ICD-10-PCS Coding Guidelines

Table of Contents

A. Conventions …….....1
B. Medical and Surgical Section Guidelines ....……...4
2. Body System …….....4
3. Root Operation…….……...5
4. Body Part ……....9
5. Approach ……..….12
6. Device ……....13
C. Obstetrics Section Guidelines…….14

Conventions

A1
ICD-10-PCS codes are composed of seven characters. Each character is an axis of classification that specifies information about the procedure performed. Within a defined code range, a character specifies the same type of information in that axis of classification.
Example: The fifth axis of classification specifies the approach in sections 0 through 4 and 7 through 9 of the system.

A2
One of 34 possible values can be assigned to each axis of classification in the seven-character code: they are the numbers 0 through 9 and the alphabet (except I and O because they are easily confused with the numbers 1 and 0). The number of unique values used in an axis of classification differs as needed.
Example: Where the fifth axis of classification specifies the approach, seven different approach values are currently used to specify the approach.

A3
The valid values for an axis of classification can be added to as needed.
Example: If a significantly distinct type of device is used in a new procedure, a new device value can be added to the system.

A4
As with words in their context, the meaning of any single value is a combination of its axis of classification and any preceding values on which it may be dependent.
Example: The meaning of a body part value in the Medical and Surgical section is always dependent on the body system value. The body part value 0 in the Central Nervous body system specifies Brain and the body part value 0 in the Peripheral Nervous body system specifies Cervical Plexus.

A5
As the system is expanded to become increasingly detailed, over time more values will depend on preceding values for their meaning.
Example: In the Lower Joints body system, the device value 3 in the root operation Insertion specifies Infusion Device and the device value 3 in the root operation Fusion specifies Interbody Fusion Device.

A6
The purpose of the alphabetic index is to locate the appropriate table that contains all information necessary to construct a procedure code. The PCS Tables should always be consulted to find the most appropriate valid code.

A7
It is not required to consult the index first before proceeding to the tables to complete the code. A valid code may be chosen directly from the tables.

A8
All seven characters must be specified to be a valid code. If the documentation is incomplete for coding purposes, the physician should be queried for the necessary information.

A9
Within a PCS table, valid codes include all combinations of choices in characters 4 through 7 contained in the same row of the table. In the example below, 0JHT3VZ is a valid code, and 0JHW3VZ is *not* a valid code.

Section: 0 Medical and Surgical
Body System: J Subcutaneous Tissue and Fascia
Operation: H Insertion: Putting in a nonbiological appliance that monitors, assists, performs, or prevents a physiological function but does not physically take the place of a body part

Body Part	Approach	Device	Qualifier
S Subcutaneous Tissue and Fascia, Head and Neck V Subcutaneous Tissue and Fascia, Upper Extremity W Subcutaneous Tissue and Fascia, Lower Extremity	0 Open 3 Percutaneous	1 Radioactive Element 3 Infusion Device	Z No Qualifier
T Subcutaneous Tissue and Fascia, Trunk	0 Open 3 Percutaneous	1 Radioactive Element 3 Infusion Device V Infusion Pump	Z No Qualifier

A10
"And," when used in a code description, means "and/or."
Example: Lower Arm and Wrist Muscle means lower arm and/or wrist muscle.

A11
Many of the terms used to construct PCS codes are defined within the system. It is the coder's responsibility to determine what the documentation in the medical record equates to in the PCS definitions. The physician is not expected to use the terms used in PCS

code descriptions, nor is the coder required to query the physician when the correlation between the documentation and the defined PCS terms is clear.
Example: When the physician documents “partial resection” the coder can independently correlate “partial resection” to the root operation Excision without querying the physician for clarification.

Medical and Surgical Section Guidelines (section 0)

B2. Body System

General guidelines
B2.1a
The procedure codes in the general anatomical regions body systems should only be used when the procedure is performed on an anatomical region rather than a specific body part (e.g., root operations Control and Detachment, drainage of a body cavity) or on the rare occasion when no information is available to support assignment of a code to a specific body part.
Example: Control of postoperative hemorrhage is coded to the root operation Control found in the general anatomical regions body systems.

B2.1b
Body systems designated as upper or lower contain body parts located above or below the diaphragm respectively.
Example: Vein body parts above the diaphragm are found in the Upper Veins body system; vein body parts below the diaphragm are found in the Lower Veins body system.

B3. Root Operation

General guidelines
B3.1a
In order to determine the appropriate root operation, the full definition of the root operation as contained in the PCS Tables must be applied.

B3.1b
Components of a procedure specified in the root operation definition and explanation are not coded separately. Procedural steps necessary to reach the operative site and close the operative site are also not coded separately.
Example: Resection of a joint as part of a joint replacement procedure is included in the root operation definition of Replacement and is not coded separately. Laparotomy performed to reach the site of an open liver biopsy is not coded separately.

Multiple procedures
B3.2
During the same operative episode, multiple procedures are coded if:
a. The same root operation is performed on different body parts as defined by distinct values of the body part character.
Example: Diagnostic excision of liver and pancreas are coded separately.
b. The same root operation is repeated at different body sites that are included in the same body part value.
Example: Excision of the sartorius muscle and excision of the gracilis muscle are both included in the upper leg muscle body part value, and multiple procedures are coded.
c. Multiple root operations with distinct objectives are performed on the same body part.
Example: Destruction of sigmoid lesion and bypass of sigmoid colon are coded separately.
d. The intended root operation is attempted using one approach, but is converted to a different approach.
Example: Laparoscopic cholecystectomy converted to an open cholecystectomy is coded as percutaneous endoscopic Inspection and open Resection.

Discontinued procedures
B3.3
If the intended procedure is discontinued, code the procedure to the root operation performed. If a procedure is discontinued before any other root operation is performed, code the root operation Inspection of the body part or anatomical region inspected.
Example: A planned aortic valve replacement procedure is discontinued after the initial thoracotomy and before any incision is made in the heart muscle, when the patient becomes hemodynamically unstable. This procedure is coded as an open Inspection of the mediastinum.

Biopsy followed by more definitive treatment
B3.4
If a diagnostic Excision, Extraction, or Drainage procedure (biopsy) is followed by a more definitive procedure, such as Destruction, Excision or Resection at the same procedure site, both the biopsy and the more definitive treatment are coded.
Example: Biopsy of breast followed by partial mastectomy at the same procedure site, both the biopsy and the partial mastectomy procedure are coded.

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

Bypass procedures
B3.6a
Bypass procedures are coded by identifying the body part bypassed "from" and the body part bypassed "to." The fourth character body part specifies the body part bypassed from, and the qualifier specifies the body part bypassed to.
Example: Bypass from stomach to jejunum, stomach is the body part and jejunum is the qualifier.

B3.6b
Coronary arteries are classified by number of distinct sites treated, rather than number of coronary arteries or anatomic name of a coronary artery (e.g., left anterior descending). Coronary artery bypass procedures are coded differently than other bypass procedures as described in the previous guideline. Rather than identifying the body part bypassed from, the body part identifies the number of coronary artery sites bypassed to, and the qualifier specifies the vessel bypassed from.
Example: Aortocoronary artery bypass of one site on the left anterior descending coronary artery and one site on the obtuse marginal coronary artery is classified in the body part axis of classification as two coronary artery sites and the qualifier specifies the aorta as the body part bypassed from.

B3.6c
If multiple coronary artery sites are bypassed, a separate procedure is coded for each coronary artery site that uses a different device and/or qualifier.
Example: Aortocoronary artery bypass and internal mammary coronary artery bypass are coded separately.

Control vs. more definitive root operations
B3.7
The root operation Control is defined as, "Stopping, or attempting to stop, postprocedural bleeding." If an attempt to stop postprocedural bleeding is initially unsuccessful, and to stop the bleeding requires performing any of the definitive root operations Bypass,

Detachment, Excision, Extraction, Reposition, Replacement, or Resection, then that root operation is coded instead of Control.
Example: Resection of spleen to stop postprocedural bleeding is coded to Resection instead of Control.

Excision vs. Resection
B3.8
PCS contains specific body parts for anatomical subdivisions of a body part, such as lobes of the lungs or liver and regions of the intestine. Resection of the specific body part is coded whenever all of the body part is cut out or off, rather than coding Excision of a less specific body part.
Example: Left upper lung lobectomy is coded to Resection of Upper Lung Lobe, Left rather than Excision of Lung, Left.

Excision for graft
B3.9
If an autograft is obtained from a different body part in order to complete the objective of the procedure, a separate procedure is coded.
Example: Coronary bypass with excision of saphenous vein graft, excision of saphenous vein is coded separately.

Fusion procedures of the spine
B3.10a
The body part coded for a spinal vertebral joint(s) rendered immobile by a spinal fusion procedure is classified by the level of the spine (e.g. thoracic). There are distinct body part values for a single vertebral joint and for multiple vertebral joints at each spinal level.
Example: Body part values specify Lumbar Vertebral Joint, Lumbar Vertebral Joints, 2 or More and Lumbosacral Vertebral Joint.

B3.10b
If multiple vertebral joints are fused, a separate procedure is coded for each vertebral joint that uses a different device and/or qualifier.
Example: Fusion of lumbar vertebral joint, posterior approach, anterior column and fusion of lumbar vertebral joint, posterior approach, posterior column are coded separately.

B3.10c
Combinations of devices and materials are often used on a vertebral joint to render the joint immobile. When combinations of devices are used on the same vertebral joint, the device value coded for the procedure is as follows:

- If an interbody fusion device is used to render the joint immobile (alone or containing other material like bone graft), the procedure is coded with the device value Interbody Fusion Device

- If internal fixation is used to render the joint immobile and an interbody fusion device is *not* used, the procedure is coded with the device value Internal Fixation Device
- If bone graft is the *only* device used to render the joint immobile, the procedure is coded with the device value Nonautologous Tissue Substitute or Autologous Tissue Substitute
- If a mixture of autologous and nonautologous bone graft (with or without biological or synthetic extenders or binders) is used to render the joint immobile, code the procedure with the device value Autologous Tissue Substitute

Examples: Fusion of a vertebral joint using a cage style interbody fusion device containing morsellized bone graft is coded to the device Interbody Fusion Device.
Fusion of a vertebral joint using a bone dowel interbody fusion device made of cadaver bone and packed with a mixture of local morsellized bone and demineralized bone matrix is coded to the device Interbody Fusion Device.
Fusion of a vertebral joint using rigid plates affixed with screws and reinforced with bone cement is coded to the device Internal Fixation Device.
Fusion of a vertebral joint using both autologous bone graft and bone bank bone graft is coded to the device Autologous Tissue Substitute.

Inspection procedures
B3.11a
Inspection of a body part(s) performed in order to achieve the objective of a procedure is not coded separately.
Example: Fiberoptic bronchoscopy performed for irrigation of bronchus, only the irrigation procedure is coded.

B3.11b
If multiple tubular body parts are inspected, the most distal body part inspected is coded.
If multiple non-tubular body parts in a region are inspected, the body part that specifies the entire area inspected is coded.
Examples: Cystoureteroscopy with inspection of bladder and ureters is coded to the ureter body part value.
Exploratory laparotomy with general inspection of abdominal contents is coded to the peritoneal cavity body part value.

B3.11c
When both an Inspection procedure and another procedure are performed on the same body part during the same episode, if the Inspection procedure is performed using a different approach than the other procedure, the Inspection procedure is coded separately.
Example: Endoscopic Inspection of the duodenum is coded separately when open Excision of the duodenum is performed during the same procedural episode.

Occlusion vs. Restriction for vessel embolization procedures
B3.12

If the objective of an embolization procedure is to completely close a vessel, the root operation Occlusion is coded. If the objective of an embolization procedure is to narrow the lumen of a vessel, the root operation Restriction is coded.
Examples: Tumor embolization is coded to the root operation Occlusion, because the objective of the procedure is to cut off the blood supply to the vessel.
Embolization of a cerebral aneurysm is coded to the root operation Restriction, because the objective of the procedure is not to close off the vessel entirely, but to narrow the lumen of the vessel at the site of the aneurysm where it is abnormally wide.

Release procedures
B3.13
In the root operation Release, the body part value coded is the body part being freed and not the tissue being manipulated or cut to free the body part.
Example: Lysis of intestinal adhesions is coded to the specific intestine body part value.

Release vs. Division
B3.14
If the sole objective of the procedure is freeing a body part without cutting the body part, the root operation is Release. If the sole objective of the procedure is separating or transecting a body part, the root operation is Division.
Examples: Freeing a nerve root from surrounding scar tissue to relieve pain is coded to the root operation Release. Severing a nerve root to relieve pain is coded to the root operation Division.

Reposition for fracture treatment
B3.15
Reduction of a displaced fracture is coded to the root operation Reposition and the application of a cast or splint in conjunction with the Reposition procedure is not coded separately. Treatment of a nondisplaced fracture is coded to the procedure performed.
Examples: Putting a pin in a nondisplaced fracture is coded to the root operation Insertion.
Casting of a nondisplaced fracture is coded to the root operation Immobilization in the Placement section.

Transplantation vs. Administration
B3.16
Putting in a mature and functioning living body part taken from another individual or animal is coded to the root operation Transplantation. Putting in autologous or nonautologous cells is coded to the Administration section.
Example: Putting in autologous or nonautologous bone marrow,
pancreatic islet cells or stem cells is coded to the Administration section.

B4. Body Part

General guidelines
B4.1a
If a procedure is performed on a portion of a body part that does not have a separate body part value, code the body part value corresponding to the whole body part.
Example: A procedure performed on the alveolar process of the mandible is coded to the mandible body part.

B4.1b
If the prefix "peri" is combined with a body part to identify the site of the procedure, the procedure is coded to the body part named.
Example: A procedure site identified as perirenal is coded to the kidney body part.

Branches of body parts
B4.2
Where a specific branch of a body part does not have its own body part value in PCS, the body part is coded to the closest proximal branch that has a specific body part value.
Example: A procedure performed on the mandibular branch of the trigeminal nerve is coded to the trigeminal nerve body part value

Bilateral body part values
B4.3
Bilateral body part values are available for a limited number of body parts. If the identical procedure is performed on contralateral body parts, and a bilateral body part value exists for that body part, a single procedure is coded using the bilateral body part value. If no bilateral body part value exists, each procedure is coded separately using the appropriate body part value.
Example: The identical procedure performed on both fallopian tubes is coded once using the body part value Fallopian Tube, Bilateral. The identical procedure performed on both knee joints is coded twice using the body part values Knee Joint, Right and Knee Joint, Left.

Coronary arteries
B4.4
The coronary arteries are classified as a single body part that is further specified by number of sites treated and not by name or number of arteries. Separate body part values are used to specify the number of sites treated when the same procedure is performed on multiple sites in the coronary arteries.
Examples: Angioplasty of two distinct sites in the left anterior descending coronary artery with placement of two stents is coded as Dilation of Coronary Arteries, Two Sites, with Intraluminal Device.
Angioplasty of two distinct sites in the left anterior descending coronary artery, one with stent placed and one without, is coded separately as Dilation of Coronary Artery, One Site with Intraluminal Device, and Dilation of Coronary Artery, One Site with no device.

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

Skin, subcutaneous tissue and fascia overlying a joint
B4.6
If a procedure is performed on the skin, subcutaneous tissue or fascia overlying a joint, the procedure is coded to the following body part:

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

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

B5. Approach

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

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

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

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

B6. Device

General guidelines
B6.1a
A device is coded only if a device remains after the procedure is completed. If no device remains, the device value No Device is coded.

B6.1b
Materials such as sutures, ligatures, radiological markers and temporary post-operative wound drains are considered integral to the performance of a procedure and are not coded as devices.

B6.1c
Procedures performed on a device only and not on a body part are specified in the root operations Change, Irrigation, Removal and Revision, and are coded to the procedure performed.
Example: Irrigation of percutaneous nephrostomy tube is coded to the root operation Irrigation of indwelling device in the Administration section.

Drainage device
B6.2
A separate procedure to put in a drainage device is coded to the root operation Drainage with the device value Drainage Device.

Obstetric Section Guidelines (section 1)

C. Obstetrics Section

Products of conception
C1
Procedures performed on the products of conception are coded to the Obstetrics section. Procedures performed on the pregnant female other than the products of conception are coded to the appropriate root operation in the Medical and Surgical section.
Example: Amniocentesis is coded to the products of conception body part in the Obstetrics section. Repair of obstetric urethral laceration is coded to the urethra body part in the Medical and Surgical section.

Procedures following delivery or abortion
C2
Procedures performed following a delivery or abortion for curettage of the endometrium or evacuation of retained products of conception are all coded in the Obstetrics section, to the root operation Extraction and the body part Products of Conception, Retained. Diagnostic or therapeutic dilation and curettage performed during times other than the postpartum or post-abortion period are all coded in the Medical and Surgical section, to the root operation Extraction and the body part Endometrium.