ICD-10 Roundtable 138

September 28, 2021

Selective Coding Clinic Review

Third Quarter 2021, issue effective with discharges September 20, 2021

CM

Acute Myeloid Leukemia and Anemia due to Chemotherapy

Question:
A patient was admitted with anemia due to chemotherapy. The patient had previously received chemotherapy for primary refractory acute myeloid leukemia now in remission. When a patient with acute myeloid leukemia in remission is admitted for treatment of anemia due to chemotherapy, which condition should be sequenced as the principal diagnosis?

Answer:
Sequence code D64.81, Anemia due to antineoplastic chemotherapy, as the principal diagnosis. Also assign codes T45.1X5A, Adverse effect of antineoplastic and immunosuppressive drugs, initial encounter, and C92.01, Acute myeloblastic leukemia, in remission. Although there is an Excludes 1 note at category D64, Other anemias, which means the two codes cannot be assigned together, both codes are required to capture anemia due to chemotherapy and acute myeloid leukemia. These are separate conditions, which are unrelated, as the anemia was caused by the chemotherapy not the AML and thus an exception to the Excludes1 note.

Acute Kidney Injury due to Acute Tubular Necrosis due to Contrast Nephropathy

Question:
A 60-year-old female was diagnosed with acute kidney injury (AKI) due to acute tubular necrosis (ATN) secondary to contrast nephropathy. What are the appropriate code assignments for acute kidney injury due to acute tubular necrosis secondary to contrast nephropathy?

Answer:
Assign codes N17.0, Acute kidney failure with tubular necrosis, N14.1, Nephropathy induced by other drugs, medicaments and biological substances, and T50.8X5A, Adverse effect of diagnostic agents, initial encounter, for acute kidney injury (AKI) due to acute tubular necrosis (ATN) secondary to contrast nephropathy

Contrast-Induced Nephropathy

Question:
A patient with a history of congestive heart failure and Stage IV chronic kidney disease presented due to dyspnea, edema and orthopnea. During the patient's admission, contrast was used for radiologic imaging and the patient was diagnosed with contrast-induced nephropathy (CIN) within 48 hours of exposure to the contrast. Would the contrast be reported as a drug or toxic substance? What are the appropriate code assignments for contrast-induced nephropathy?

Answer:
Assign codes N14.1, Nephropathy induced by other drugs, medicaments and biological substances, and T50.8X5A, Adverse effect of diagnostic agents, initial encounter, for contrast-induced nephropathy.

Celiac Artery Stenosis

Question:
The patient is a 58-year-old with celiac artery stenosis (CAS) who underwent balloon angioplasty of the stenosis. ICD-10-CM classifies CAS to code I77.4, Celiac artery compression syndrome; however, celiac artery stenosis and celiac artery compression syndrome do not appear to be the same condition. What is the correct code assignment for CAS when provider documentation does not state celiac artery compression syndrome?

Answer:
Assign code I77.1, Stricture of artery, for CAS. Although the Index to Diseases directs to code I77.4, Celiac artery compression syndrome, the provider did not document this condition. The basic rule of coding is that further research is required if the title of the code suggested by the Index does not identify the condition correctly.

Comment

Celiac artery compression syndrome, also known as median arcuate ligament syndrome (MALS), is a condition where a muscular fibrous band of the diaphragm, the median arcuate ligament, compresses the celiac axis, which supplies blood to the upper abdominal organs

It is also referred to as celiac axis syndrome, median arcuate ligament syndrome, and Dunbar syndrome

For more information: https://www.bcm.edu/healthcare/specialties/cardiovascular-medicine/vascular-health/celiac-artery-compression-syndrome

Cardiomyopathy due to Methamphetamine Abuse

Question:
The provider diagnosed chronic methamphetamine-induced cardiomyopathy. Although the patient had a history of methamphetamine abuse in the past, he is no longer abusing the drug and is currently in remission. What are the diagnosis code assignments for cardiomyopathy due to past methamphetamine abuse, currently in remission?

Answer:
Assign codes I42.7, Cardiomyopathy due to drug and external agent, for the methamphetamine-induced cardiomyopathy. Assign code F15.11, Other stimulant abuse, in remission, as an additional diagnosis, since the provider has documented, "history of methamphetamine abuse, currently in remission." Code T43.621A, Poisoning by amphetamines, accidental (unintentional), initial encounter, is not appropriate for chronic cardiomyopathy due to the patient's past abuse of methamphetamines. This is not an acute poisoning from a single use of methamphetamine.

Comment
Similar example: Cannabinoid hyperemesis syndrome associated with excessive cannabis use
ICD-10-CM/PCS Coding Clinic, First Quarter ICD-10 2020 Page:8 Effective with discharges: March 5, 2020

In-Stent Restenosis Not Further Specified

Question:
A patient presented with chest pain and underwent cardiac workup, including coronary angiography. The patient has known coronary artery disease, status post stent placement in the left anterior descending (LAD), left circumflex (LCx) and right coronary (RCA) arteries. The provider documented, "in-stent" restenosis in all three previously placed coronary artery stents. In many cases, the health record documentation does not provide the specificity needed to determine the cause of the stenosis. How is "in-stent" restenosis not further specified coded? In this instance, should the coding professional query the provider to determine the cause of the "in-stent" restenosis?

Answer:
Assign code T82.855A, Stenosis of coronary artery stent, initial encounter, for the "in-stent" restenosis and I25.10, Atherosclerotic heart disease of native coronary artery without angina pectoris, for the CAD. ICD-10-CM classifies stenosis or narrowing that is within the stent or "in-stent," as a complication, unless specifically documented as due to disease progression.

Non-ST Elevated Myocardial Infarction and In-Stent Restenosis (Culprit Lesion)

Question:
A patient, who has known coronary artery disease (CAD) status post coronary artery intervention with stent insertion, is admitted due to acute non-ST elevated myocardial infarction (NSTEMI). Coronary angiography demonstrates multiple vessel CAD. The provider's final diagnostic statement lists, "Previously placed stent in the mid right coronary artery with a focal area of in-stent restenosis, which is the culprit lesion." Some coding professionals are interpreting "culprit lesion" as disease progression rather than a complication of the stent. How should this case be coded?

Answer:
Assign codes T82.855A, Stenosis of coronary artery stent, initial encounter, I21.A9, Other myocardial infarction type, and I25.10, Atherosclerotic heart disease of native coronary artery without angina

pectoris, for the NSTEMI caused by in-stent restenosis of the right coronary artery (culprit lesion) and CAD.

ICD-10-CM classifies stenosis or narrowing of a vessel involving a previously placed stent described as "within the stent" or "in-stent" restenosis, as a complication, unless specifically documented as due to disease progression. Documentation of "culprit lesion" should not be interpreted as disease progression without clarification from the provider.

Non-ST Elevated Myocardial Infarction due to Coronary Artery Disease and In-Stent Restenosis

Question:
A patient was admitted secondary to an acute non-ST elevated myocardial infarction (NSTEMI) and underwent percutaneous coronary intervention. During the intervention, the previously placed stent in the right coronary artery (RCA) was dilated with a balloon. The distal marginal branch of the circumflex artery was then dilated and stented. The provider documented, "Severe two-vessel disease of the circumflex artery and RCA in-stent stenosis, NSTEMI due to native CAD and in-stent restenosis of the RCA." Since ICD-10-CM classifies a NSTEMI due to CAD and an NSTEMI due to in-stent restenosis differently, is it appropriate to assign two codes to show both sources of the NSTEMI in this case?

Answer:
Assign codes T82.855A, Stenosis of coronary artery stent, initial encounter, I21.4, Non-ST elevation (NSTEMI) myocardial infarction, I21.A9 Other myocardial infarction type, and I25.10, Atherosclerotic heart disease of native coronary artery without angina pectoris, for the NSTEMI due to native artery CAD and in-stent restenosis. Both MI codes are needed to fully describe the patient's condition.

PCS

Curettage of Bilateral Humeral Head and Bone Graft Placement

Question:
The patient is a 16-year-old who is admitted for surgical treatment of avascular necrosis (AVN) of both humeral heads, secondary to sickle cell vaso-occlusive disease. He underwent curettage and bone graft of both humeral heads. During the procedure, a C-arm was utilized to identify the lesion on the left upper extremity where an incision was made with dissection down to the periosteum. The periosteum was incised; a guidewire was drilled into the lesion of the humeral head; and an expandable reamer umbrella was opened to core out the lesion. The reamer was then withdrawn leaving the protection sleeve in place, Pro-dense™ bone graft was mixed and injected via cannula into the lesion. The procedure was then repeated on the right. What are the appropriate root operations for curettage and Pro-dense™ bone grafts to treat AVN of the bilateral humeral heads?

Answer:
Assign the following procedure codes:

0PCC3ZZ Extirpation of matter from right humeral head, percutaneous approach, for curettage/coring out AVN from the right humeral head.
0PCD3ZZ Extirpation of matter from left humeral head, percutaneous approach, for curettage/coring out AVN from the left humeral head.
0PUC3JZ Supplement right humeral head with synthetic substitute, percutaneous approach, for injecting Pro-dense™ bone graft into the right humeral head.
0PUD3JZ Supplement left humeral head with synthetic substitute, percutaneous approach, for injecting Pro-dense™ bone graft into the left humeral head.

The curettage/coring out of the lesions (AVN) with the reamer supports the root operation Extirpation—Taking or cutting out solid matter from a body part. The injection of Pro-dense™ bone graft supports the root operation Supplement—Putting in or on biological or synthetic material that physically reinforces and/or augments the function of a portion of a body part.

Left Internal Mammary Artery Free Graft between Obtuse Marginal Saphenous Vein Graft and Left Anterior Descending Artery

Question:
A patient with coronary artery disease presents for three-vessel aortocoronary artery bypass graft surgery. After sternotomy, reverse saphenous vein aortocoronary anastomoses were completed from the ascending aorta to the right coronary artery (RCA) and to the obtuse marginal (OM) artery. After obtaining a left internal mammary artery (LIMA) free graft, the distal end of the graft was anastomosed to the left anterior descending artery (LAD) and the proximal end was anastomosed to the hood of the completed vein graft anastomosis at the OM. What is the appropriate qualifier value for bypass grafting using the LIMA as a free graft between the LAD and the OM vein graft?

Answer:
Assign the following ICD-10-PCS code:
02100A3 Bypass coronary artery, one artery from coronary artery with autologous arterial tissue, open approach, for the bypass utilizing a free LIMA graft between the obtuse marginal saphenous vein graft and the LAD.

In this case, the obtuse marginal saphenous vein graft is functioning as a coronary artery. The LIMA graft allows blood flow from the functional coronary artery to the LAD. The ICD-10-PCS *Official Guidelines for Coding and Reporting guideline* B3.6a states that the qualifier value specifies the vessel bypassed from, therefore, qualifier "3, Coronary artery" is assigned.

Section	**0**	Medical and Surgical
Body System	**2**	Heart and Great Vessels
Operation	**1**	Bypass: Altering the route of passage of the contents of a tubular body part

Body Part	*Approach*	*Device*	*Qualifier*
0 Coronary Artery, One Artery **1** Coronary Artery, Two Arteries **2** Coronary Artery, Three Arteries **3** Coronary Artery, Four or More Arteries	**0** Open	**8** Zooplastic Tissue **9** Autologous Venous Tissue **A** Autologous Arterial Tissue **J** Synthetic Substitute **K** Nonautologous Tissue Substitute	**3** Coronary Artery **8** Internal Mammary, Right **9** Internal Mammary, Left **C** Thoracic Artery **F** Abdominal Artery **W** Aorta
0 Coronary Artery, One Artery **1** Coronary Artery, Two Arteries **2** Coronary Artery, Three Arteries **3** Coronary Artery, Four or More Arteries	**0** Open	**Z** No Device	**3** Coronary Artery **8** Internal Mammary, Right **9** Internal Mammary, Left **C** Thoracic Artery **F** Abdominal Artery