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Coding Clinic, Q4, 2017

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ICD-10-CM New/Revised Codes

Coding Clinic for ICD-10-CM/PCS, Fourth Quarter 2017: Pages 4-29

- Acute Respiratory Distress
- Amyloidosis
- Avoidant/Restrictive Food Intake Disorder
- Blindness and Low Vision
- Clostridium Difficile Enterocolitis
- Degenerative Myopia
- Dermatomyositis
- External Cause of Injury Codes for All-Terrain Vehicles, Dirt Bike and Motor Cross Bike
- Gestational Alloimmune Liver Disease
- Gingival Recession
- Intestinal Obstruction
- Intracranial Injury
- Lump in Breast
- Mastocytosis and Certain Other Mast Cell Disorders
- Maternal Care for Abnormalities of Fetal Heart Rate or Rhythm
- Motor Neuron Disease
- Neonatal Encephalopathy
- Non-Pressure Chronic Ulcer
- Other Heart Failure
- Pediatric Cryptorchidism (Undescended and Nonpalpable Testicle)
- Pediatric Glasgow Coma Scale
- Pulmonary Hypertension
- Pulmonary Hypertension of Newborn and Other Persistent Fetal Circulation
- Spinal Stenosis with and without Neurogenic Claudication
- Substance Related Disorders, In Remission
- Tubal and Ovarian Pregnancy
- Type 2 Diabetic Ketoacidosis
- Types of Acute Myocardial Infarction
- Umbilical Granuloma in Perinatal Period
- Unspecified Injuries
- Z Code Update
### ICD-10-PCS New/Revised Codes

**Coding Clinic for ICD-10-CM/PCS, Fourth Quarter 2017: Pages 30-78**

<table>
<thead>
<tr>
<th>Added and Revised Device Values</th>
<th>Section 0-MedSurg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Added Approach Values</td>
<td>Section 0-MedSurg</td>
</tr>
<tr>
<td>Administration of Influenza Vaccine</td>
<td>Section 3-Admin</td>
</tr>
<tr>
<td>Angiography of Pulmonary Trunk</td>
<td>Section B-Imaging</td>
</tr>
<tr>
<td>Central Nervous System and Cranial Nerves</td>
<td>Section 0-MedSurg</td>
</tr>
<tr>
<td>Correction of Congenital Heart Defects</td>
<td>Section 0-MedSurg</td>
</tr>
<tr>
<td>Dilation and Bypass of Cerebral Ventricle</td>
<td>Section 0-MedSurg</td>
</tr>
<tr>
<td>Drug-Coated Balloon Dilation of Lower Arteries</td>
<td>Section 0-MedSurg</td>
</tr>
<tr>
<td>Extracorporeal Carbon Dioxide Removal:</td>
<td>Section 5-Extracorporeal or System Assist &amp; Perf</td>
</tr>
<tr>
<td>Extraction Procedures</td>
<td>Section 0-MedSurg</td>
</tr>
<tr>
<td>Graft Replacement</td>
<td>Section 0-MedSurg</td>
</tr>
<tr>
<td>Hemodialysis &amp; RRT</td>
<td>Section 5-Extracorporeal or System Assist &amp; Perf</td>
</tr>
<tr>
<td>Insertion of External Heart Assist Devices</td>
<td>Section 0-MedSurg</td>
</tr>
<tr>
<td>Intramuscular Autologous Bone Marrow Cell Therapy</td>
<td>Section X-New Technology</td>
</tr>
<tr>
<td>Intraoperative Treatment of Vascular Grafts</td>
<td>Section X-New Technology</td>
</tr>
<tr>
<td>Magnetic Growth Rods</td>
<td>Section X-New Technology</td>
</tr>
<tr>
<td>Manual Extraction of Retained Products of Conception</td>
<td>Section 1-OB</td>
</tr>
<tr>
<td>New and Revised Body Part Values</td>
<td>Section 0-MedSurg</td>
</tr>
<tr>
<td>New Qualifier Values</td>
<td>Section 0-MedSurg</td>
</tr>
<tr>
<td>New Therapeutic Substances</td>
<td>Section X-New Technology</td>
</tr>
<tr>
<td>Oxidized Zirconium on Polyethylene Bearing Surface</td>
<td>Section 0-MedSurg</td>
</tr>
<tr>
<td>Percutaneous Endoscopic Administration</td>
<td>Section 3-Admin</td>
</tr>
<tr>
<td>Radiolucent Porous Interbody Fusion Device</td>
<td>Section X-New Technology</td>
</tr>
<tr>
<td>Radiotherapeutic Brain Implant:</td>
<td>Section 0-MedSurg</td>
</tr>
<tr>
<td>Resuscitative Endovascular Balloon</td>
<td>Section 0-MedSurg</td>
</tr>
</tbody>
</table>

**Section 4-Measurement and Monitoring**

**Section 5-Extracorporeal or System Assist & Perf**

**Section 6-Extracorporeal or Systemic Therapies**

**Section X-New Technology**
Changes to the ICD-10-CM Official Guidelines for Coding and Reporting
Coding Clinic for ICD-10-CM/PCS, Fourth Quarter 2017: Page 79

Section I.
A. Conventions for the ICD-10-CM . . .

15. "With"

The word "with" or "in" should be interpreted to mean "associated with" or "due to" when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List. The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated or when another guideline exists that specifically requires a documented linkage between two conditions (e.g., sepsis guideline for "acute organ dysfunction that is not clearly associated with the sepsis").

For conditions not specifically linked by these relational terms in the classification or when a guideline requires that a linkage between two conditions be explicitly documented, provider documentation must link the conditions in order to code them as related. . . .

17. "Code also" note

A "code also" note instructs that two codes may be required to fully describe a condition, but this note does not provide sequencing direction. The sequencing depends on the circumstances of the encounter. . . .

Section II.
K. Admissions/Encounters for Rehabilitation . . .

If the condition for which the rehabilitation service is being provided is no longer present, report the appropriate aftercare code as the first-listed or principal diagnosis, unless the rehabilitation service is being provided following an injury. For rehabilitation services following active treatment of an injury, assign the injury code with the appropriate seventh character for subsequent encounter as the first-listed or principal diagnosis. For example, if a patient with severe degenerative osteoarthritis of the hip, underwent hip replacement and the current encounter/admission is for rehabilitation, report code Z47.1, Aftercare following joint replacement surgery, as the first-listed or principal diagnosis. If the patient requires rehabilitation post hip replacement for right intertrochanteric femur fracture, report code S72.141D, Displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, as the first-listed or principal diagnosis.
Changes to the ICD-10-PCS Official Guidelines for Coding and Reporting

Coding Clinic for ICD-10-CM/PCS, Fourth Quarter 2017: Page 93

B3. Root Operation . . .
Discontinued or incomplete procedures

B3.3
Control vs. more definitive root operations

If the intended procedure is discontinued or otherwise not completed, 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.

B3.7

The root operation Control is defined as, "Stopping, or attempting to stop, postprocedural or other acute bleeding." If an attempt to stop postprocedural or other acute bleeding is initially unsuccessful, and to stop the bleeding requires performing any of the definitive root operations a more definitive root operation, such as Bypass, Detachment, Excision, Extraction, Reposition, Replacement, or Resection, then the more definitive root operation is coded instead of Control.

B4. Body Part . . .

B4.1c
If a procedure is performed on a continuous section of a tubular body part, code the body part value corresponding to the furthest anatomical site from the point of entry.

Example: A procedure performed on a continuous section of artery from the femoral artery to the external iliac artery with the point of entry at the femoral artery is coded to the external iliac body part.

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.

In limited root operations, the classification provides the qualifier values Temporary and Intraoperative, for specific procedures involving clinically significant devices, where the purpose of the device is to be utilized for a brief duration during the procedure or current inpatient stay.
Bacterial Pneumonia, Influenza A, & Acute Exacerbation of COPD

Coding Clinic for ICD-10-CM/PCS, Fourth Quarter 2017: Page 96

Question:

The patient was admitted with wheezing and shortness of breath. The provider's diagnostic statement listed, "Bacterial pneumonia on top of influenza A, exacerbation of chronic obstructive pulmonary disease (COPD)." Would a combination code be assigned for the influenza with pneumonia and COPD and pneumonia; or should each condition be coded separately? Does the fact that a combination code is assigned for COPD with acute lower respiratory infection affect assigning an additional code for influenza with pneumonia? How would this case be coded?

Answer:

Assign code J10.08, Influenza due to other identified influenza virus with other specified pneumonia; code J44.0, Chronic obstructive pulmonary disease with acute lower respiratory infection; code J15.9, Unspecified bacterial pneumonia; and code J44.1, Chronic obstructive pulmonary disease with (acute) exacerbation. All four codes are needed to capture the diagnostic statement. The circumstances of the admission would determine the principal diagnosis.

Please note that effective October 1, 2017, the "use additional code to identify the infection" note at code J44.0, Chronic obstructive pulmonary disease with acute lower respiratory infection, has been revised to "Code also to identify infection."
**COPD and Emphysema**

*Coding Clinic for ICD-10-CM/PCS, Fourth Quarter 2017: Page 97*

**Question:**

How should COPD and emphysema be coded when both are documented and supported in the medical record?

**Answer:**

Assign code J43.9, Emphysema, unspecified. Emphysema is a specific type of COPD.

Effective October 1, 2017, the indexing for these conditions has been changed to:

```
Disease, diseased --see also Syndrome
lung J98.4
obstructive (chronic) J44.9
    with
        acute
            bronchitis J44.0
            exacerbation NEC J44.1
            lower respiratory infection J44.0
        alveolitis, allergic J67.9
        asthma J44.9
        bronchiectasis J47.9
            with
                exacerbation (acute) J47.1
                lower respiratory infection J47.0
        bronchitis J44.9
            with
                exacerbation (acute) J44.1
                lower respiratory infection J44.0
        emphysema J43.9
```
Severe Sepsis and Acute Organ Dysfunction/Failure

Question:

The AHA Central Office has received several questions whether sepsis with any acute organ dysfunction is assumed to be linked by the term "with" or if the physician must directly link it with the sepsis to code as severe sepsis. Providers are documenting conditions such as, but not limited to, hypoperfusion, hyperbilirubinemia, lactic acidosis, encephalopathy, thrombocytopenia, hypoxia and hypotension, etc., as an acute organ dysfunction in severe sepsis. **Is it appropriate to report severe sepsis with acute organ dysfunction when the provider has documented conditions, such as hyperbilirubinemia, but has not explicitly linked the conditions?**

Answer:

Code assignment is based on the provider's documentation, the instructions in the classification, as well as the current coding guidelines.

The *Official Guidelines for Coding and Reporting* must be followed. Section I, C, 1, d, 1, a, (iii) of the guidelines states that a code is assigned for severe sepsis, when the provider documents sepsis and an associated acute organ dysfunction or multiple organ dysfunction. It is also appropriate to assign a code for severe sepsis when the provider documents "severe sepsis," or when the Index to Diseases directs the coder to the code for "severe sepsis."

**The conditions that represent an acute organ dysfunction in severe sepsis which are listed under subcategory R65.2-, Severe sepsis, is not an exhaustive list.** Therefore, if the documentation is unclear regarding whether a specific condition is considered organ dysfunction/failure, query the physician for clarification, since this is a clinical question.
Diabetes and Cellulitis

Coding Clinic for ICD-10-CM/PCS, Fourth Quarter 2017: Page 100

Question:

A 79-year-old male with type 2 diabetes mellitus presented due to acute cellulitis of the left lower leg. The patient was admitted and started on broad-spectrum antibiotics. When assigning the diabetes code, would it be appropriate to report the code for diabetes “with skin complication NEC?” What is the appropriate code assignment for cellulitis in a patient with type 2 diabetes?

Answer:

In order to link the diabetes and the cellulitis, the provider would need to document cellulitis as a diabetic skin complication. When the causal relationship is unclear, query the provider regarding the linkage and whether cellulitis is a skin complication caused by the diabetes. Each case is patient specific, and the relationship between diabetes and cellulitis should be clearly documented by the provider. When the coder is unable to determine whether a condition is a diabetic complication, or the ICD-10-CM classification does not provide instruction, it is appropriate to query the physician for clarification so that the appropriate codes may be reported.

"Diabetes with skin complication NEC," is indexed, but "diabetes with cellulitis" is not specifically indexed. The "with" guideline does not apply to "not elsewhere classified (NEC)" index entries that cover broad categories of conditions. Specific conditions must be linked by the terms "with," "due to" or "associated with." Coding professionals should not assume a causal relationship when the diabetic complication is "NEC." The ICD-10-CM classification presumes a cause and effect relationship with certain specific conditions when the Alphabetic Index links the conditions by the terms "with", "due to" or "associated with".
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Encounter for Brachytherapy due to Cervical Malignancy

Coding Clinic for ICD-10-CM/PCS, Fourth Quarter 2017: Page 103

**Question:**

A patient is admitted for brachytherapy due to cervical cancer. Intrauterine tandem and ovoids are placed and brachytherapy is provided. When coding encounters for brachytherapy, should code Z51.0, Encounter for antineoplastic radiation therapy, be assigned as the principal diagnosis, or should a code for the malignancy be assigned as the principal diagnosis? **What is the appropriate code assignment for an encounter for brachytherapy due to cervical cancer?**

**Answer:**

Assign code C53.9, Malignant neoplasm of cervix uteri, unspecified, as the principal diagnosis for a patient who presents for brachytherapy due to cervical cancer.

Effective October 1, 2017, the *Official Guidelines for Coding and Reporting*, Section I.C.2 have been revised to clarify that code Z51.0, Encounter for antineoplastic radiation therapy, is intended for encounters for external beam radiation therapy. Further guidance has been added specifying that for admission/encounters for the insertion or implantation of radioactive elements (e.g., brachytherapy) sequence the appropriate code for the malignancy as the principal or first-listed diagnosis.

**Brachytherapy**

Brachytherapy, or interstitial radiation therapy, puts a source of radiation in or near the cancer. This type of radiation only travels a short distance. The type of brachytherapy used most often to treat cervical cancer is known as *intrauterine brachytherapy*. The radiation source is placed in a device in the vagina (and sometimes in the cervix). This is often used in addition to EBRT as a part of the main treatment for cervical cancer.

There are two types of brachytherapy:

- **Low-dose rate (LDR) brachytherapy** is completed over a few days. During this time, the patient stays in bed in a private room in the hospital with instruments holding the radioactive material in place. While the radiation therapy is being given, the hospital staff will care for you, but also take precautions to lessen their own radiation exposure.

- **High-dose rate (HDR) brachytherapy** is done as an outpatient over several treatments (often at least a week apart). For each high-dose treatment, the radioactive material is inserted for a few minutes and then removed. The advantage of HDR treatment is that you do not have to stay in the hospital or stay still for long periods of time.

To treat cervical cancer in women who have had a hysterectomy, the radioactive material is placed in a tube in the vagina.

To treat a woman who still has a uterus, the radioactive material can be placed in a small metal tube (called a tandem) that goes in the uterus, along with small round metal holders (ovoids) placed near the cervix. This is sometimes called tandem and ovoid treatment. Another option is called tandem and ring. For this, a round holder (like a disc) is placed close to the uterus. The choice of which one to use depends on what type of brachytherapy is planned.
Intrauterine Brachytherapy & Placement of Tandems & Ovoids

Coding Clinic for ICD-10-CM/PCS, Fourth Quarter 2017: Page 104

Question:

A 52-year-old woman with squamous cell carcinoma of the cervix presents for her first brachytherapy treatment with intrauterine tandem and ovoid placement. The vagina was prepped and draped, a tandem was placed into the uterus, and two ovoids were placed adjacent to the cervix. Low-dose radiation was administered using Cesium 137. Is both the insertion of the tandem and ovoids coded, with the brachytherapy service, or is the insertion of these devices inherent to the brachytherapy? What are the appropriate code assignments for this brachytherapy treatment?

Answer:

Assign the following ICD-10-PCS codes:

0WHR7YZ
Insertion of other device into genitourinary tract, via natural or artificial opening, for the insertion of tandem and ovoid placement, and

DU11B7Z
Low dose rate (LDR) brachytherapy of cervix using Cesium 137 (Cs-137), for the brachytherapy

The tandem and ovoids are specialized applicators through which the brachytherapy is delivered; they themselves are not radioactive elements.
**Question:**

The patient was admitted for placement of a Watchman™ left atrial appendage device in the os of the left atrial appendage. Under fluoroscopic and echocardiographic guidance, the device was advanced into the left atrial appendage. However, the device was removed prior to the completion of the procedure when it was ultimately found to be unstable due to inadequate size. What is the code assignment for this procedure?

**Answer:**

In this case, the Watchman device was inserted. Before the termination of the operative episode, while the patient was still under anesthesia, the effectiveness of the device was assessed and found to be inadequate. A procedure to remove the device was then performed. Both the insertion and the removal are coded. Assign the following ICD-10-PCS codes:

- **02H73DZ**
  Insertion of intraluminal device into left atrium, percutaneous approach, for transcatheter insertion of the Watchman device

- **02PA3DZ**
  Removal of intraluminal device from heart, percutaneous approach, for transcatheter removal of the Watchman device
Nasal Packing for Epistaxis

Question:

The patient presents to the Emergency Department (ED) and is admitted as an inpatient for treatment of epistaxis associated with anticoagulant use. While in the ED, the provider packed the nose with a nasal tampon to stop the bleeding. What is the appropriate ICD-10-PCS code assignment for the use of nasal tampon to treat epistaxis?

Answer:

Assign the following ICD-10-PCS code:

2Y41X5Z
Packing of nasal region using packing material

The root operation “Packing” in the Placement section is the most appropriate code assignment, for nasal packing.
Total Ankle Replacement versus Revision

Coding Clinic for ICD-10-CM/PCS, Fourth Quarter 2017: Page 107

Question:

What is the correct ICD-10-PCS root operation for revision of right total ankle replacement? Is the correct root operation "Revision" or "Removal" and "Replacement" when a portion of the existing prosthesis is revised?

Answer:

Although the provider may document "revision," for correct code assignment it is important to understand what the procedure is.

Any time a joint replacement is adjusted, but not removed, the procedure is coded to the root operation "Revision." The definition for the root operation "Revision" is "correcting, to the extent possible, a malfunctioning or misplaced device without taking out and putting a whole new device in its place."

Assign the following ICD-10-PCS code for adjustment of a previously placed right ankle joint prosthesis:

0SWF0JZ

Revision of synthetic substitute in right ankle joint, open approach

When components of a joint prosthesis are removed and new components are inserted during the same encounter, code both the removal of the old components and placement of the new components with the root operations "Removal" and "Replacement." The full definition of the root operation "Removal" is "Taking out or off a device from a body part." The full definition of the root operation "Replacement" is "Putting in or on biological or synthetic material that physically takes the place and/or function of all or a portion of a body part."

Assign the following ICD-10-PCS codes for the removal of old joint prosthesis components and placement of new components in the right ankle:

0SPF0JZ

Removal of synthetic substitute from right ankle joint, open approach, and

0SRF0JA

Replacement of right ankle joint with synthetic substitute, uncemented, open approach
Malnutrition and Malabsorption

Coding Clinic for ICD-10-CM/PCS, Fourth Quarter 2017: Page 108

Question:

A 45-year-old patient, who was diagnosed with scleroderma, severe gastroparesis, weight loss, severe malnutrition, and severe malabsorption, was admitted for total parenteral nutrition and placement of a peripherally inserted central catheter. Code E43, Unspecified severe protein-calorie malnutrition, is assigned for severe malnutrition and code K90.9, Intestinal malabsorption, unspecified, is assigned for malabsorption. There is an Excludes2 note at the beginning of Chapter 11 (K00-K95), and an Excludes1 note at the beginning category E40-E46. Based on the conflicting Excludes notes, please clarify whether the coding professional may assign code E43 and code K90.9 together?

Answer:

Assign both code K90.9, Intestinal malabsorption, unspecified, and code E43, Unspecified severe protein-calorie malnutrition. Although there is an Excludes1 note, these are separate conditions, which can exist independently. In order to convey the complete clinical picture and in the interest of reliable data, both codes should be used. The CDC/NCHS has agreed to consider revising the Excludes1 note through the ICD-10 Coordination and Maintenance Committee process.
Unstageable Pressure Ulcer (Injury)

Coding Clinic for ICD-10-CM/PCS, Fourth Quarter 2017: Page 109

Question:

What are the correct ICD-10-CM codes and POA indicator for an unstageable pressure ulcer in which an eschar is removed during the patient's stay to reveal either stage III or stage IV pressure ulcer?

Answer:

If a patient is admitted with an unstageable pressure ulcer, and the eschar is removed to reveal the stage of the ulcer, assign the code for the ulcer site with the highest stage reported during the stay with a POA indicator of “Y”. Do not assign a code for unstageable pressure ulcer, as the true stage of an unstageable ulcer cannot be determined until the slough/eschar is removed. The opening of the wound does not indicate a progression to a higher stage. The code for unstageable pressure ulcer should only be assigned when it is not possible to stage the ulcer during the current encounter.
Question:

_Coding Clinic_, Fourth Quarter 2016, page 149, states "A facility may require that a physician use a particular clinical definition or set of criteria when establishing a diagnosis". Would it be appropriate for facilities to develop a policy to omit a diagnosis code based on the provider's documentation not meeting established criteria?

Answer:

No. It is not appropriate to develop internal policies to omit codes automatically when the documentation does not meet a particular clinical definition or diagnostic criteria. Facilities may review documentation to clinically validate diagnoses and develop policies for querying the provider for clarification to confirm a diagnosis that may not meet particular criteria.

Facilities should also work with their medical staff to ensure conditions are appropriately diagnosed and documented. If after querying, the attending physician affirms that a patient has a particular condition in spite of certain clinical parameters not being met, the facility should request the physician document the clinical rationale and be prepared to defend the condition if challenged in an audit. The facility should assign the appropriate code(s) for the conditions documented.
Correction Notice: Exchange of Ureteral Stent

Coding Clinic for ICD-10-CM/PCS, Fourth Quarter 2017: Page 111

Advice published in Coding Clinic, Second Quarter 2016, pages 26-27, regarding ureteral stent exchange contained a typographical error. Both codes describing removal of ureteral stent and dilation of ureter should have the approach value "8" (via natural or artificial opening endoscopic) as follows:

0TP98DZ
Removal of intraluminal device from ureter, via natural or artificial opening endoscopic and;

0T768DZ
Dilation of right ureter with intraluminal device, via natural or artificial opening endoscopic
Follow-up

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