: General endotracheal.

INDICATIONS: Patient with a valgus impacted femoral neck fracture and was able to walk quite impressively despite significant impaction. Plan was for a stress radiograph under anesthesia to assure that this is indeed a well-impacted fracture. If it is indeed a well-impacted fracture, we will perform our percutaneous pinning. If it is not, we will perform an open reduction and pinning.
Case #1 – Femoral Neck Fracture

PROCEDURE AS FOLLOWS: Patient was brought back to the operating room and given general anesthesia as per the anesthesia staff and placed on the fracture table. The boot was laid loose and under live fluoroscopic views significant traction and rotation was made on the hip, and it was determined that the head and neck definitely moved as a unit even under significant stress with no movement of the fracture, so the leg was put into the boot and the leg was then prepped and draped in the usual fashion.

A surgical pause was taken to identify correct site, correct patient, correct surgery, and prophylactic antibiotics were given.

Once this was confirmed by nursing and anesthesia staff, using a stab incision and then using guidewires a first screw was placed inferior central. Second screw was placed posterior superior. A third screw was placed anterior superior, and a fourth and final screw was placed perpendicular to the fracture line and up inferior in the head.

Once all these guidewires were in appropriate position they were measured and partially threaded screws of appropriate length were placed, all with excellent purchase in compression. The wound was then irrigated and closed with 2-0 Vicryl, 3-0 nylon.

Postoperative plan is for nonweightbearing for 8 weeks.
### Case #1 – Femoral Neck Fracture

<table>
<thead>
<tr>
<th>PROCEDURES</th>
<th>CPT PROCEDURE CODES</th>
<th>ICD-9 PROCEDURE CODES</th>
<th>DIAGNOSIS CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Closed reduction of femoral neck fracture with percutaneous skeletal fixation</td>
<td>72735</td>
<td>79.15</td>
<td>820.02</td>
</tr>
<tr>
<td>Manual application of stress for joint radiography</td>
<td>77071-26</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Radiological exam of hip during operative procedure</td>
<td>73530-26</td>
<td>88.26</td>
<td></td>
</tr>
</tbody>
</table>

**CASE NOTES:** Percutaneous skeletal fixation is a technique which involves internal fixation, and sometimes open incision, but without direct visualization of the fracture site for reduction.

*External Cause of injury code (E-code) cannot be determined via this note, but may be detailed elsewhere in complete record.*

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**Percutaneous Treatment of Femoral Fracture**

72735  
Femoral fracture treatment without fracture exposure

*Source:* CPT™ 2013, pg. 132; ©2012 AMA.
Case Study #2: Right Femoral Neck Fracture

NAME OF PROCEDURE: Closed reduction and percutaneous screw fixation right femoral neck fracture.

IMPLANT: (Brand) cannulated screws times three.

HISTORY AND INDICATION: This is a 28-year-old gentleman who sustained a displaced right femoral neck fracture. He has a below-knee amputation on that same side. He remains severely sedated due to seizures yesterday and was unable to get informed consent. I obtained informed consent today. I discussed all of the risks and benefits of operative versus nonoperative treatment including the risks of avascular necrosis, malunion, nonunion, and posttraumatic arthritis with him in detail. All risks and benefits were gone over in detail. He presents now for open reduction and internal fixation with placement of a traction pin.

V49.75
820.02
780.33 / 780.39

DESCRIPTION OF FINDINGS AND PROCEDURE: After informed consent was obtained, he was taken to the operating room suite and underwent general endotracheal tube anesthesia. Under sterile conditions, a distal femur traction pin was placed. He was then placed on the fracture table and the using traction and internal rotation, we attempted to reduce the fracture. With doing this, it was noted that there was a comminution medially on the neck. Laterally, we were able to line up anatomic, but medially there was still comminution. This was consistent with the CT scan. The right hip was then prepped and draped in the usual sterile manner.
Case Study #2: Right Femoral Neck Fracture

A longitudinal incision was made on the lateral aspect of the hip. Three guidepins were placed (one superior/anterior, one superior/posterior, and one directly inferior). The inferior one was angled somewhat due to the comminution for best purchase. It was confirmed under fluoroscopy, and these were over-drilled laterally and then three screws were placed with good purchase.

The wound was irrigated out. The wound was closed using #2-0 (brand) sutures and skin staples. The wound was dressed with sterile 4 x 4s, absorbent dressing, and foam tape. Estimated blood loss 50 cc.

PLAN: For the patient to remain in-house for intravenous antibiotics and physical therapy.

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Closed reduction of femoral neck fracture with percutaneous skeletal fixation</td>
<td>27235</td>
<td>79.15</td>
<td>820.02</td>
</tr>
</tbody>
</table>

CASE NOTES: A diagnosis code was added in 2011 (780.33 – post traumatic seizures), which is identified as a CC in the Medicare Hospital Inpatient Prospective Payment System (MS-DRGs), whereas 780.39 (Seizures NOS) is not a CC.
Case #3 - Distal Radius Fractures

ANESTHESIA: General.
ESTIMATED BLOOD LOSS: 10 mL.
TOURNIQUET TIME: 38 minutes.

PREOPERATIVE DIAGNOSIS: Right distal radius fracture. 813.42
POSTOPERATIVE DIAGNOSIS: Same. E888.9

PROCEDURE: Open reduction and internal fixation of right distal radius fracture.

INDICATIONS: A 74-year-old female patient who fell and sustained a displaced distal radius fracture. Risks, benefits and alternatives of various treatment options were discussed. She elected to proceed with surgery. No guarantees of success were made. I was very clear with her that she may require other procedures including removal of hardware, bone grafting. She may have chronic pain, disability or stiffness associated with this. Other medical or surgical complications can and do occur.

She was taken to the operating room and general anesthesia was administered without any complications. The right upper extremity was prepped and draped in the usual sterile fashion. An Esmarch was used to exsanguinate. Tourniquet was inflated to 250 mmHg. An incision over the flexor carpi radialis was taken through skin and subcutaneous tissue. The underlying sheath was identified and opened. Swelling was encountered and the volar compartment fascia was released and a minimal amount of nonviable tissue was debrided. Blunt dissection was taken down to the pronator quadratus, which was lifted off the distal radius.

There were two separate fractures, one in the distal radius and one into the radial shaft. This required a separate utilization of a longer plate than is typically utilized in this procedure to fix the radial shaft.
Case #3 - Distal Radius Fractures

The brachial radialis was lengthened to remove it as a deforming force from the radial styloid. Fracture was then reduced distally. The plate was applied and K-wires were used for provisional fixation. Length was then achieved by applying one screw into the shaft.

Attention was then turned towards the radial shaft. The shaft portion was then reduced and multiple screws were placed into the shaft.

Attention was shifted back to the distal radius. Fixation was completed on greater than three fragments by placing multiple locking screws distally. This completed fixation of the distal radius.

The wound was then thoroughly irrigated with normal saline. Tourniquet was released. Fluoroscopic images confirmed acceptable reduction of the fracture and position of the hardware. There was no instability either radiographically or on clinical exam at the distal radial ulnar joint.

The deep dermal layer was closed with interrupted buried 3-0 [suture] and skin was closed with running 3-0 subcuticular [suture] and covered with adhesive strips. The patient tolerated the procedure well and was taken to the recovery room in stable condition.
Case #3 - Distal Radius Fractures

<table>
<thead>
<tr>
<th>PROCEDURES</th>
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<th>ICD-9 PROCEDURE CODES</th>
<th>DIAGNOSIS CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open treatment of distal radial extra-articular fracture, with internal fixation</td>
<td>25607</td>
<td>79.32</td>
<td>813.42</td>
</tr>
<tr>
<td>Open treatment of radial shaft fracture, includes internal fixation</td>
<td>25515</td>
<td></td>
<td>813.21</td>
</tr>
<tr>
<td>Lengthening or shortening of flexor or extensor tendon, forearm and/or wrist, single, each tendon</td>
<td>25280</td>
<td>83.85</td>
<td>813.42 813.21</td>
</tr>
</tbody>
</table>

CASE NOTES: Although two distinct fractures are treated, which can be identified distinctly in CPT, the ICD-9 code for the procedure would be reported only once.

Intraoperative fluoroscopic imaging is bundled into 25607 per CCI.

Case #4 -- Distal Tibia / Fibular Fracture

PREOPERATIVE DIAGNOSIS: Open fracture of the tibia and fibula. 823.32

POSTOPERATIVE DIAGNOSIS(ES): Same.

PROCEDURE(S):
1. Removal of an external fixator.
2. Irrigation and debridement of skin, muscle, soft tissue, fascia and bone associated with an open fracture of the leg.
3. Intramedullary nailing of tibial shaft fracture.
4. Removal of deep implant from the tibia.

ANESTHESIA: General endotracheal.

COMPLICATIONS: None.
Case #4 -- Distal Tibia / Fibular Fracture

INDICATIONS FOR PROCEDURE: 63-year-old male with multiple comorbid conditions who had an open fracture of the tibia and fibula below a plate. He was transferred here for a higher level of care. The patient understands the complexity of the injury and the possibility of limb loss.

DESCRIPTION OF PROCEDURE(S): After it was confirmed consent was obtained for the above procedure and we agreed it was the right leg to be operated on, the patient was taken to the OR where anesthetic was obtained. IV antibiotics were infused. The external fixator was removed in toto. The right lower extremity was prepped and draped in sterile fashion. An incision was made through the old proximal scar and dissection was carried down to the old proximal tibial plate. All the screws from the plate were removed in toto. The plate was removed in toto.

We then using a suprapatellar technique made an incision above the patellar tendon and inserted a guidewire in the proximal end of the tibia. Opened with an opening reamer and advanced the finger reduction tool down beyond the fracture site. We then advanced the guidewire to the distal end of the tibia and then reamed stepwise to 11.5 mm. We then selected a 42 cm long nail and seated it over the guidewire.
Case #4 -- Distal Tibia / Fibular Fracture

We then used the computer navigation system and placed two distal cross-lock screws by pre-drilling bicortically from medial to lateral. We then placed two proximal cross-lock screws using the outrigger, pre-drilling bicortically through the proximal bone, measuring out the calibrated drill bit and placing the appropriate size screws. We irrigated the wounds copiously and closed in layers with 2-0 PDS and 3-0 nylon.

Disposition of the patient is stable to the recovery room. Postoperative plan will be IV antibiotics times 24 hours. Absolute smoking cessation and treatment of his alcoholism. Weightbearing as tolerated.

## Case #4 -- Distal Tibia / Fibular Fracture

<table>
<thead>
<tr>
<th>PROCEDURES</th>
<th>CPT PROCEDURE CODES</th>
<th>ICD-9 PROCEDURE CODES</th>
<th>DIAGNOSIS CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of tibial shaft fracture (with or without fibular fracture) by intramedullary implant, with or without interlocking screws</td>
<td>27759</td>
<td>79.36</td>
<td></td>
</tr>
<tr>
<td>Debridement of open fracture site; skin, subcutaneous tissue, muscle fascia, muscle, and bone</td>
<td>11012</td>
<td>79.66</td>
<td>823.32</td>
</tr>
<tr>
<td>Computer-assisted musculoskeletal navigation</td>
<td>0054T, 0055T, or 20985</td>
<td>00.39</td>
<td></td>
</tr>
<tr>
<td>Removal of external fixation device</td>
<td>20964</td>
<td>78.67</td>
<td></td>
</tr>
</tbody>
</table>
Case #4 -- Distal Tibia / Fibular Fracture

CASE NOTES:

2013 CCI instructions state, “Removal of internal fixation devices are not separately reportable if the removal is performed as a necessary integral component of another procedure.” However, there is not a similar statement with regards to external fixation systems.

Documentation does not specify the imaging modality associated with computerized musculoskeletal navigation – request clarification and check other ancillary documents.

PREOPERATIVE DIAGNOSIS(ES):

1. Open fracture of the right tibial plateau, type IIIA.

POSTOPERATIVE DIAGNOSIS(ES): Same.

PROCEDURE(S):

1. Irrigation and debridement of skin, muscle, soft tissue, fascia and bone associated with an open fracture of the upper end of the tibia and fibula.
2. Application of a multiplanar external fixator of the right lower extremity.
3. Closed treatment of fracture of the upper end of the tibia with manipulation.

ANESTHESIA: General endotracheal.

COMPLICATIONS: None.

Case #5 - Tibial Fracture

PREOPERATIVE DIAGNOSIS(ES):

1. Open fracture of the right tibial plateau, type IIIA.

POSTOPERATIVE DIAGNOSIS(ES): Same.

PROCEDURE(S):

1. Irrigation and debridement of skin, muscle, soft tissue, fascia and bone associated with an open fracture of the upper end of the tibia and fibula.
2. Application of a multiplanar external fixator of the right lower extremity.
3. Closed treatment of fracture of the upper end of the tibia with manipulation.

ANESTHESIA: General endotracheal.

COMPLICATIONS: None.
Case #5 - Tibial Fracture

INDICATIONS FOR PROCEDURE: Motorcyclist that hit the back of a car and flew through the air and sustained the above injuries. The patient is concussive at the time of evaluation and therefore his family was consented for the procedure. They understand the risk of infection, neurologic injury, vascular injury, decreased range of motion and chronic pain and are ready to proceed.

The patient was prepped. There was no bone grafting. The amount of skin debrided total was 18 cm. The amount of muscle debrided was 3 cm. The amount of fascial tissue debrided was 18 cm. The amount of bone debrided was 2 cm. Each wound had low pressure. We used 6 L of irrigant. The fracture was a IIIA. All wounds were closed at the end of the procedure. No tourniquet was used. There was no definitive fixation tonight. The patient was put in an external fixator. The postoperative fracture gap was less than 1 cm. No antibiotic beads were used. There are no further procedures planned for either wound.

Case #5 - Tibial Fracture

DESCRIPTION OF PROCEDURE(S): After it was confirmed consent was obtained for the above procedure and we agreed it was the right lower extremity to be operated on, the patient was taken to the operating room where anesthetic was obtained. IV antibiotics were infused. The right lower extremity was prepped and draped in sterile fashion. We made incisions proximally and distally over the transverse wound over the patella and the vertical wound over the medial aspect of the tibia. We dissected all the way down to the periosteum of the patella and the periosteum of the tibia. We directly visualized the fracture of the tibia and curetted it. We then irrigated copiously with 6 L of normal saline under low pressure. We removed nonviable-appearing muscle, fascia and skin. The wounds were then closed in layers with 2-0 PDS and 3-0 nylon.
Case #5 - Tibial Fracture

We then constructed a multiplanar external fixator. This was done by making two small stab incisions on the anterolateral thigh and anteromedial tibial crest. We dissected down with a drill bit, we predrilled bicortically and then placed 5.0 mm half pins in the femur and the tibia. We checked our placement under fluoroscopy. We then constructed a multiplanar external fixator, manipulated the fracture under fluoroscopy and locked the external fixator in position.

The wounds were then dressed and a compressive dressing applied.

DISPOSITION: The patient is stable to the recovery room. Postoperative plan will be IV antibiotics x24 hours. Nonweightbearing of the right lower extremity, and CT scan. We will definitively fixate the fracture at a later date after the skin has declared itself.

Case #5 -- Tibia Fracture

<table>
<thead>
<tr>
<th>PROCEDURES</th>
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<th>ICD-9 PROCEDURE CODES</th>
<th>DIAGNOSIS CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of proximal tibia fracture with manipulation</td>
<td>27532 vs. 27535</td>
<td>79.06 vs. 79.26</td>
<td>823.10</td>
</tr>
<tr>
<td>Debridement of open fracture site; skin, subcutaneous tissue, muscle fascia, muscle</td>
<td>11011</td>
<td>79.66</td>
<td></td>
</tr>
<tr>
<td>Application of multi-plane external fixation device</td>
<td>20962</td>
<td>78.17</td>
<td></td>
</tr>
</tbody>
</table>

CASE NOTES: Documentation potentially contradictory, using term “closed treatment”, while describing open dissection with direct visualization of fracture. CPT guidelines state, “Closed treatment specifically means that the fracture site is not surgically opened (exposed to the external environment and directly visualized).” However, manipulation is performed after debridement and closure of wounds. Closed treatment is the more conservative coding, with statement of intent for possible future definitive fixation of fracture, but documentation does identify elements of open fracture care.

ICD-9-CM instructs to code type of external fixation, if known – not stated whether ring or hybrid system.
Case #6 -- Multiple Site Tibial Fractures

PREOPERATIVE DIAGNOSIS: Right tibial fracture of the plateau, tubercle, and shaft.

PROCEDURE PERFORMED:
1. Right tibial plateau open reduction and internal fixation.
2. Right tibial tubercle open reduction and internal fixation.
3. Right tibial shaft reduction and intramedullary nail fixation.
4. Fasciotomy four compartments with debridement of nonviable tissue in anterior compartment.

ANESTHESIA TYPE: General.
DRAINS: None.
TOURNIQUET: None.
ESTIMATED BLOOD LOSS: 200 mL.

MEDICAL NECESSITY: 34-year-old female status post fall. She presented with clinical and radiographic evidence of a right tibial plateau fracture, tubercle and shaft fracture with early presentation of compartment syndrome.

Risks and benefits of injury and surgery were discussed at length including risk of infection, bleeding, neurovascular injury, malunion, nonunion, hardware failure, fracture failure, cosmetic and/or functional deformity. Anesthesia complications including death were all discussed. Patient provided written consent.

OPERATIVE SUMMARY: Patient was brought to the operating room and placed in supine position, underwent successful general endotracheal anesthesia as well as preprocedural IV antibiotics. Patient safety timeout was performed to confirm patient identity as well as operative location and procedure.

At this time attention was taken to right leg, was prepped and draped in standard sterile fashion. Under guidance of fluoroscopy incisions were made around the knee area.
Case #6 -- Multiple Site Tibial Fractures

A reduction clamp was then placed followed by a cannulated screw. It was confirmed to be in appropriate position on AP and lateral x-ray. At this time attention was taken to placement of suprapatellar guide. This was placed appropriately on multi-view fluoroscopy. Proximal reaming was performed. Entry of the guidewire was performed to enable reduction techniques. Multiple percutaneous incisions made with reduction clamp as well as reduction tool and screws were placed appropriately to prevent procurvatum as occurs in this fracture as well as valgus displacement. These were placed appropriately, and at this time progressive reaming was then performed followed by nail selection. Nail was then guided carefully and then confirmed to be in appropriate position on multi-view fluoroscopy.

At this time the tubercle appeared to be well maintained, and then screws were then placed into the distal aspect using the computer imageless system. Three screws were then placed proximally. Multi-view fluoroscopy confirmed reduction was maintained. Screws were in appropriate position and appropriate length, and these images were saved to the PACS system for documentation.

Wound was copiously irrigated and closed in layered fashion. Patient had full range of motion of the knee passively, and sterile dressing applied. All needle and sponge counts were accurate.
Case #6 -- Multiple Site Tibial Fractures

A fasciotomy was performed of all four tibial compartments. This was done as patient had extensive pain preoperatively as well as increased swelling. Debridement of nonviable tissue in anterior compartment was then performed appropriately. Wound VAC was applied as well as sterile dressing.

DISPOSITION: Extubated, stable, transferred to PACU.

POSTOPERATIVE PLAN: Patient will continue IV antibiotics. She will return to the OR in 48 hours for probable closure of the fasciotomy. She will be monitored closely otherwise.

<table>
<thead>
<tr>
<th>PROCEDURES</th>
<th>CPT PROCEDURE CODES</th>
<th>ICD-9 PROCEDURE CODES</th>
<th>DIAGNOSIS CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of tibial shaft fracture (with or without fibular fracture) by intramedullary implant, with or without interlocking screws</td>
<td>27759</td>
<td>79.36</td>
<td>823.00 823.20</td>
</tr>
<tr>
<td>X-ray tibia &amp; fibula; 2 views</td>
<td>73590-26</td>
<td>88.27</td>
<td></td>
</tr>
<tr>
<td>Computer-assisted musculoskeletal navigation, imageless</td>
<td>20985</td>
<td>00.34</td>
<td></td>
</tr>
<tr>
<td>Decompression fasciotomy, anterior and/or lateral, and posterior compartment(s)</td>
<td>27602</td>
<td>83.09</td>
<td>958.92</td>
</tr>
<tr>
<td>Negative pressure wound therapy</td>
<td>G0456 / G0457</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

CASE NOTES: X-ray would require formal interpretation report for physician to code; may be reported by Radiologist. Although multiple tibial fracture sites are noted, insertion of intramedullary implant captures all sites in combined technique described. There is no ICD-9 code for wound vacuum.
Case #7 -- Multiple Distinct Site Fractures

PREOPERATIVE DIAGNOSIS(ES): Right proximal humerus fracture and right tibial plateau fracture.

POSTOPERATIVE DIAGNOSIS: Same. 823.00 812.00

PROCEDURE(S) PERFORMED:
1. Open reduction, internal fixation of right proximal humerus fracture.
2. Percutaneous pinning of right unicortical tibial plateau fracture.

ANESTHESIA: General endotracheal.

ESTIMATED BLOOD LOSS: 75 mL.

INDICATIONS: Please see full consult but this is a 71-year-old male status post motorcycle accident sustaining the above injuries. Procedure to be dictated as follows. E819.2

Patient was brought back to the operating room and given general anesthesia as per the anesthesia staff. Both the right upper and right lower extremity were prepped and draped in the usual fashion and beach-chair position on the table had been achieved, and prior to prepping and draping, we confirmed we had been able to get good AP and lateral x-rays of the shoulder. A surgical pause was then taken to identify correct site, correct patient, correct surgery and that prophylactic antibiotics had been given.

Once confirmed with nursing and anesthesia staff, an anterolateral approach to the humerus was made over the acromion process itself and then approximately one-third of the way back. A incision was made approximately 5 cm long with sharp dissection through the skin, subcutaneous tissue down to the deltoid muscle.
Case #7 -- Multiple Distinct Site Fractures

The junction between the anterior raphe and the middle raphe was identified and bluntly dissected. Using a finger, the axillary nerve was able to be palpated, identified and protected throughout the remainder of the case.

Next, the interval around the head was dissected. The greater tuberosity which was grossly displaced was identified and a #5 FiberWire was placed. Similarly, a #5 FiberWire was placed in the insertion of the lesser tuberosity. These were manipulated back in place, held with K-wires, and a two-hole proximal humeral locking plate was positioned appropriately. Fluoroscopic views demonstrated anatomic reduction of the fracture.

Please note that while on preoperative x-rays it appeared that the humeral head had a fracture but was nondisplaced, once we were in there, it was clearly moving in a separate piece with rotation of the arm.

Once everything was lined up on fluoroscopy, a nonlocking screw was placed in the shaft and seven locking screws were placed in the head. One nonlocking screw had been placed first bringing it securely down to the bone. A second nonlocking screw was then placed in the shaft.

Final fluoroscopic views demonstrated that all screws were within the head and anatomic reduction had been achieved. The #5 wires were then sewn into the plate into the holes. Axillary nerve was once again identified and that it had been preserved.

Wound was irrigated. The deltid was repaired with a 0-0 [suture]. Skin was closed with 2-0 [suture] and 3-0 [suture].
Case #7 -- Multiple Distinct Site Fractures

Our attention was brought to the knee. Fluoroscopy demonstrated our anatomic reduction was confirmed, and using a perfect lateral, two stab incisions were made for two guidewires with a 6.5 drill. These were measured and the appropriate length partially threaded 6.5 screws were placed in the tibial plateau, both with excellent purchase, one with a washer. Confirmation with fluoroscopy the fracture did not displace. Wound was irrigated and closed with 3-0 [suture].

POSTOPERATIVE PLAN(S): Patient will be on the right lower extremity. Will be non-weight bearing but will not need a brace and will begin early range of motion. He will begin weight bearing as tolerated on this right lower extremity at 6 weeks. On the right proximal humerus, he will begin early pendulum exercises and may begin passive range of motion immediately but no active range of motion for 6 weeks.

Case #7 -- Multiple Distinct Site Fractures

**PROCEDURES**

<table>
<thead>
<tr>
<th>PROCEDURES</th>
<th>CPT PROCEDURE CODES</th>
<th>ICD-9 PROCEDURE CODES</th>
<th>DIAGNOSIS CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open treatment of proximal humeral fracture, includes internal fixation,</td>
<td>29615</td>
<td>79.31</td>
<td>812.03 812.09</td>
</tr>
<tr>
<td>includes repair of tuberosity(s)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percutaneous skeletal fixation of tibial shaft fracture</td>
<td>27756</td>
<td>79.16</td>
<td>823.00</td>
</tr>
<tr>
<td>Motorcycle accident, unspecified</td>
<td>N/A</td>
<td>N/A</td>
<td>E819.2</td>
</tr>
</tbody>
</table>

**CASE NOTES:** Although two distinct fracture sites are noted on the humerus, ICD-9-CM coding is reported only once. In CPT, there is also a single all-inclusive code which captures treatment of the proximal humeral fracture and includes repair of tuberosity.
Case #8 - Multiple Trauma

PREOPERATIVE DIAGNOSIS(ES):  
Left femur fracture,  
APC II pelvic fracture, right knee injury/dislocation.

POSTOPERATIVE DIAGNOSIS(ES):  
Same plus left open great toe fracture.

PROCEDURE(S) PERFORMED:
1. Placement of multiplanar external fixator on the pelvis.
2. Closed treatment with manipulation of pelvic fracture.
3. Placement of uniplanar external fixator left femur.
4. Closed treatment with manipulation of left femoral shaft fracture.
5. Examination under anesthesia right knee.
6. Irrigation debridement of open fracture of left great toe.
7. Repair of nailbed left great toe.

TYPE OF ANESTHESIA:  General endotracheal.

FINDINGS:
1. Open left toe fracture with nailbed disruption.
2. Examination of the right knee in the operating room demonstrated deficits of his lateral collateral ligament posterior lateral corner and most likely his posterior cruciate ligament. MCL appeared to be intact. Also noted his initial hematocrit was 45. On entrance to the operating room after 4 L of saline, hematocrit was rechecked and it was 25 with a base deficit of -5. At the end of the case this was rechecked and it was 23 and -6.

Patient was brought back to operating given general anesthesia as per anesthesia staff. The right lower extremity was examined and determined it would be stable in the knee immobilizer left lower extremity, and the pelvis was then prepped and draped in usual fashion.
Case #8 - Multiple Trauma

A surgical pause was taken and identified correct site, correct patient, correct surgery and prophylactic [antibiotic] given. Once this was confirmed with Nursing and Anesthesia staff, first the pelvic external fixator was placed first on the left side.

A obturator outlet view/TP view was obtained and a transverse incision of skin was made over the anterior inferior iliac spine. A guide was placed down over the bone and drilled under fluoroscopy and then a 5 mm x 200 mm pin was placed. An identical pin was placed on the right side. The pelvis then closed down and bars and clamps put into place.

The left femur gross traction was pulled and two pins were placed proximal and two pins were placed distal to the fracture. Confirmation of appropriate length on fluoroscopy and two connecting bars were placed.

Case #8 - Multiple Trauma

On the left toe the nail was removed. The open fracture was copiously irrigated and curetted. The nail bed was then repaired with 4-0 [suture] and the nail which was allowed to sit in peroxide was then replaced to keep the nailbed open. Dressings were then placed over all wounds. 3-0 nylon was used to close around the pin sites. Patient went up to the ICU.

POSTOPERATIVE PLAN: Patient will need intramedullary nail of the left femur and ORIF of the pelvis when stable. We will consult in a few days when he is stable. We will consult sports medicine team to take care of his right knee dislocation.
Case #8 - Multiple Trauma

<table>
<thead>
<tr>
<th>PROCEDURES</th>
<th>CPT PROCEDURE CODES</th>
<th>ICD-9 PROCEDURE CODES</th>
<th>DIAGNOSIS CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Closed treatment of pelvic ring fracture, dislocation,</td>
<td>27194</td>
<td>79.09</td>
<td>808.2</td>
</tr>
<tr>
<td>diastasis, or subluxation, with manipulation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Closed treatment of femoral shaft fracture with</td>
<td>27502</td>
<td>79.05</td>
<td>821.00</td>
</tr>
<tr>
<td>manipulation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Application of multi-plane external fixation system</td>
<td>20692</td>
<td>78.19</td>
<td>808.2</td>
</tr>
<tr>
<td>(pelvis)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Application of uniplane external fixation system</td>
<td>20690</td>
<td>78.15</td>
<td>821.00</td>
</tr>
<tr>
<td>(femur)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repair of nail bed</td>
<td>11760</td>
<td>86.59</td>
<td>959.7</td>
</tr>
<tr>
<td>Examination of knee joint under anesthesia</td>
<td>27570</td>
<td>89.39</td>
<td>826.1</td>
</tr>
<tr>
<td>Nonexcisional debridement of wound/fracture site (toe)</td>
<td>Bundled</td>
<td>86.28</td>
<td>826.1</td>
</tr>
</tbody>
</table>

Case #8 - Multiple Trauma

**CASE NOTES:** 2013 CCI notes state:

“When it is necessary to perform skeletal/joint manipulation under anesthesia to assess range of motion, reduce a fracture or for any other purpose during another procedure in an anatomically related area, the corresponding manipulation code (e.g., CPT codes 22505, 23700, 27275, 27570, 27860) is not separately reportable.”

However, in this example, although multiple other surgical procedures are performed, this is the only service which is performed on the knee.
Case #9 - Pelvic Ring Fracture

PREOPERATIVE DIAGNOSIS:  
1. Is a zone II fracture of the left sacrum.  
2. Fractures of the anterior pelvic ring.  
3. Right proximal humeral and humeral shaft fractures.

POSTOPERATIVE DIAGNOSIS(ES): The same.

PROCEDURE(S):  
1. Percutaneous fixation of sacral fracture on the left with navigation.  
2. Application of a multiplanar external fixator of the pelvis.  
3. Closed treatment of pelvic fractures with manipulation.  
4. Intramedullary nailing of humeral shaft fracture and proximal humeral fracture.

COMPLICATIONS: None.

Case #9 - Pelvic Ring Fracture

INDICATIONS FOR PROCEDURE: Bicycle versus car with multiple injuries. He is critically ill in the ICU. His family has been educated in some detail on the nature of the injuries and the surgical intervention and she is ready to proceed.

DESCRIPTION OF PROCEDURE(S): After it was confirmed consent was obtained for the above procedure and we agreed it was the left pelvis and the right humerus to be operated on, the patient was taken to OR where anesthetic was obtained. IV antibiotics were infused. The abdomen and left lower extremity were prepped and draped in sterile fashion.

We made an incision over the anterior-superior iliac spine and then drilled a half pin into the pelvic bone and then placed the probe instrument in the pelvis. We then performed a spin with the O-arm. We then calibrated the navigation system.
Case #9 - Pelvic Ring Fracture

We then made an incision over the lateral buttock and advanced a guidewire into the S1 body above the neural foramen and anterior to the canal of the spinal column using the navigation system. We checked placement under fluoroscopy and then selected a 95 mm terminally threaded cannulated screw and placed it over the guidewire. It had excellent purchase across the fracture site. We confirmed its placement under fluoroscopy.

We then made small incisions over the anterior inferior iliac spines bilaterally and then predrilled and placed half pins down the superior acetabular bone into the sciatic buttress, then constructed a multiplanar external fixator of the pelvis, manipulated the pelvis, and locked it into position. The wounds were dressed after being closed.

Case #9 - Pelvic Ring Fracture

We then prepped the right upper extremity in standard sterile fashion. An incision was made from the acromion 5 cm down through the deltoid. The dissection was carried down to the proximal humerus. There was a severe amount of comminution of the lateral aspect of the humerus proximally. We found the starting point of the proximal humerus, drilled, advanced the guidewire, and then reamed stepwise and then selected a 26 mm x 8 mm diameter nail. We seated the nail. We then placed two proximal cross-lock screws using the outrigger. One of the cross-lock screws had a large washer on it to facilitate reduction of the greater tuberosity fracture of the proximal humerus.
We then made an incision over the distal arm, dissected down to bone, and then using circles, predrilled bicortically through the nail and the bone, measured with the depth gauge, and placed the appropriate size distal cross-lock screws. The wounds were irrigated and closed in layers with 2-0 PDS and staples. The disposition of the patient is stable back to the intensive care unit. Postoperative plan will be IV antibiotics times 24 hours. Nonweightbearing through the right upper extremity.

Nonweightbearing bilateral lower extremities. He may sit up head of bed as much as is allowable with the external fixator on. He may do gentle range of motion of the right shoulder when he is extubated.

### Case #9 - Pelvic Ring Fracture

<table>
<thead>
<tr>
<th>PROCEDURES</th>
<th>CPT PROCEDURE CODE</th>
<th>ICD-9 PROCEDURE CODE</th>
<th>DIAGNOSIS CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, unilateral</td>
<td>27216</td>
<td>78.59</td>
<td>805.6</td>
</tr>
<tr>
<td>Closed treatment of pelvic ring fracture, dislocation, diastasis, or subluxation, with manipulation</td>
<td>27194</td>
<td>79.09</td>
<td>808.43</td>
</tr>
<tr>
<td>Application of multi-plane external fixation system (pelvis)</td>
<td>20692</td>
<td>78.19</td>
<td>808.43</td>
</tr>
<tr>
<td>Open treatment of humeral shaft fracture with intramedullary nail, with or without cerclage and/or locking screws</td>
<td>24516</td>
<td>79.31</td>
<td>812.00 812.21</td>
</tr>
<tr>
<td>Computer-assisted musculoskeletal navigation, with fluoroscopy</td>
<td>0054T</td>
<td>00.33</td>
<td>805.6</td>
</tr>
</tbody>
</table>

**CASE NOTES:** Confirm with physician that these multiple pelvic fractures disrupt the pelvic ring, as this affects selection of both diagnosis code and CPT procedure code.
Diagnostic Coding Issues

• Annual code changes are effective Oct. 1st.
• ICD-9-CM is published as a three-volume set
  • Volume 1 -- Tabular List of Diseases
  • Volume 2 -- Alphabetic Index
  • Volume 3 -- Procedures
• There are sixteen basic guidelines for physicians and outpatient services.
• A copy of the complete guidelines are available from the Center for Healthcare Statistics: http://www.cdc.gov/nchs/icd9.htm
• ICD-9-CM Changes for FY 2013 -- **NONE**
Data Collection Challenges

- Quality data extracted from current coding is clinically less specific
- Retrospective chart review, while clinically more specific, is burdensome
- The current clinical classification system (ICD-9-CM) is not designed for quality or safety reporting or risk stratification

ICD-10-CM

- ICD-10 is the international standard to report and monitor diseases and mortality, with U.S. implementation scheduled for October 2013.
- ICD-10-CM reflects advances in medicine and medical terminology.
- ICD-10-CM provides codes to allow comparison of mortality and morbidity data.
- ICD-10 provides better data for:
  - Measuring care furnished to patients;
  - Designing payment systems;
  - Processing claims;
  - Making clinical decisions;
  - Tracking public health;
  - Identifying fraud and abuse; and
  - Conducting research.
ICD-10-CM

On January 16, 2009, the Department of Health and Human Services (HHS) published a Final Rule for the adoption of ICD-10-CM and ICD-10-PCS, with a compliance date of October 1, 2013 (now 2014).

Under the electronic health transaction standards final rule, also issued on January 16, 2009, covered entities must comply with Version 5010 (for some health care transactions) and Version D.0 (pharmacy transactions) on January 1, 2012 (extended to July 1).


However, the codes in ICD-10 are not currently valid for any purpose or use in the United States.

ICD-9-CM vs. ICD-10-CM

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
<th>Implementation Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-5 digit codes</td>
<td>3-6 digit codes (possibly 7)</td>
<td>All computer fields must be able to accommodate additional characters</td>
</tr>
<tr>
<td>0 as spacer</td>
<td>X as spacer</td>
<td>Ensure fields can accept alphabetic characters in any digit position. Ensure distinction between numbers and letters (although O and I not used, to minimize confusion).</td>
</tr>
<tr>
<td>Numeric values except V and E codes</td>
<td>All alphanumeric, including 1st and sometimes subsequent digits</td>
<td></td>
</tr>
<tr>
<td>1-2 digits after decimal</td>
<td>1-4 digits after decimal</td>
<td>Ensure system can accept up to 4 digits after decimal.</td>
</tr>
<tr>
<td>Partial descriptors for 4th &amp; 5th digits</td>
<td>Full descriptors for every code</td>
<td>Ensure format reflects full descriptors, not “cumulative” data.</td>
</tr>
<tr>
<td>Hierarchical structure</td>
<td>Hierarchical structure</td>
<td>Programming expanded to recognize at least one more level to hierarchy</td>
</tr>
<tr>
<td>Approximately 17,000 diagnosis codes and 5,000 procedure codes</td>
<td>Potentially 70,000 diagnosis codes and almost 120,000 procedure codes</td>
<td>Additional training and education, documentation improvements, revised reference guides, computerized coding support</td>
</tr>
</tbody>
</table>
ICD-9-CM vs. ICD-10-CM

• Some codes do have direct translations from ICD-9-CM to ICD-10-CM.
• Some ICD-10 diagnosis codes combine multiple presentations or facets of a condition into a single code – such as incorporating underlying cause, concurrent condition, or complication as a subclassification -- which in ICD-9-CM requires 2 or more codes.
• For some categories, terms may be defined in different ways, or whole chapters are organized along a different axis of classification, such that the mapping is only a series of approximations or possible compromises.
• There are cases where ICD-9 contains more detail than ICD-10, where a clinical concept or axis of classification is no longer deemed essential information.
• ICD-9 may also contain more detail than ICD-10 when ICD-9-CM captured information on issues relating to procedures, which ICD-10 does not consider an appropriate element of the diagnosis code.

Sample Code Comparisons

And many of the ICD-10 categories offer a much greater degree of specificity / granularity than is possible with ICD-9, such as more precise anatomic site, laterality, and / or episode of care.

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>811.0x Fracture of scapula, closed</td>
<td>ICD-10 has 252 codes for fracture of the scapula, which include subclassifications describing:</td>
</tr>
<tr>
<td>811.1x Fracture of scapula, open</td>
<td>• Anatomic site (7 choices -- unspecified part, body of scapula, acromial process, coracoid process, glenoid cavity, neck of scapula, and other part of scapula)</td>
</tr>
<tr>
<td>(ICD-9 offers five choices for 5th digit: 0 unspecified part 1 acromial process 2 coracoid process 3 glenoid cavity and neck of scapula 9 other for a total of 10 codes.)</td>
<td>• Right, left, or unspecified scapula</td>
</tr>
<tr>
<td></td>
<td>• Displaced or nondisplaced fracture</td>
</tr>
<tr>
<td></td>
<td>• Initial or subsequent encounter:</td>
</tr>
<tr>
<td></td>
<td>• For initial encounters, open or closed fracture</td>
</tr>
<tr>
<td></td>
<td>• For subsequent encounters, indicate whether with routine healing, delayed healing, nonunion, malunion, or for treatment of sequela of fracture</td>
</tr>
</tbody>
</table>
Gustilo Open Fracture Classification

<table>
<thead>
<tr>
<th>Gustilo Grade</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Open fracture, clean wound, wound &lt;1 cm in length</td>
</tr>
<tr>
<td>II</td>
<td>Open fracture, wound &gt; 1 cm in length without extensive soft-tissue damage, flaps, avulsions</td>
</tr>
<tr>
<td>III</td>
<td>Open fracture with extensive soft-tissue laceration, damage, or loss or an open segmental fracture. This type also includes open fractures caused by farm injuries, fractures requiring vascular repair, or fractures that have been open for 8 hr prior to treatment</td>
</tr>
<tr>
<td>IIIA</td>
<td>Type III fracture with adequate periosteal coverage of the fracture bone despite the extensive soft-tissue laceration or damage</td>
</tr>
<tr>
<td>IIIB</td>
<td>Type III fracture with extensive soft-tissue loss and periosteal stripping and bone damage. Usually associated with massive contamination. Will often need further soft-tissue coverage procedure (i.e. free or rotational flap)</td>
</tr>
<tr>
<td>IIIC</td>
<td>Type III fracture associated with an arterial injury requiring repair, irrespective of degree of soft-tissue injury</td>
</tr>
</tbody>
</table>
ICD-10-PCS

ICD-10-PCS is designed to permit assignment of a unique code to each substantially different procedure, with the flexible open structure easily allowing the incorporation of future new procedures. There is no numeric listing of codes; rather, there are 16 sections with sub-tables to determine code selection.

- 0 Medical and Surgical
- 1 Obstetrics
- 2 Placement
- 3 Administration
- 4 Measurement and Monitoring
- 5 Extracorporeal Assistance and Performance
- 6 Extracorporeal Therapies
- 7 Osteopathic
- 8 Other Procedures
- 9 Chiropractic
- B Imaging
- C Nuclear Medicine
- D Radiation Oncology
- F Physical Rehabilitation and Diagnostic Audiology
- G Mental Health
- H Substance Abuse Treatment

The first character identifies the type of service/procedure provided (the section), and each subsequent place in the code also has a specific function, the meaning of which may differ from one section to another. For example:

**Medical and Surgical Codes (Section 0):**

<table>
<thead>
<tr>
<th>Section</th>
<th>Body System</th>
<th>Root Operation</th>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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</table>

**Imaging Codes (Section B):**

<table>
<thead>
<tr>
<th>Section</th>
<th>Body System</th>
<th>Type</th>
<th>Body Part</th>
<th>Contrast</th>
<th>Qualifier</th>
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<tr>
<td>1</td>
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<tr>
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**Extracorporeal Assistance and Performance Codes (Section 5):**

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<th>Section</th>
<th>Physiological Systems</th>
<th>Root Operation</th>
<th>Body System</th>
<th>Duration</th>
<th>Function</th>
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ICD-10-PCS

• All terminology is standardized, and defined within the reference tables
• Diagnosis information is not part of the procedure code descriptor
• There are no eponyms (procedures identified by a person’s name, rather than clinical description)

• If multiple procedures as defined by distinct objectives are performed, then multiple codes should be assigned

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<thead>
<tr>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
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What Can I Do?

• Step 1 – Examine Affect on Facility Departments
• Step 2 – Confirm Compliance with Contractors
• Step 3 – Train for ICD-10-CM
• Step 4 – Perform Internal Tests
• Step 5 – Implement ICD-10-CM

Coding and Documentation Improvement

• With complete information in the record, coders can effectively analyze, code, and report necessary information for claims and for quality measures
  • Physician review / sign all facility documentation
  • Make sure key elements are captured – query when needed
  • Specificity of diagnosis documentation, including documentation for POA indicators
• Without such documentation, the application of all coding guidelines is a difficult, if not impossible, task – and accuracy of reimbursement is affected
Coding and Documentation Improvement

- Health care is increasingly data driven
- Cross functional skill sets support evolving activities
- Enhanced roles of HIM and Coding Department staff in quality of information
- Education and open communication are key
- Work Smart

Questions?
THANK YOU ALL FOR PARTICIPATING!

Presented by:
Sheila Sylvan
IMPACT!
Spring 2013

Hosted by:
DePuySynthes

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