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RECORDSONE

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

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

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

Coding Clinic for ICD-10-CM/PCS, Fourth Quarter 2017: Page 98

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:

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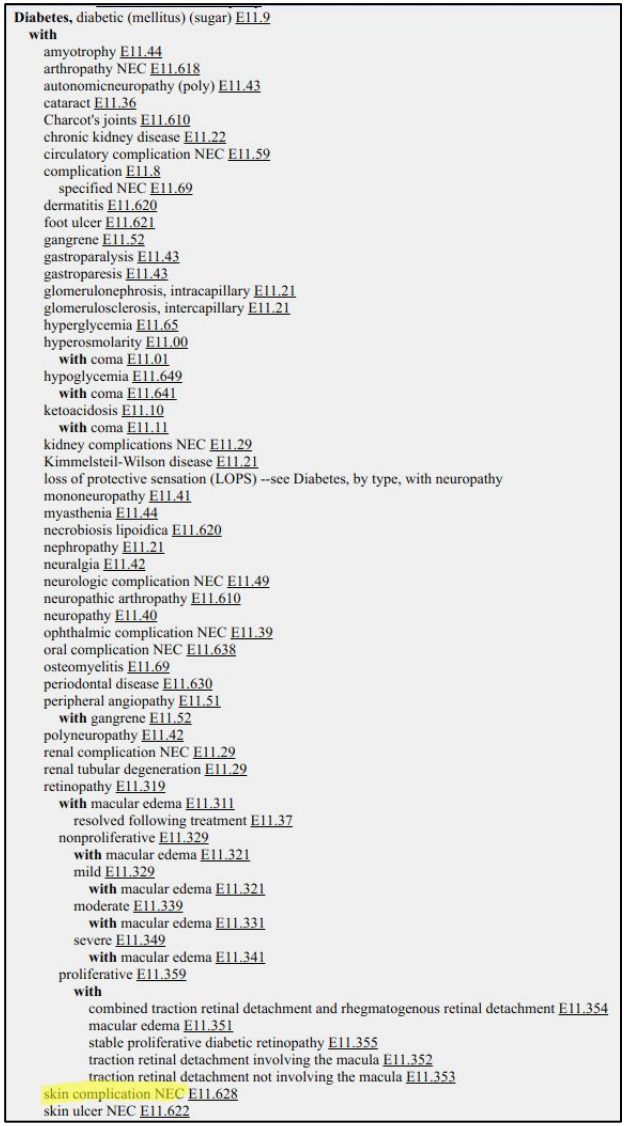
A 79-year-old male with type 2 diabetes mellitus presented due to acute cellulitis of the left lower leg. The patient was admitted and started on broad-spectrum antibiotics. When assigning the diabetes code, would it be appropriate to report the code for diabetes "with skin complication NEC?" What is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



Diabetes, diabetic (mellitus) (sugar) E11.9
- **with**
  - amyotrophy E11.44
  - arthropathy NEC E11.618
  - autonomicneuropathy (poly) E11.43
  - cataract E11.36
  - Charcot's joints E11.610
  - chronic kidney disease E11.22
  - circulatory complication NEC E11.59
  - complication E11.8
    - specified NEC E11.69
  - dermatitis E11.620
  - foot ulcer E11.621
  - gangrene E11.52
  - gastroparalysis E11.43
  - gastroparesis E11.43
  - glomerulonephrosis, intracapillary E11.21
  - glomerulosclerosis, intercapillary E11.21
  - hyperglycemia E11.65
  - hyperosmolarity E11.00
    - **with** coma E11.01
  - hypoglycemia E11.649
    - **with** coma E11.641
  - ketoacidosis E11.10
    - **with** coma E11.11
  - kidney complications NEC E11.29
  - Kimmelsteil-Wilson disease E11.21
  - loss of protective sensation (LOPS) --see Diabetes, by type, with neuropathy
  - mononeuropathy E11.41
  - myasthenia E11.44
  - necrobiosis lipoidica E11.620
  - nephropathy E11.21
  - neuralgia E11.42
  - neurologic complication NEC E11.49
  - neuropathic arthropathy E11.610
  - neuropathy E11.40
  - ophthalmic complication NEC E11.39
  - oral complication NEC E11.638
  - osteomyelitis E11.69
  - periodontal disease E11.630
  - peripheral angiopathy E11.51
    - **with** gangrene E11.52
  - polyneuropathy E11.42
  - renal complication NEC E11.29
  - renal tubular degeneration E11.29
  - retinopathy E11.319
    - **with** macular edema E11.311
      - resolved following treatment E11.37
    - nonproliferative E11.329
      - **with** macular edema E11.321
      - mild E11.329
        - **with** macular edema E11.321
      - moderate E11.339
        - **with** macular edema E11.331
      - severe E11.349
        - **with** macular edema E11.341
    - proliferative E11.359
      - **with**
        - combined traction retinal detachment and rhegmatogenous retinal detachment E11.354
        - macular edema E11.351
        - stable proliferative diabetic retinopathy E11.355
        - traction retinal detachment involving the macula E11.352
        - traction retinal detachment not involving the macula E11.353
  - skin complication NEC E11.628
  - skin ulcer NEC E11.622

Diabetes and Skin Complication NEC

Coding Clinic for ICD-10-CM/PCS, Fourth Quarter 2017: Page 102

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".

Encounter for Brachytherapy due to Cervical Malignancy

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

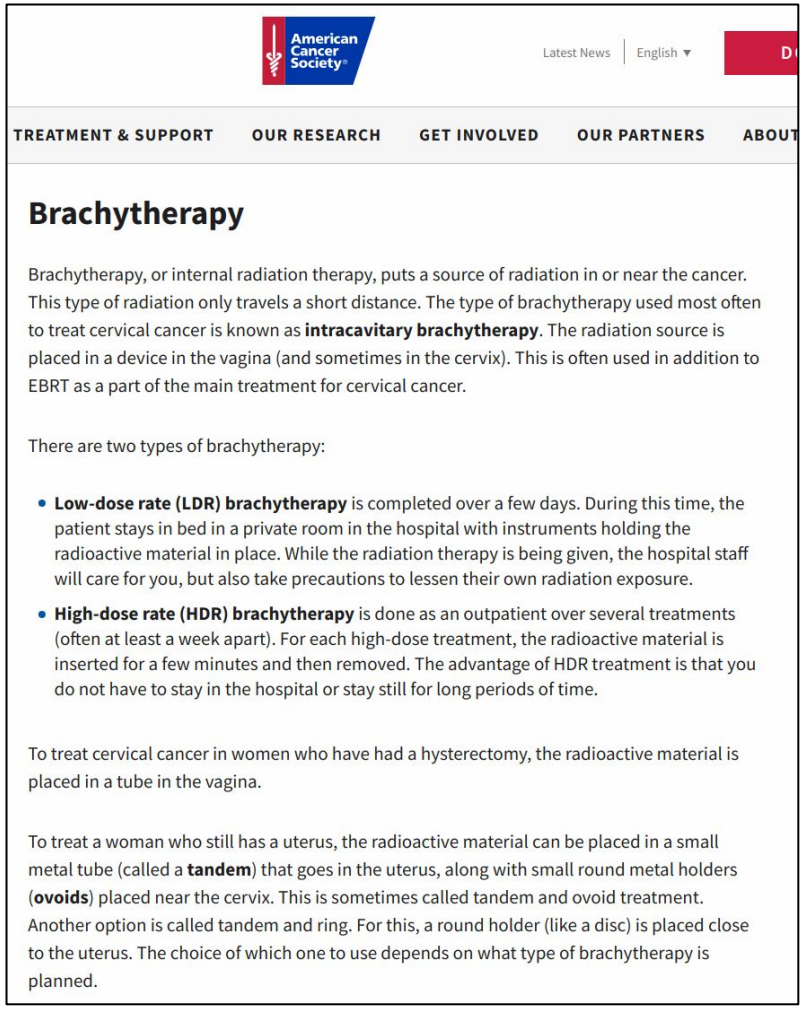
Question:

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.



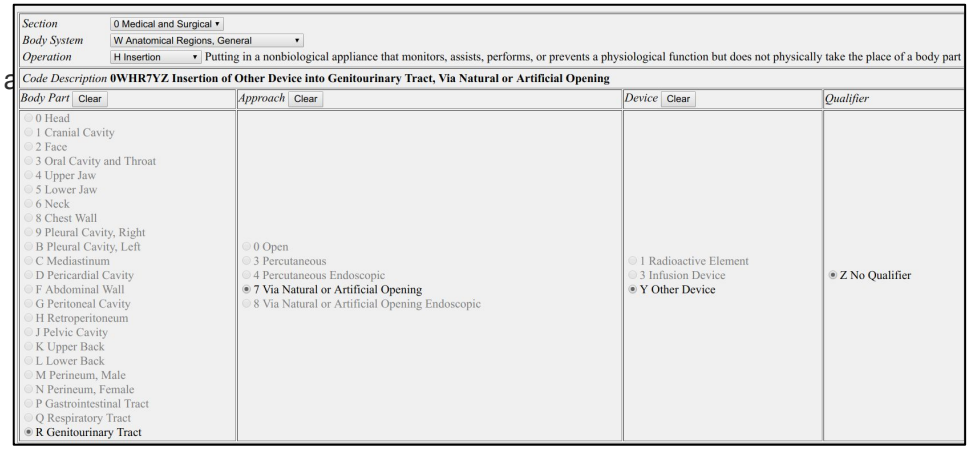
Intrauterine Brachytherapy & Placement of Tandems & Ovoids

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, a 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.

Placement of Watchman™ Left Atrial Appendage Device

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

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

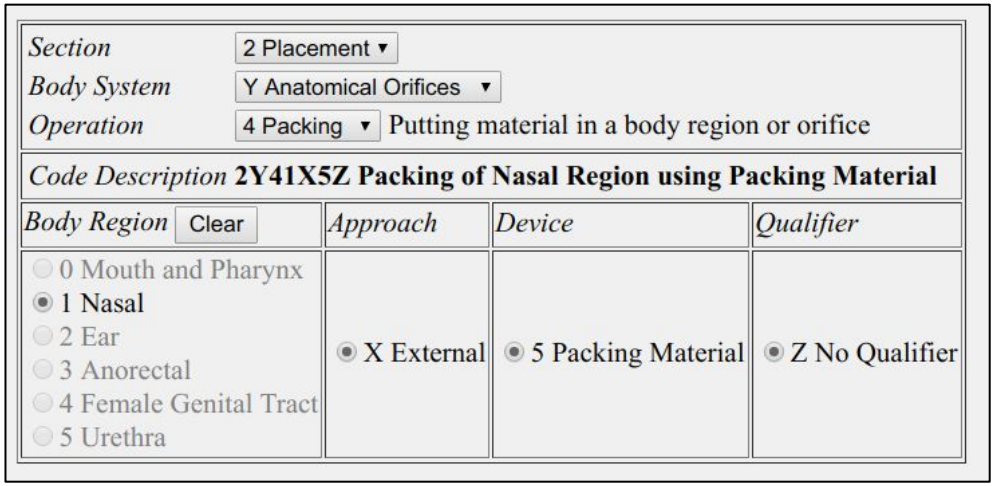
Nasal Packing for Epistaxis

Coding Clinic for ICD-10-CM/PCS, Fourth Quarter 2017: Page 106

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?



Section	2 Placement		
Body System	Y Anatomical Orifices		
Operation	4 Packing — Putting material in a body region or orifice		
Code Description **2Y41X5Z Packing of Nasal Region using Packing Material**			
Body Region Clear	*Approach*	*Device*	*Qualifier*
0 Mouth and Pharynx 1 Nasal 2 Ear 3 Anorectal 4 Female Genital Tract 5 Urethra	X External	5 Packing Material	Z No Qualifier

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
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

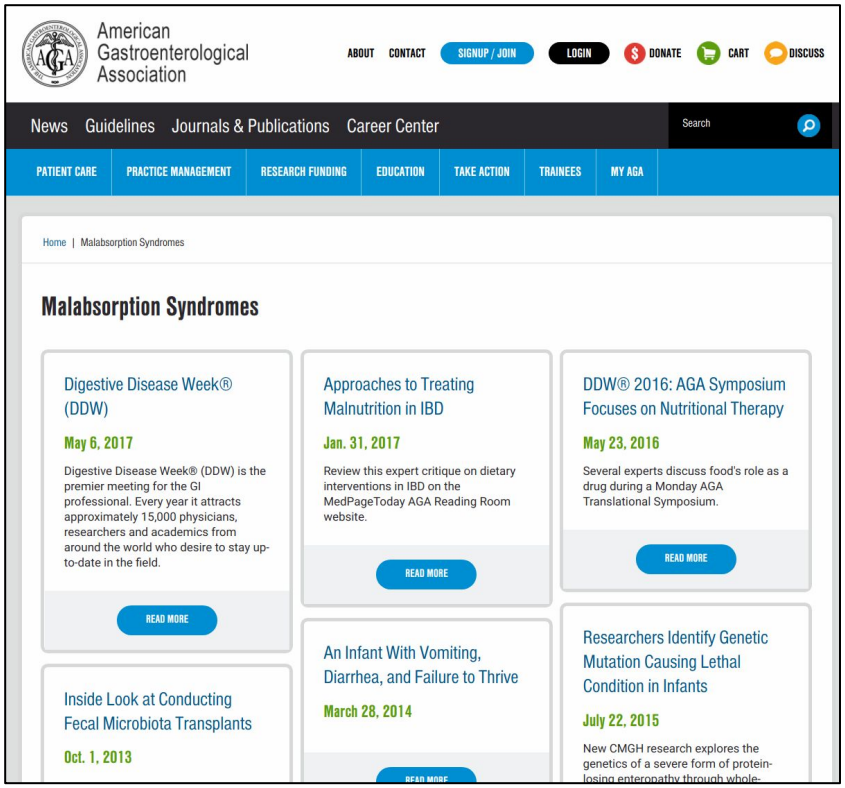
Malnutrition and Malabsorption

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.

Omitting ICD-10-CM Codes

Coding Clinic for ICD-10-CM/PCS, Fourth Quarter 2017: Page 110

Question:

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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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