
AHIMA Product # AC201113

As of 6/2/2014

Chapter 2 P. 57 Last two lines of the last paragraph should read:

The complete code is 0JBJ0ZX. The same steps are followed for the left hand, using the body part character of K for the subcutaneous tissue and fascia of the left hand: 0JBK0ZX.

Chapter 3 P.74 Last two paragraphs. Delete and change to read:

The term “ray” is used to designate the fingers and associated metacarpals and toes and associated metatarsals. The 1st ray is the thumb and 1st metacarpal in the hand and the great toe and 1st metacarpal in the foot. The same designation is made for the 2nd ray, index finger and associated metacarpal of the hand and 2nd toe and metatarsal of the foot; 3rd ray, middle finger and associated metacarpal of the hand and 3rd toe and metatarsal of the foot; 4th ray, ring finger and associated metacarpal of the hand, 4th toe and metatarsal of the foot; and 5th ray, little finger and associated metacarpal of the hand and little toe and metatarsal of the foot.

For example, a complete detachment of the ring finger and associated metacarpal of the left hand would be coded as OX6K0Z7.

Chapter 3 P. 85 Question number 9. Revise to read:

The patient undergoes cystoscopy and laser lithotripsy for calculus of the left ureter.

Chapter 3, Page 87 Procedure Description: 2nd paragraph- 3rd line, should read “The toe was completely removed....”

Chapter 5, Page 93 the last paragraph under Reattachment is changed to read:

“In Reattachment procedures, a body part that has been cut off or avulsed is reattached to the body. The blood supply is restored and the nerve supply may or may not be restored based on the circumstances of the case. Examples are reattachment of an avulsed kidney or a finger. Completely severed body parts are reattached. The root operation of Repair, covered in chapter 6, would be assigned for reconnection of partially separated body parts, such as a partially severed ear.”

Chapter 5 Page 117 last paragraph.
Delete the first and second sentences.

Revise the fourth sentence to read:

In this procedure the damaged native hip ball and/or socket are reshaped and augmented with a metal prosthesis,

Chapter 6 Page 126. Change the first sentence to read:

Inspection may also be coded as an additional procedure if a procedure is started using an endoscopic approach but is changed to a different approach.

Chapter 7, Page 147 Table 7.1

2nd degree should be coded as 0KQM0ZZ

3rd degree should be coded as 0KQM0ZZ, 0DQR0ZZ

4th degree should be coded as 0KQM0ZZ, 0DQR0ZZ, 0DQP0ZZ

Page 157 Procedure Statement Coding #8 change the second sentence to read “The drainage device is percutaneously pulled from the wound.”

Chapter 11, Page 251

Coding Knowledge Check #4, choice D. Change to read “Nothing, the qualifier value of Z is assigned.”

Procedure Statement Coding #1 – Change to read: “Double aorto-coronary artery bypass.....”

Chapter 14, Page 314 Example 1 – Change to read:

Code Characters:

<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>Medical and Surgical</td>
<td>Subcutaneous Tissue and Fascia</td>
<td>Removal</td>
<td>Subcutaneous Tissue and Fascia, Trunk</td>
<td>Open</td>
<td>Vascular Access Device</td>
<td>No Qualifier</td>
</tr>
<tr>
<td>0</td>
<td>J</td>
<td>P</td>
<td>T</td>
<td>0</td>
<td>X</td>
<td>Z</td>
</tr>
</tbody>
</table>

Rationale for the Answer: The root operation Removal is coded when devices are taken out or off from a body part. The implantable port is a vascular access device that was implanted in the subcutaneous layer of the patient’s chest. Removal of
Implantable devices requires an incision and therefore the approach value of 0, Open is assigned. The device value is X, Vascular Access Device. The correct code assignment is 0JPT0XZ.

Chapter 15, Page 240 Procedure Statement Coding #9 should read:

“Incision of the tendon sheath of extensor digitorum brevis in the right foot, percutaneous approach”

Chapter 19, Page 422 Procedure Statement Coding #2. Change to read, “Bilateral tubal ligation by Falope Ring, laparoscopic

Chapter 22 Page 483 Procedure Statement Coding. Delete item #8. Make the current # 9 #8 and the current #10 #9.

Appendix B, Page 626 Chapter 5, Which Root Operation Is It?, #7 should read:

7. Root Operation: Restriction ICD-10-PCS Code: 02VW3DZ

Change the qualifier to read “No Qualifier” and “Z”.

Appendix B, Page 627 Chapter 5, Case Study #1 should read:

1. There was an open insertion of the dual chamber pacemaker in the subcutaneous pocket of the chest. The cardiac leads were inserted in the right atrium and right ventricle percutaneously.

0JH606Z, 02H63JZ, 02HK3JZ

Appendix B, Page 633 Chapter 8, Case Study #9 answer should read:

9. ICD-10-PCS code: 0JWS0JZ

Rationale: Because an incision was made, the root operation of Change cannot be coded. The root operation of Revision is used because a portion of a device is repaired or replaced. This portion of the device lives in the subcutaneous layer of the head and neck. The device is a synthetic substitute because the valve controls the flow of CSF in a manner similar to the normal anatomy using a synthetic substitute. The device key says that a Holter Valve Ventricular Shunt is coded to “Synthetic Substitute”. If the ventricular catheter portion of this device had been revised, it would be code 00W60JZ. If the peritoneal catheter portion of this device had been revised, it would be coded as 0WWG0JZ. This provides three individual codes for the common work of revising a portion of this complicated device, with each being coded in their particular body part location.