RecordsOne Pit Stop*

Coding Clinic, Q3, 2017

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* 20 slides which advance every 15 seconds
The patient has a history of bowel perforation and obstruction, and is status post complex abdominal surgery due to intestinal anastomotic leak. She was transferred to the long-term care hospital (LTCH) for ongoing care of her abdominal wound. The patient presented with an enterocutaneous fistula with a large open abdominal wound and surgical wound dehiscence. Should the fistula be coded as a persistent postoperative fistula or according to the site of the fistula?

Answer:

Assign codes T81.83X-, Persistent postoperative fistula, and K63.2, Fistula of intestine, for the enterocutaneous postsurgical fistula. Both codes are needed to show the postoperative complication and the specific site of the fistula. Assign also code T81.32X-, Disruption of internal operation (surgical) wound, not elsewhere classified, for the wound dehiscence. The assignment of the 7th character "A" depends on whether active treatment is still being provided.

The postoperative fistula is considered "persistent," because it is a continuing problem requiring care.
Femoral Artery to Posterior Tibial Artery Bypass Using Autologous and Synthetic Grafts

**Question:**
A patient with critical limb ischemia presented with thrombosis of her previous popliteal artery bypass with rest pain of the right lower leg. She underwent an open bypass of the common femoral artery to the posterior tibial artery using polytetrafluoroethylene (PTFE) spliced to a reverse greater saphenous vein graft (SVG) that was harvested from a separate site on the right leg. Are two ICD-10-PCS codes assigned for the bypass utilizing SVG and synthetic graft/PTFE? What codes should be assigned for this procedure?

**Answer:**
ICD-10-PCS Table 041 does not have a single device value to capture both SVG and synthetic graft/PTFE; therefore, two codes from table 041 are necessary to completely describe the procedure, in addition to the code for harvesting the saphenous vein graft.

Assign the following codes:

- **041K09N** Bypass right femoral artery to posterior tibial artery with autologous venous tissue, open approach, for the femoral-tibial artery bypass using saphenous vein graft (SVG)
- **041K0JN** Bypass right femoral artery to posterior tibial artery with synthetic substitute, open approach, for the femoral-tibial artery bypass using PTFE/synthetic graft
- **06BP0ZZ** Excision of right greater saphenous vein, open approach, for the harvesting of saphenous vein graft

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<td>Altering the route of passage of the contents of a tubular body part</td>
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<td>Q Lower Extremity Artery</td>
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<td>R Lower Artery</td>
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<td>S Lower Extremity Vein</td>
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* 0 Open 4 Percutaneous Endoscopic 9 Autologous Venous Tissue A Autologous Arterial Tissue J Synthetic Substitute K Nonautologous Tissue Substitute Z No Device
Question:

A pediatric patient with intussusception of the colon underwent examination via rectal insufflation of air at a pressure of 120 mmHg using pulsed fluoroscopy. An ileocolic intussusception was encountered in the hepatic flexure of the colon, which was successfully reduced with good reflux of air into the terminal ileum. What is the correct root operation for reduction of ileocolic intussusception of the hepatic flexure of the colon, via air enema?

Answer:

Intussusception is the prolapse of one part of the intestine into the lumen of an immediately adjacent part of the intestine, causing intestinal obstruction. Ileocolic intussusception is a common problem in pediatric cases. The intent of the air enema is to push the intussusception/prolapse to relieve the obstruction; therefore, the appropriate root operation is "Reposition" - Moving to its normal location, or other suitable location, all or a portion of a body part. Assign the following ICD-10-PCS codes:

**0DSB7ZZ** Reposition ileum, via natural or artificial opening

**0DSK7ZZ** Reposition ascending colon, via natural or artificial opening

The body parts being repositioned are the ileum and the hepatic flexure, and the Body Part Key instructs "use Ascending Colon" for the hepatic flexure.
Question:
A child with Chiari malformation and syrinx was admitted for Chiari decompression. During surgery, a suboccipital craniectomy was extended down to the foramen magnum. C1 laminectomy was performed and the dura was opened. Microdissection of adhesions at the cerebellar tonsils allowed decompression of the brainstem and cervicomedullary junction. After confirming there was no obstruction over the fourth ventricle outflow, an AlloDerm dural graft was placed and the site was closed. What are the ICD-10-PCS codes for this procedure?

Answer:
The craniectomy and laminectomy are procedural steps necessary to the reach the site of decompression and should not be coded separately. Assign the following ICD-10-PCS codes:

00NC0ZZ Release cerebellum, open approach, for the decompression of the brainstem and cervicomedullary junction

00U20KZ Supplement dura mater with nonautologous tissue substitute, open approach, for the placement of the AlloDerm

AlloDerm has a biological basis so it is classified as a nonautologous tissue substitute.
Question:

A 64-year-old patient with new onset ascites presents for abdominal paracentesis. An ultrasound guided diagnostic and therapeutic paracentesis are both performed via a catheter. Is it appropriate to report two procedure codes for the diagnostic and therapeutic paracentesis?

Answer:

Assign only the following code:

0W9G3ZZ Drainage of peritoneal cavity, percutaneous approach, for the diagnostic and therapeutic paracentesis

If there is a therapeutic component to the procedure, only the qualifier "Z" is used, rather than the qualifier "X." The qualifier "X" is exclusively used for diagnostic procedures only. If there are two separate procedures, one diagnostic and the other therapeutic, then both procedures are code separately. For example, a diagnostic drainage procedure that uses a different approach or samples a different site from the therapeutic drainage procedure requires two separate codes to capture both the diagnostic procedure (biopsy) and the therapeutic procedure.
Implantation of Bilateral Neurostimulator Electrodes

Question: A patient underwent placement of a responsive neurostimulator with bilateral hippocampal depth electrodes. During the procedure, a stereotactic Leksell frame was fitted to the patient’s head. A linear incision was then extended in an arc from the left occiput to the right parietal region. The left-sided depth electrode coordinate was programmed into the Leksell arc and a myocutaneous flap was created to expose the surface of the skull where the burr hole would be centered. A burr hole was then created via a perforated drill bit. The dura and pia were opened and the NeuroPace depth electrode was inserted into the cannula. The burr hole was plugged and the outer cannula was removed. The same procedure was repeated for insertion of the right-sided depth electrode. Would the approach value for the insertion of neurostimulator leads via burr holes be reported as “open or percutaneous”?

Answer:

"Percutaneous" is the correct approach value for the insertion of neurostimulator leads via burr holes.

A burr hole is a small hole that is drilled through the skull. In this case, the neurostimulator leads were inserted through the burr holes to reach the targeted area. The ICD-10-PCS definition for "percutaneous approach" is entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to reach the site of the procedure.
Bronchoscopy with Suctioning and Washings for Removal of Mucus Plug

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Question:

A bronchoscopy was performed due to abnormal radiologic findings in the lung field. **The right middle lobe bronchus was occluded by a large mucus plug.** Mucomyst was administered locally and the mucus plug was washed and suctioned. Bronchial washings were submitted for microbiology. What is the correct code assignment for washing/lavage with suction of mucus plug?

Answer:

This procedure meets the definition of the root operation "Extirpation" – taking or cutting out solid matter from a body part. Assign the following ICD-10-PCS code:

0BC58ZZ

Extirpation of matter from right middle lobe bronchus, via natural or artificial opening endoscopic, for suctioning of the mucus plug.

The suctioning (extirpation) is the definitive procedure, and it is not required to code separately the irrigation (washing).
Question:

The patient was seen for removal of retained secretions. The bronchoscope was passed via the endotracheal tube. **Purulent secretions were suctioned from the lower lobes of the lung.** What is the correct code assignment for this procedure?

Answer:

Assign the following ICD-10-PCS code:

0B9M8ZZ

Drainage of bilateral lungs, via natural or artificial opening endoscopic, for the suctioning of the lower lobes of the lung

This procedure meets the definition of the root operation "Drainage"—taking or letting out fluids and/or gases from a body part.
Intra-Aortic Balloon Pump Removal

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Question:

A patient was transferred to our facility status post placement of an intra-aortic balloon pump (IABP) due to persistent cardiogenic shock. The patient subsequently underwent bedside removal of the IABP. The IABP was disconnected and the catheter and sheath were withdrawn. A Fem-Stop was then applied. What is the appropriate ICD-10-PCS code assignment for removal of an IABP performed at bedside?

Answer:

Facilities are not required to report the non-operative removal of an intra-aortic balloon pump separately. In ICD-10-PCS, the use of an IABP is classified in the Extracorporeal Assistance and Performance sections (5A0) where a device value does not exist. It would be inappropriate to report the removal of a device code from the Medical and Surgical section within ICD-10-PCS for an IABP when it is not specifically identified as a device in the classification.
Anterior Repair of Cystocele

Question:

A 59-year-old patient with uterine prolapse with cystocele presents for anterior repair. At surgery, a linear incision was made from the vaginal cuff to below the urethra and the vaginal mucosa was dissected off the pubovesical fascia with sharp and blunt dissection. The pubovesical fascia was then re-supported in the midline with layered sutures, thus reducing the cystocele. Is "repair" the appropriate root operation for the anterior cystocele repair? If so, there does not appear to be an appropriate approach value for the anterior repair of the cystocele. What is the appropriate code assignment for this procedure?

Answer:

Yes, "Repair" is the correct root operation for procedures performed to treat cystocele, rectocele and enterocele. Assign the following ICD-10-PCS code:

0JQC0ZZ Repair pelvic region subcutaneous tissue and fascia, open approach

In this case, an open approach is coded, because "a linear incision was made from the vaginal cuff to below the urethra" to expose the pubovesical fascia directly, and then the repair was performed.
Question:

A 73-year-old patient, who is status post partial right nephrectomy due to renal cell carcinoma, presented due to a urine leak with a urinary fistula and retroperitoneal fluid collection. Urinary diversion was performed by placing a right ureteral stent. A double J ureteral stent was placed with the proximal curl in the upper pole calyx and the distal curl in the bladder. What is the appropriate root operation for this procedure?

Answer:
The stent was placed to keep the ureteral valve between the bladder and the ureter open. This helps facilitate normal drainage of the urine, into the bladder rather than out the urinary fistula. Assign the following ICD-10-PCS code:

0T9680Z Drainage of right ureter with drainage device, via natural or artificial opening endoscopic, for the insertion of the urinary stent for urinary leakage
Question:
A patient presented to undergo replacement of his skull bone flap status post an emergent decompressive craniectomy. During the procedure, the incision was opened down to the level of the periosteum. The incision was further dissected, and the myocutaneous flap was elevated from the dura. The bone flap was removed from the abdominal wall and reattached to the skull with titanium plates and screws. What are the procedure code assignments for retrieval of bone flap from abdominal wall with replacement into skull?

Answer:
Assign the following ICD-10-PCS codes:

**0JC80ZZ** Extirpation of matter from abdomen subcutaneous tissue and fascia, open approach, for removal of the bone flap from the abdominal wall

**0NS004Z** Reposition skull with internal fixation device, open approach, for the replacement of the skull bone flap
Laparoscopic Esophagomyotomy (Heller Type) and Toupet Fundoplication

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Question:

A patient diagnosed with achalasia underwent laparoscopic esophagomyotomy (Heller type) and Toupet fundoplication. The provider completed myotomy of the esophagus and stomach. The provider sutured the posterior aspect of the stomach to the cut side of the myotomy on the right side, and sutured the anterior stomach to the cut side of the myotomy on the left side, giving a nice Toupet fundoplication that held open the myotomy site. What is the correct ICD-10-PCS code for laparoscopic esophagomyotomy (Heller type) and Toupet fundoplication to treat achalasia?

Answer:

The Heller type esophagomyotomy fits the root operation definition of "Division," which is defined as cutting into a body part without draining fluids and/or gases from the body part in order to separate or transect a body part. "Division" is a more specific depiction than "Dilation" of what was done. Additionally, the Toupet fundoplication is coded using the root operation "Restriction," because the intent of the fundoplication is to make the lumen of the tubular body part smaller. Assign the following ICD-10-PCS codes:

0D844ZZ Division of esophagogastric junction, percutaneous endoscopic approach, for the myotomy
0DV44 ZZ Restriction of esophagogastric junction, percutaneous endoscopic approach for the fundoplication
Emaciation and Malnutrition

Question:

The ICD-10-CM Index for Diseases lists the following: Emaciation (due to malnutrition) E41. The Tabular List of Diseases lists E41 as Nutritional Marasmus. If a physician documents Emaciation, given that "due to malnutrition" is a nonessential modifier, the Index classifies the term "emaciation" as E41, Nutritional marasmus. If a physician documents "emaciation" without documenting malnutrition, would it be appropriate to assign code E41?

Answer:

First, it should be noted that marasmus by definition is a type of protein-energy malnutrition occurring in infants or young children, that is caused by a severe calorie deficiency. If that is not applicable for the case, then it is not correct to assign code E41, Nutritional marasmus, even if the physician only documents emaciated or emaciation without the documentation of "malnutrition." Assign code R64, Cachexia, for a diagnosis of emaciated/emaciation. If the provider intended to describe malnutrition, then it should be documented as such. Emaciated is a descriptive term, meaning unusually thin due to wasting. Although the Index currently refers to code E41, a basic rule of coding is that further research is done if the title of the code suggested by the Index does not identify the condition correctly.
Severe Malnutrition

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Question:

Can code E40, Kwashiorkor or code E42, Marasmic kwashiorkor, be assigned to capture a diagnosis of severe malnutrition?

Answer:

No, do not assign code E40, Kwashiorkor or code E42, Marasmic kwashiorkor, for severe malnutrition unless this condition is specifically documented. Assign code E43, Unspecified severe protein-calorie malnutrition. Code E43 can found by looking up “Malnutrition, severe” in the Alphabetic Index as follows: (image)

Kwashiorkor is a condition caused by severe protein deficiency that is usually seen in poor, underdeveloped countries. It is extremely rare in the United States.
Late Preterm Infant

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Question:

An infant was born at 37 weeks and five days gestation via low transverse cesarean section. The provider’s diagnostic statement listed, “Late preterm infant.” The ICD-10-CM does not provide a code for preterm infants with a gestational age greater than 36 completed weeks. However, the ICD-10-CM Official Guidelines for Coding and Reporting state, "Providers utilize different criteria in determining prematurity. A code for prematurity should not be assigned unless it is documented." What code is assigned for a late preterm infant, who is beyond 36 weeks gestation?

Answer:

Do not assign a code for "late preterm infant". Query the physician whether the newborn is "small for dates" or "light for dates." ICD-10-CM does not classify a diagnosis of "late preterm infant." The clinical definition of a "late preterm" infant, according to a statement from the American Academy of Pediatrics, refers to infants born at 34 0/7 through 36 6/7 weeks' gestation. See the following link for the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists position statement pertaining to "Late Preterm Infant": http://pediatrics.aappublications.org/content/120/6/1390

ICD-10-CM does not classify infants with a gestational age of 37 weeks or more as preterm. There is an existing code P07.39, Preterm newborn, gestational age 36 completed weeks. This has an inclusion term, "Preterm newborn, gestational age 36 weeks, 0 days through 36 weeks, 6 days."
GI Bleeding Secondary to Gastric Ulcer

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Question:

A patient presents due to acute gastrointestinal bleed (GI). An esophagogastroduodenoscopy (EGD) was performed, which showed gastric ulcers as well as portal hypertension. The physician does not link the bleeding to the ulcer nor is it documented that these conditions are unrelated. Under the revised “With” guideline, it appears that we may assume a relationship between the gastrointestinal bleed and the ulcer. How should we report gastric ulcer in a patient with gastrointestinal bleeding?

Answer:

It would be appropriate to assign code K25.4, Chronic or unspecified gastric ulcer with hemorrhage. As stated in the ICD-10-CM Official Guidelines for Coding and Reporting, (I.A.15) the classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. Unless the provider documents a different cause of the bleeding or states that the conditions are unrelated, it is appropriate to assign the combination code for these conditions.
Correction Notice: Tunneled Vascular Access Device

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Coding Clinic Fourth Quarter 2015, pages 30-31 contained a misprint regarding the creation of a pocket in the chest subcutaneous tissue for placement of a port for a tunneled hemodialysis catheter. A pocket is not created in the chest wall subcutaneous tissue for a tunneled catheter. As stated in Coding Clinic, Second Quarter 2017, pages 24-25, a tunneled catheter is typically advanced via the internal jugular vein into the superior/inferior vena cava, or right atrium under fluoroscopic guidance. The other end of the catheter is tunneled beneath the skin and subcutaneous tissue; and a second incision is made at the exit site on the chest.
Follow-up

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