ICD-10 Roundtable 140

November 9, 2021

For discussion….

Our stance…

History of HIV managed by medication, addressing encoder logic and Other non-official coding references

A coder made me aware that when using a particular logic based encoder, the encoder is providing the code B20 for HIV + , asymptomatic HIV status on antiretrovirals. However, we believe this is an error in the logic.

Check your book—nothing is there indicating that B20 should automatically assigned just because the patient is on antiretrovirals. What do the guidelines say?

Per coding guidelines "HIV disease" or "AIDS" or "HIV -related illness" is classified to B20, Human immunodeficiency virus [HIV] disease. However, "HIV positive," "known HIV," "HIV test positive," or similar terminology is classified to Z21, Asymptomatic human immunodeficiency virus [HIV] infection status. They updated the guidelines for FY 22 based on the bolded text (see below), *History of HIV managed by medication* . Please note, "HIV disease" not "HIV positive stasus" was referenced in the new guideline. Please also see the coding clinic on "asymptomatic HIV positive patient on antiretroviral therapy" referenced below.

Please note the guidelines, the index or tabular, does not lead you to B20 for "HIV positive" without documentation of HIV disease or AIDS or HIV related illness. At this time based on the guidelines noted below we believe this is an error in the coding logic.

History of HIV managed by medication
If a patient with documented history of *HIV disease* is currently managed on antiretroviral medications, assign code B20, Human immunodeficiency virus [HIV] disease. Code Z79.899, Other long term (current) drug therapy, may be assigned as an additional code to identify the long-term (current) use of antiretroviral medications.

Asymptomatic human immunodeficiency virus
Z21, Asymptomatic human immunodeficiency virus [HIV] infection status, is to be applied when the patient without any documentation of symptoms is listed as being "HIV positive," "known HIV," "HIV test positive," or similar terminology. Do not use this code if the term "AIDS" **or "HIV disease"** is used or if the patient is treated for any HIV-related illness or is described as having any condition(s) resulting from his/her HIV positive status; use B20 in these cases.

Previously diagnosed HIV-related illness
Patients with any known prior diagnosis of an HIV-related illness should be coded to B20. Once a patient has developed an HIV-related illness, the patient should always be assigned code B20 on every subsequent admission/encounter. Patients previously diagnosed with any HIV illness (B20) should never be assigned to R75 or Z21, Asymptomatic human immunodeficiency virus [HIV] infection status

Follow-up care for asymptomatic HIV positive patient on antiretroviral therapy
ICD-10-CM/PCS Coding Clinic, First Quarter ICD-10 2019 Page: 11 Effective with discharges: March 20, 2019
Question:
A 25-year-old asymptomatic HIV positive patient, who is on antiretroviral therapy, presents to the physician's office for follow-up care. The patient is asymptomatic, has not been diagnosed with any HIV illnesses or related diseases, and is taking antiretroviral medication prophylactically. How should this case be coded since the patient is being treated (code B20 or code Z21)?
Answer:
Assign code Z21, Asymptomatic human immunodeficiency virus [HIV] infection status, as the first-listed diagnosis. The protocol is to treat asymptomatic patients prophylactically with antiretroviral drugs to suppress the virus and prevent progression

of the illness. The fact that the patient is receiving medication does not indicate AIDS or HIV disease.

Did anyone notice these index and tabular changes for FY 2022?

Postoperative Anemia

Anemia, postoperative

No Change	- postoperative (postprocedural)
Revise from	- - specified NEC D64.9
Revise to	- - specified NEC D64.89

Emaciation

Revise from	**Emaciation (due to malnutrition)** E43
Revise to	**Emaciation** R64
Add	- due to malnutrition E43

Emaciation and malnutrition

ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2017 Pages: 24-25 Effective with discharges: July 27, 2017

Related Information

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.

Bronchiectasis

No Change	**J47 Bronchiectasis**
No Change	**J47.0 Bronchiectasis with acute lower respiratory infection**
Delete	**Use Additional** code to identify the infection
Add	**Code also** to identify infection, if applicable

Selective Coding Clinic Review

Fourth Quarter 2021, issue effective with discharges October 1, 2021

CM

Anaplasmosis

Question:
A 63-year-old patient presented to the hospital with abrupt onset of fevers, chills, and muscle weakness. Diagnostic blood work came back positive for Lyme disease co-infected with Ehrlichia, and Anaplasmosis. The patient reported a tick bite while hiking through the woods about one week ago. The provider diagnosed Ehrlichia, Lyme disease and Anaplasmosis; treated the patient with an antibiotic; and discharged the patient home. What are the appropriate ICD-10-CM code assignments for this admission?

Answer:
Assign code A69.20, Lyme disease, unspecified, and code A79.82, Anaplasmosis [A. phagocytophilum]. The Excludes1 note at subcategory A77.4, Ehrlichiosis, prohibits assigning code A79.82 and code A77.40, Ehrlichiosis, unspecified, together.

A77.4 Ehrlichiosis

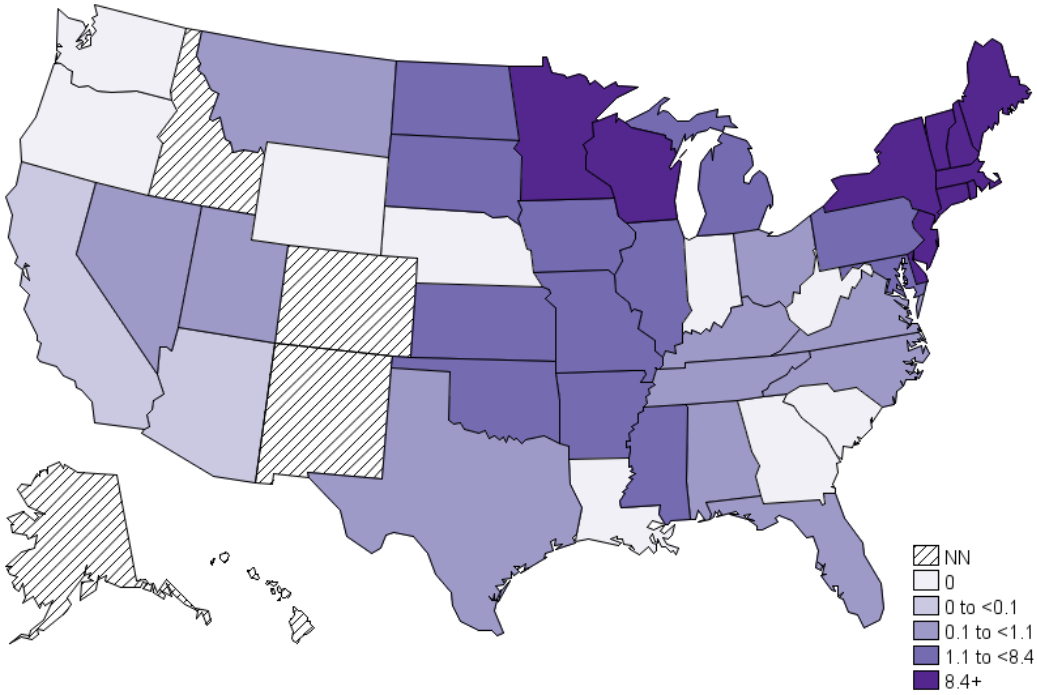
Excludes1: anaplasmosis [A. phagocytophilum] (A79.82)
rickettsiosis due to Ehrlichia sennetsu (A79.81)

A77.40 Ehrlichiosis, unspecified

A77.41 Ehrlichiosis chafeensis [E. chafeensis]

A77.49 Other ehrlichiosis
Ehrlichiosis due to E. ewingii
Ehrlichiosis due to E. muris euclairensis

Figure 3 – Annual reported incidence (per million population) for anaplasmosis – United States, 2018. (NN= Not notifiable)



Depression Not Otherwise Specified

Question:
A 25-year-old male patient was seen in his physician's office for a follow up visit. He continues to express feelings of loneliness, sadness, and loss of interest in hobbies that he once enjoyed. The

provider diagnosed depression. What is the correct code assignment for depression?
Answer:
Assign code F32.A, Depression, unspecified, for depression not further specified.

No Change	**Mood [affective] disorders (F30-F39)**
Revise from	**F32 Major depressive disorder, single episode**
Revise to	**F32 Depressive episode**
No Change	**F32.9 Major depressive disorder, single episode, unspecified**
Delete	Depression NOS
Delete	Depressive disorder NOS
Add	**F32.A Depression, unspecified**
Add	Depression NOS
Add	Depressive disorder NOS

Cervicogenic Headache

Question:
A patient with cervical disc displacement of C2- C3 presented to their provider's office due to frequent headaches and neck pain. The patient was diagnosed with cervicogenic headaches (CGH) associated with disc displacement and was prescribed medication for pain management. What is the appropriate code assignment for CGH associated with C2-C3 disc displacement?
Answer:
Assign code G44.86, Cervicogenic headache, for CGH. Code M50.21, Other cervical disc displacement, high cervical region, should also be assigned to capture the associated condition.

G44.86 Cervicogenic headache

Code also associated cervical spinal condition, if known

Non-Ischemic Myocardial Injury

Code **I5A, Non-ischemic myocardial injury (non-traumatic),** has been created to identify a non-traumatic, non-ischemic myocardial injury. The definition of a non-ischemic myocardial infarction (MI) was most recently updated in 2018.

According to the Fourth Universal Definition of Myocardial Infarction, an acute myocardial injury is characterized by the rise and/or fall of cardiac troponin levels with at least one value above the 99th percentile upper reference limit. A diagnosis of MI is reserved for patients with myocardial ischemia as the cause of myocardial injury, whether attributable to acute atherothrombosis (type 1 MI) or supply/

demand mismatch without acute atherothrombosis (type 2 MI). Myocardial injury in the absence of ischemia is categorized as acute or chronic nonischemic myocardial injury. Based on high sensitivity troponin tests, clinicians can now distinguish whether patients have suffered a non-ischemic myocardial injury versus one of the other MI subtypes. This new code will allow for the appropriate classification of these patients.

When assigning code I5A, sequence the underlying cause first, such as acute kidney failure, acute myocarditis, etc., if known and/or applicable.

Question:
A patient presents to the Emergency Department after becoming progressively somnolent. Diagnostic workup revealed elevated troponin level and intermittent atrial fibrillation and the patient was admitted for further cardiology management. The patient never reported any chest pain; did not demonstrate electrocardiogram (ECG) changes; troponin levels stabilized; and at discharge, the provider diagnosed non- ischemic myocardial injury. How would non-ischemic myocardial injury be coded?

Answer:
Assign code I5A, Non-ischemic myocardial injury (non-ischemic), for non-ischemic myocardial injury.

I5A Non-ischemic myocardial injury (non-traumatic)

Acute (non-ischemic) myocardial injury
Chronic (non-ischemic) myocardial injury
Unspecified (non-ischemic) myocardial injury

Code first the underlying cause, if known and applicable, such as:
- acute kidney failure (N17.-)
- acute myocarditis (I40.-)
- cardiomyopathy (I42.-)
- chronic kidney disease (CKD) (N18.-)
- heart failure (I50.-)
- hypertensive urgency (I16.0)
- nonrheumatic aortic valve disorders (I35.-)
- paroxysmal tachycardia (I47.-)
- pulmonary embolism (I26.-)
- pulmonary hypertension (I27.0, I27.2-)
- sepsis (A41.-)
- takotsubo syndrome (I51.81)

Excludes1: acute myocardial infarction (I21.-)
injury of heart (S26.-)

Excludes2: other acute ischemic heart diseases (I24.-)

Previous advice:

Non-traumatic myocardial injury

ICD-10-CM/PCS Coding Clinic, **Second Quarter ICD-10 2019** Pages: 5-6 Effective with discharges: June 21, 2019

Question:

An 89-year-old woman presented to the Emergency Department (ED) due to an unwitnessed fall. The patient was diagnosed with a urinary tract infection and treated with Bactrim. During the ED encounter, the patient became progressively more somnolent. Additional workup revealed elevated troponin level and intermittent atrial fibrillation. The patient was admitted for further cardiology management. She never reported any chest pain; did not demonstrate electrocardiogram (ECG) changes; troponin levels stabilized; and at discharge, the provider diagnosed non-traumatic myocardial injury. What is the appropriate ICD-10-CM code for non-traumatic myocardial injury?

Answer:

Assign code I51.89, Other ill-defined heart diseases, for a non-traumatic myocardial injury.

Irritant Contact Dermatitis

Codes have been created for irritant contact dermatitis that is associated with prolonged exposure to moisture as follows:

- **L24.A0, Irritant contact dermatitis due to friction or contact with body fluids, unspecified**
- **L24.A1, Irritant contact dermatitis due to saliva**
- **L24.A2, Irritant contact dermatitis due to fecal, urinary or dual incontinence**

L24.A9, Irritant contact dermatitis due friction or contact with other specified body fluids

- **L24.B0, Irritant contact dermatitis related to unspecified stoma or fistula**
- **L24.B1, Irritant contact dermatitis related to digestive stoma or fistula**
- **L24.B2, Irritant contact dermatitis related to respiratory stoma or fistula**
- **L24.B3, Irritant contact dermatitis related to fecal or urinary stoma or fistula**

One of the many functions of skin is to protect the body against substances that penetrate its outer layer and cause damage before the skin is able to recover and repair itself. Plants, chemicals, detergents, oils, solvents, acids, and infectious microorganisms are among the list of irritants that cause irritant contact dermatitis. Irritant contact dermatitis is damage to the outer layer of skin in reaction to contact with a substance. A red, itchy, rash or dry, cracked, scaly skin may develop within minutes to hours of exposure. The area may become swollen and burn as the irritant penetrates and causes inflammation. Moisture-associated skin damage causes inflammation and erosion of the epidermis due to prolonged exposure to secretions of the body and peristomal moisture. When there is overexposure to excess amounts of water, the skin softens, swells and becomes wrinkled, as the body is unable to regulate the absorption of water. The erosion of the epidermis may produce an exudate that macerates and breaks down the skin. The warm, humid and soiled conditions may allow microorganisms to colonize with and without skin infection.

Question:

A patient, who is status post colectomy secondary to ulcerative colitis, presents with complaints of skin irritation around his ileostomy. The provider diagnosed irritant contact dermatitis caused by leakage of stool related to the retraction of the ileostomy. What are the appropriate diagnosis code assignments for the encounter?

Answer:

Assign code L24.B3, Irritant contact dermatitis related to fecal or urinary stoma or fistula, for the irritant contact dermatitis involving the skin around the ileostomy. Assign code K94.13, Enterostomy malfunction, for retraction of the ileostomy.

Question:

An adult patient with stress urinary incontinence is diagnosed with urine-induced vulvar contact dermatitis. What are the diagnosis code assignments for the encounter?

Answer:

Assign code L24.A2, Irritant contact dermatitis due to fecal, urinary or dual incontinence. Contact dermatitis that is associated with prolonged exposure to urine is a form of irritant contact dermatitis. Assign code N39.3, Stress incontinence (female) (male), for the stress urinary incontinence.

Question:

An 80-year-old patient, who wears adult diapers because of urinary and fecal incontinence, presents to the Emergency Department due to painful, irritated and excoriated skin of the vulva and buttocks. The provider's diagnostic statement lists, "Contact dermatitis due to fecal and urinary incontinence." What is the ICD-10- CM code assignment for contact dermatitis in an incontinent patient who wears adult diapers?

Answer:

Assign code L22, Diaper dermatitis, for contact dermatitis due to irritation from urine and feces and diaper wear. Also, assign codes R15.9, Full incontinence of feces, and R32, Unspecified urinary incontinence, as secondary diagnoses.

Question:

What codes are assigned for leakage of a cystostomy catheter causing irritant contact dermatitis due to urine?

Answer:

Assign codes T83.030A, Leakage of cystostomy catheter, initial encounter, and L24.B3, Irritant contact dermatitis related to fecal or urinary stoma or fistula.

No Change	**Dermatitis and eczema (L20-L30)**
No Change	**L24 Irritant contact dermatitis**
Add	**L24.A Irritant contact dermatitis due to friction or contact with body fluids**
Add	**Excludes1:** irritant contact dermatitis related to stoma or fistula (L24.B-)
Add	**Excludes2:** erythema intertrigo (L30.4)
Add	**L24.A0 Irritant contact dermatitis due to friction or contact with body fluids, unspecified**
Add	**L24.A1 Irritant contact dermatitis due to saliva**
Add	**L24.A2 Irritant contact dermatitis due to fecal, urinary or dual incontinence**
Add	**Excludes1:** diaper dermatitis (L22)
Add	**L24.A9 Irritant contact dermatitis due friction or contact with other specified body fluids**
Add	Irritant contact dermatitis related to endotracheal tube
Add	Wound fluids, exudate
Add	**L24.B Irritant contact dermatitis related to stoma or fistula**
Add	**Use Additional** code to identify any artificial opening status (Z93.-), if applicable, for contact dermatitis related to stoma secretions
Add	**L24.B0 Irritant contact dermatitis related to unspecified stoma or fistula**
Add	Irritant contact dermatitis related to fistula NOS
Add	Irritant contact dermatitis related to stoma NOS
Add	**L24.B1 Irritant contact dermatitis related to digestive stoma or fistula**
Add	Irritant contact dermatitis related to gastrostomy
Add	Irritant contact dermatitis related to jejunostomy
Add	Irritant contact dermatitis related to saliva or spit fistula
Add	**L24.B2 Irritant contact dermatitis related to respiratory stoma or fistula**
Add	Irritant contact dermatitis related to tracheostomy
Add	**L24.B3 Irritant contact dermatitis related to fecal or urinary stoma or fistula**
Add	Irritant contact dermatitis related to colostomy
Add	Irritant contact dermatitis related to enterocutaneous fistula
Add	Irritant contact dermatitis related to ileostomy

Vertebrogenic Pain

Question:
A patient previously underwent a magnetic resonance imaging (MRI) of the spine for low back pain, and the provider's final interpretation was Modic type endplate changes. He now presents for a follow-up visit for the low back pain, and the provider diagnosed vertebrogenic low back pain. What is the correct code assignment for vertebrogenic low back pain?

Answer:
Assign code M54.51, Vertebrogenic low back pain.

No Change	**M54 Dorsalgia**
No Change	**M54.5 Low back pain**
Delete	Loin pain
Delete	Lumbago NOS
Add	**M54.50 Low back pain, unspecified**
Add	Loin pain
Add	Lumbago NOS
Add	**M54.51 Vertebrogenic low back pain**
Add	Low back vertebral endplate pain
Add	**M54.59 Other low back pain**
No Change	**M54.8 Other dorsalgia**
No Change	**Excludes1:**
Revise from	low back pain (M54.5)
Revise to	low back pain (M54.5-)

Newborn Affected by Maternal Group B Streptococcus Colonization

A new code **P00.82, Newborn affected by (positive) maternal group B streptococcus (GBS) colonization**, has been created.
Group B streptococcus (GBS), also known as Group B Strep, is a type of bacterial infection that can be found in a pregnant patient's genital area. Typically, GBS infection does not cause problems in healthy patients before pregnancy. However, GBS can cause serious illness in the newborn, such as sepsis, pneumonia, meningitis, or seizures. Approximately one in four pregnant patients (25%) have GBS in their rectum or vagina. During pregnancy, the mother can pass GBS to the baby or the infant may be infected from the mother's genital tract during birth.
Providers routinely test the newborn for GBS as part of the infant's prenatal care. However, not every infant who is born to a mother who tests positive for GBS will become ill. Newborns are at increased risk for GBS infection if their mother tests positive for the bacteria during pregnancy. GBS infection is a leading cause of meningitis and bloodstream infections in a newborn's first three months of life. Because of the high risk of morbidity and mortality for infants who are born to GBS positive mothers, the American Academy of Pediatrics (AAP) requested the creation of this code to capture important clinical information and to allow for adequate tracking and monitoring.

Question:
A newborn, who had a normal vaginal delivery, is diagnosed with group B streptococcus colonization and is administered antibiotics prophylactically. What code should be assigned for this condition?
Answer:
Assign code Z38.00, Single liveborn infant, delivered vaginally, as the principal diagnosis. Assign code P00.82 Newborn affected by (positive) maternal group B streptococcus (GBS) colonization, for GBS colonization.

Does this replace previous advice? Does P00.82 replace the Z20.818 in previous advice below? Does a

P00.82	**Newborn affected by (positive) maternal group B streptococcus (GBS) colonization**

Contact with positive maternal group B streptococcus

Based on the intent of these codes does this code really belong here if the baby is not affected (no symptoms)?

Suspected newborn group B Streptococcal infection ruled out

ICD-10-CM/PCS Coding Clinic, Second Quarter ICD-10 2019 Pages: 10-11 Effective with discharges: June 21, 2019

Question:
What code should be assigned for an asymptomatic infant born to a group B Streptococcus (GBS) positive mother, when the provider has ruled out GBS infection in the newborn after the clinical evaluation and work-up is negative? Does the fact that the infant received prophylactic antibiotics affect code assignment?

Answer:

Assign codes Z05.1, Observation and evaluation of newborn for suspected infectious condition ruled out, and Z20.818, Contact with and (suspected) exposure to other bacterial communicable diseases, for an infant workedup and/or treated prophylactically for GBS, which is later ruled-out.

The Official Guidelines for Coding and Reporting state, "Assign a code from category Z05, Observation and evaluation of newborns and infants for suspected conditions ruled out, to identify those instances

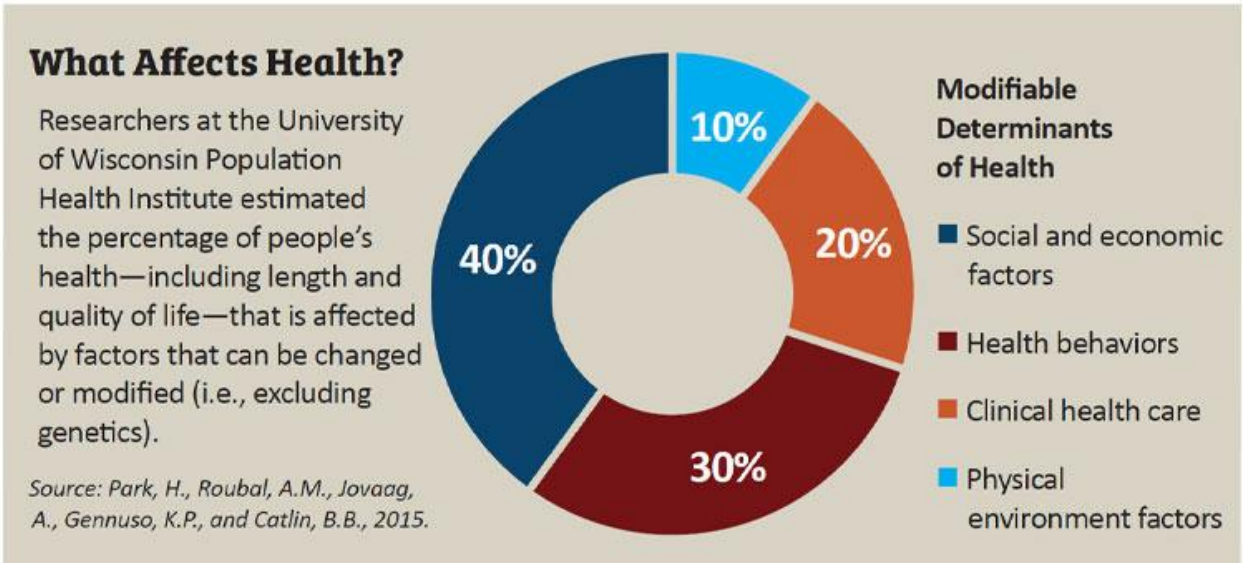
when a healthy newborn is evaluated for a suspected condition that is determined after study not to be present. Do not use a code from category Z05 when the patient has identified signs or symptoms of a suspected problem; in such cases code the sign or symptom."

Abnormal Findings of Blood Amino-Acid Level

A new code was created to describe abnormal findings of blood amino-acid level **(R79.83)**, which includes homocysteinemia.
Previously, ICD-10-CM classified homocysteinemia and homocystinuria to code E72.11, Homocystinuria, within subcategory E72.1, Disorders of sulfur-bearing amino-acid metabolism. However, clinically, homocysteinemia is distinct from homocystinuria, as homocystinuria generally refers to an inborn error of metabolism, and typically manifests with certain phenotypes representing disease states. Homocysteinemia is defined as elevation of homocysteine levels in blood. Therefore, using the term homocysteinemia in the clinical setting does not express the same meaning as homocystinuria.

Question:
What is the correct code assignment for homocysteinemia?
Answer:
Assign code R79.83, Abnormal findings of blood amino-acid level, for homocysteinemia.

Social Determinants of Health



Eleven new codes have been created to provide additional information regarding social determinants of health (SDOH) in the following categories/subcategories:

• Z55, Problems related to education and literacy – Code **Z55.5** was added for less than a high school

diploma, to distinctly represent the known risk imparted by inability to attain a high school diploma or equivalent, independent of literacy.

• Z58, Problems related to physical environment – is a new category with code **Z58.6** created to identify inadequate drinking-water supply, including lack of safe drinking water.

• Z59.0, Homelessness, has been expanded with new codes to distinguish sheltered homelessness **(Z59.01)**, unsheltered homelessness **(Z59.02)** and unspecified homelessness **(Z59.00).** A critical use case for this distinction is discharge planning from both a treatment plan and risk perspective.

• Code Z59.4, Lack of adequate food and safe drinking water, has been revised and is now a subcategory for lack of adequate food; safe drinking water has been moved to new category Z58. New codes have been created as follows: **Z59.41, Food insecurity,** and **Z59.48, Other specified lack of adequate food.** The health risks and health costs associated with food insecurity are well documented. Research by the United States Department of Agriculture indicates health risk increases as severity of food insecurity increases. Inadequate food or lack of food not specified as "food insecurity" is classified to code Z59.48.

• Subcategory Z59.8, Other problems related to housing and economic circumstances, has been expanded and a new subcategory (Z59.81) created with specific codes to classify housing instability, housed. Subcategory Z59.81 includes foreclosure on home loan, past due on rent or mortgage, and unwanted multiple moves in the last 12 months. The new codes distinguish housing instability, housed, with risk of homelessness **(Z59.811),** homelessness in past 12 months **(Z59.812)**, and unspecified **(Z59.819).**

• New code **Z59.89, Other problems related to housing and economic circumstances**, includes foreclosure on loan, isolated dwelling and problems with creditors.

The new codes are aligned with standardized screening questions and answers such as the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE), the Accountable Health Screening Tool, or the Health Leads Screening Tools.

The following commonly accepted definitions for homelessness and housing instability have been provided by the Gravity Project, a multi-stakeholder public collaborative with the goal to develop, test, and validate standardized SDOH data for use in patient care, care coordination between health and human services sectors, population health management, public health, value-based payment and clinical research.

Homelessness
Defined as because of economic difficulties, currently living in a shelter, motel, temporary or transitional living situation, scattered site housing, not having a consistent place to sleep at night, or sleeping in a place not meant for human habitation.
Source *Homelessness During Infancy: Associations With Infant and Maternal Health and Hardship Outcomes*
Source *Unstable Housing and Caregiver and Child Health in Renter Families*

Homelessness, sheltered
Defined as because of economic difficulties, currently living in a shelter, motel, temporary or transitional living situation, scattered site housing, or not having a consistent place to sleep at night.
Source *Homelessness During Infancy: Associations With Infant and Maternal Health and Hardship Outcomes*
Source *Unstable Housing and Caregiver and Child Health in Renter Families*

Homelessness, unsheltered
Defined as residing in a place not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings (on the street).
Source HUD

Housing instability, housed
Defined as currently consistently housed, but experiencing any of the following circumstances in the past 12 months: being behind on rent or mortgage, multiple moves.
Source *Promoting Caregiver and Child Health Through Housing and Stability Screening in Clinical Settings*

Housing instability, housed with risk of homelessness
Defined as currently consistently housed, but with the imminent threat of being forced to live in a shelter, motel, temporary or transitional living situation, scattered site housing, not having a consistent place to sleep at night, or in a place not meant for human habitation.

Housing instability, housed, homelessness in the past 12 months
Defined as currently consistently housed, but with a history of homelessness, for any period of time during the past 12 months.
Source *Homelessness During Infancy: Associations With Infant and Maternal Health and Hardship Outcomes*
Source *Unstable Housing and Caregiver and Child Health in Renter Families*

In addition, the ICD-10-CM *Official Guidelines for Coding and Reporting* have been revised and a new section created for Social Determinants of Health under Chapter 21, Factors influencing health status and contact with health services. Information previously found in Section I of the guidelines related to documentation that may be used for code assignment for social determinants of health has been moved to this newly created section. For the specific changes, please refer to the summary of the modifications to the ICD-10-CM *Official Guidelines for Coding and Reporting*, starting on page 95 of this issue.

Non-Suicidal Self-Harm

A new code has been created to describe non-suicidal self-harm **(R45.88).** The new code provides a way to differentiate between suicidal and non-suicidal self-harm, and allows non-suicidal self-harm to be treated and tracked in clinical databases.

Non-suicidal self-harm is directly and intentionally inflicting damage to one's own body without intention of suicide. Self-harm may include cutting, biting, burning, severe abrading or scratching, pinching, banging or punching objects and oneself, and breaking bones.

Self-harm is not a mental illness, but a behavior that indicates a need for better coping skills. It is a harmful way to cope with emotional pain, anger and frustration. Individuals engaging in self-harm report that they do it, because it feels good or it provides a rush. Several illnesses are associated with self-harm, including borderline personality disorder, depression, eating disorders, anxiety or posttraumatic stress disorder.

Self-harm has less to do with the method used to hurt one's body than the intention to hurt oneself.

Question:
A 13-year-old presented to the pediatrician's office after his mother witnessed, on several occasions the patient intentionally biting himself. He denied wanting to end his life and stated that he often feels anxious because of stressful situations at school. The provider diagnosed non-suicidal self-harm. What is the correct code assignment for non-suicidal self-harm?
Answer:
Assign code R45.88, Nonsuicidal self-harm, for this condition. Assign additional codes for any bite injury.

History (of)
Code Z91.5, Personal history of self-harm, was expanded with new codes created as noted below:
- **Z91.51 Personal history of suicidal behavior**
- **Z91.52 Personal history of nonsuicidal self-harm**

Code Z91.51 will allow the reporting of personal history of suicidal behavior, including personal history of parasuicide, personal history of self-poisoning, and personal history of suicide attempt. Code Z91.52 will allow the unique identification of personal history of nonsuicidal self-harm (self-injury), including personal history of self-inflicted injury without suicidal intent, and personal history of self-mutilation. The new codes will provide the ability to differentiate between history of suicidal behavior from history of non-suicidal self-harm. Please note that, new code **R45.88, Nonsuicidal self-harm,** was created and described earlier on page 26 of this issue of *Coding Clinic.*

Traumatic Brain Compression and Herniation

A new subcategory S06.A, Traumatic brain compression and herniation, has been created with new codes to identify traumatic brain compression with and without herniation. The new codes with the corresponding seventh characters for initial encounter, subsequent encounter and sequela are as follows:

S06.A0, Traumatic brain compression without herniation
- **S06.A1, Traumatic brain compression with herniation**

Brain compression and herniation may occur when brain tissue, cerebrospinal fluid, and blood vessels are moved or pushed away from their usual position inside the skull. Pressure resulting in such movement can be caused by brain swelling from a head injury, stroke, brain tumor, abscess, hydrocephaly, or other underlying cause. Brain herniation can occur between areas inside the skull, such as those separated by a rigid membrane like the tentorium or falx, or to the outside of the skull, through the foramen magnum, or through a craniotomy opening, or other defect, whether traumatic or congenital

Traumatic brain injury (TBI) is one of the most common causes of brain compression and brain herniation. Different parts of the brain may herniate, each causing a different clinical syndrome. Brain compression may also be significant, whether or not herniation is present. Brain compression and herniation may be fatal if not treated.

The presence or absence of brain compression or herniation is an important clinical distinction. TBI is an important area of research, and having codes to differentiate whether or not brain herniation is present will allow for enhanced research and possibly advance the care of these patients.

When assigning codes for traumatic brain herniation, sequence first a code for the underlying TBI, such as diffuse TBI, focal TBI, traumatic subdural hemorrhage, traumatic subarachnoid hemorrhage, etc. An Excludes1 note was added at code G93.5, Compression of brain, to exclude subcategory S06.A, Traumatic brain compression and herniation.

No Change	**S06 Intracranial injury**
No Change	**S06.2 Diffuse traumatic brain injury**
Add	**Use Additional** code, if applicable, for traumatic brain compression or herniation (S06.A-)
No Change	**S06.3 Focal traumatic brain injury**
Add	**Use Additional** code, if applicable, for traumatic brain compression or herniation (S06.A-)
No Change	**S06.5 Traumatic subdural hemorrhage**
Add	**Use Additional** code, if applicable, for traumatic brain compression or herniation (S06.A-)
No Change	**S06.6 Traumatic subarachnoid hemorrhage**
Add	**Use Additional** code, if applicable, for traumatic brain compression or herniation (S06.A-)

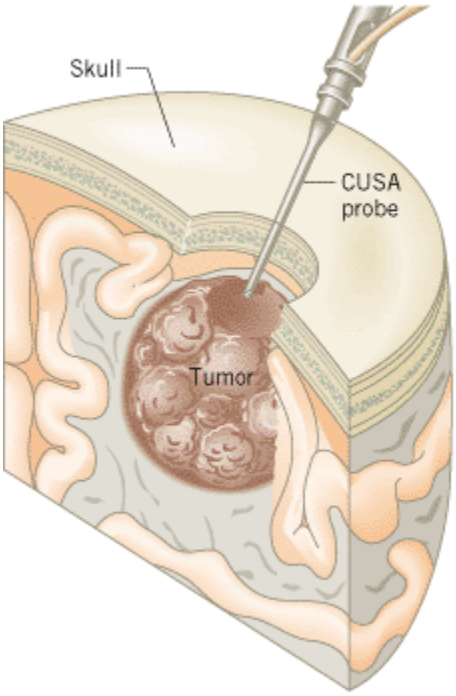
PCS

Ultrasonic Surgical Aspiration of Brain

In code Table 00D, Extraction of Central Nervous System and Cranial Nerves, the body part values 0 Brain and 7 Cerebral Hemisphere, have been added to identify procedures such as microsurgical hemispherotomy performed using cavitron ultrasonic surgical aspiration as shown below.

Body Part	Approach	Device	Qualifier
0 Brain **7** Cerebral Hemisphere	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**Z** No Device	**Z** No Qualifier

The Cavitron Ultrasonic Surgical Aspirator (CUSA) uses ultrasonic frequencies/vibrations to destroy and emulsify target tissues. The ultrasound waves cause the cells to separate from one another while the device irrigates the area with sterile saline. The CUSA then aspirates the fluid back out of the surgical site through a built-in suction tube.



Question:

A patient presented for microsurgical hemispherotomy for intractable seizures. During surgery, the incision along the previous suture line was opened. Subcutaneous dissection was carried out down to the bone flap, which was then elevated and retracted. The dura was opened along the previous suture line. At this point, entry into the temporal horn was made. Using a cavitron ultrasonic surgical aspirator (CUSA), the temporal horn was gradually removed until the atrium was reached and from the atrium, any tissue between the ventricle and the thalamus was removed. The choroid plexus was identified and medial to the choroid plexus, an additional part of the fornix was removed and sectioned. At this point under visual inspection, it was confirmed that the corpus callosum was completely resected as also the frontal basal dissection. What is the appropriate root operation for the use of a cavitron ultrasonic surgical aspirator (CUSA) to remove brain tissue?

Answer:

Assign the following procedure code:

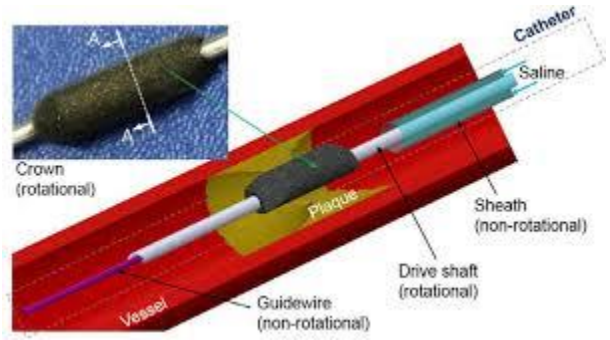
00D00ZZ Extraction of brain, open

approach, for the cavitron ultrasonic surgical aspiration of the corpus callosum, a structure that connects the cerebral hemispheres.

The ICD-10-PCS Body Part Key instructs coding professionals to use the body part value 0 Brain for procedures performed on the corpus callosum.

Coronary Orbital Atherectomy

In code Table 02C, Extirpation of Heart and Great Vessels, new codes have been created by adding Qualifier Value 7 Orbital Atherectomy Technique, for the coronary artery body parts as shown below. The change creates replacement codes in the Med/Surg Section for codes deleted as a result of updating Section X Group 1 codes. For more information on the updating of Section X, refer to page 57 of this issue.



Section:	0 Medical and Surgical
Body System	2 Heart and Great Vessels
Operation:	C Extirpation

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	**3** Percutaneous	Z No Device	**7** Orbital Atherectomy Technique

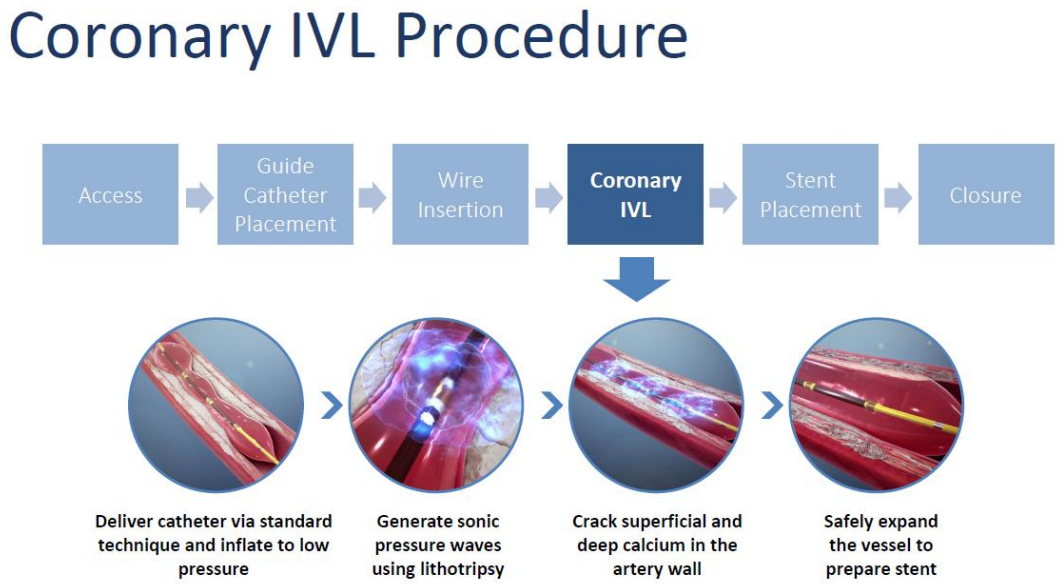
Coronary Intravascular Lithotripsy

In code Table 02F, Fragmentation of Heart and Great Vessels, body part values for coronary artery(ies) as noted below were added to identify coronary intravascular lithotripsy.

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	**3** Percutaneous	**Z** No Device	**Z** No Qualifier

Coronary intravascular lithotripsy (IVL) is a new treatment that utilizes controlled sound waves in short pulses to selectively crack intimal and medial calcium within coronary artery(ies) without affecting soft tissue. Once fractured, the calcium's resistance to balloon dilatation is reduced, thereby allowing the blood vessel to be dilated using a low-pressure angioplasty balloon prior to coronary stenting. Separate ICD-10-PCS code(s) are assigned for angioplasty or stent insertion if performed.

The procedure is performed using multiple lithotripsy emitters that are integrated into a semi-compliant balloon-catheter platform. The coronary IVL catheter is advanced to the target lesion and the integrated balloon is inflated with fluid at a low pressure to contact the arterial wall. Coronary IVL is activated, creating a small bubble within the catheter balloon that rapidly expands and collapses. Sonic pressure waves are created that travel through the innermost layer of the vessel wall to crack the calcified lesions within the vessel wall.



- Coronary IVL is performed in addition to the procedural steps to deliver and place a coronary stent

Coding Note: Qualifier Z would be used for shockwave. EKOS would utilize qualifier 0, Ultrasonic. Please note that ultrasonic is not an option for coronary arteries, only pulmonary in table 02F.

Separately assign the applicable ICD-10-PCS code(s) for angioplasty or stent insertion if performed

Coronary IVL does garner an NTAP for FY 2022 [$3666}.

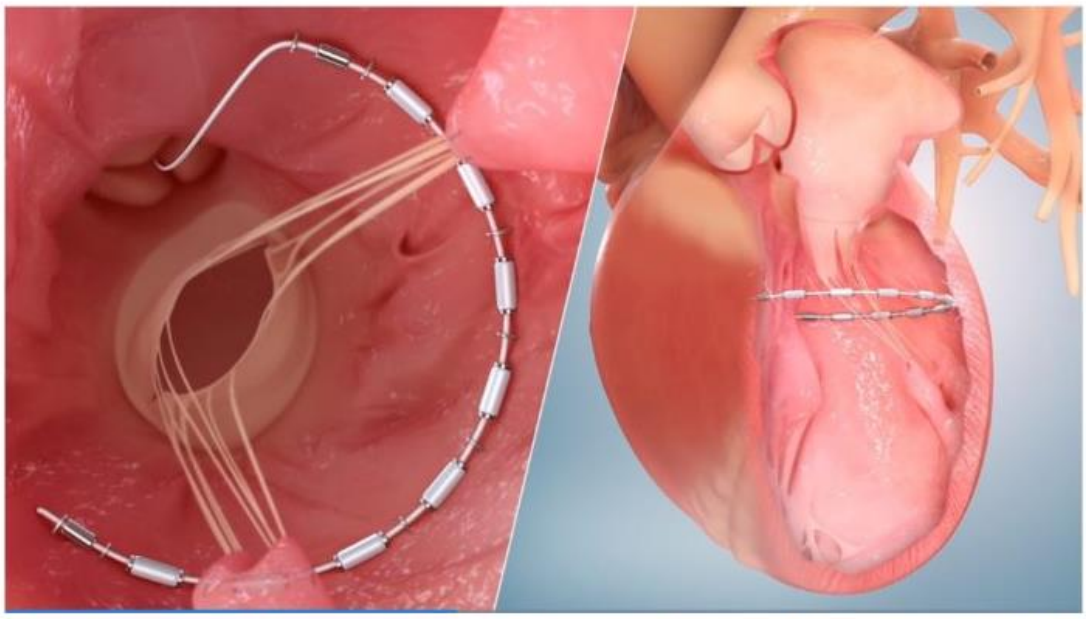
Restriction of Left Ventricle

In code Table 02V, Restriction of Heart and Great Vessels, the body part value L, Ventricle, Left, has been added to the device values listed below for all available approaches. This change will allow the identification of procedures such as placement of the Ancora AccuCinch® device. The procedure is used to treat heart failure and functional mitral regurgitation by targeting left ventricular (LV) dysfunction and abnormal dilation of the heart.

Body Part	Approach	Device	Qualifier
L Ventricle, Left	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**C** Extraluminal Device **D** Intraluminal Device **Z** No Device	**Z** No Qualifier

Question:

A patient, who had been diagnosed with heart failure, dyspnea and severe mitral regurgitation with moderate to severe left ventricular dysfunction and left ventricular ejection fraction, underwent mitral valve annuloplasty using the Ancora AccuCinch® percutaneous device. During surgery, a wire was placed across the aortic valve to gain access into the left ventricular cavity. A flexible wire delivery sheath was placed beneath the mitral annulus at the superior aspect of the ventricle and the base of the heart. The Trac™ catheter was placed around the mitral annulus. The AccuCinch® device was ultimately deployed. The device seated well and there was a reduction of mitral regurgitation. What is the appropriate ICD-10- PCS code for mitral valve annuloplasty using the Ancora AccuCinch® device?



The AccuCinch® Ventricular Restoration System is the first completely percutaneous device designed to directly reshape the left ventricle of the heart, thereby addressing the fundamental issue in the progression of systolic heart failure.

Answer:

Assign the following procedure code:

02VL3DZ Restriction of left ventricle with

intraluminal device, percutaneous approach, for the mitral valve annuloplasty using Ancora AccuCinch® device.

The AccuCinch® device (percutaneous ventricular repair system) was developed to treat both heart failure and functional mitral regurgitation. It is implanted into the subvalvular space of the left ventricle, and the objective of the procedure is to improve the abnormal dilation of the heart. Once cinched properly into place, the device is intended to reduce the size of the left ventricle by making the mitral valve opening smaller while providing strength and support to the heart wall so that the valve functions better and is less likely to leak.

Fragmentation of Intracranial Artery

In the Medical and Surgical Section table 03F, Fragmentation of Upper Arteries, a new body part value G Intracranial Artery, was added as shown below. This change allows the identification of procedures such as clot maceration performed in a cerebral artery using a microcatheter.

Body Part	Approach	Device	Qualifier
G Intracranial Artery	**3** Percutaneous	**Z** No Device	**0** Ultrasonic **Z** No Qualifier

Coding note: This is different from thrombectomy where fragments or clot are ensnared and removed (Expiration) rather than macerated.

Extraction of Bone Marrow from Other Sites

In Table 07D, Extraction of Lymphatic and Hemic Systems, the body part value T Bone Marrow, has been added as shown below to identify when bone marrow is extracted from other sites, such as the femur.

Body Part	Approach	Device	Qualifier
Q Bone Marrow, Sternum **R** Bone Marrow, Iliac **S** Bone Marrow, Vertebral **T** Bone Marrow	**0** Open **3** Percutaneous	**Z** No Device	**T** Bone Marrow

Question:
A patient with pancytopenia underwent percutaneous bone marrow biopsy. A dermatotomy was created on the right thigh. A bone marrow biopsy needle was advanced into the femoral diaphysis just below the surgical neck, for bone marrow aspiration. Next, a bone marrow core biopsy sample was obtained from a second puncture site. What are the correct code assignments for the biopsies?

Answer:

Assign the following ICD-10-PCS codes:

079T3ZX Drainage of bone marrow, percutaneous approach, diagnostic, for the fine needle aspiration biopsy, and

07DT3ZX Extraction of bone marrow, percutaneous approach, diagnostic, for the needle core biopsy performed at a separate site on the femur.

Drainage is the correct root operation when bone marrow is aspirated to obtain bone marrow cells suspended in fluid. Extraction is the root operation for removal of a sample of solid bone marrow.

Division of Liver for Staged Hepatectomy

In Table 0F8, Division of Hepatobiliary System and Pancreas, all liver body part values have been added as shown below. The change will allow the reporting of associating liver partition and portal vein ligation for staged hepatectomy (ALPPS).

Body Part	Approach	Device	Qualifier
0 Liver **1** Liver, Right Lobe **2** Liver, Left Lobe **G** Pancreas	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**Z** No Device	**Z** No Qualifier

Question:
A patient presents for associating liver partition and portal vein ligation for staged hepatectomy (ALPPS) due to intrahepatic cholangiocellular carcinoma of the right liver lobe. The procedure is carried out in order to create hypertrophy in the small left lateral liver lobe. After achieving pneumoperitoneum robotic ports were placed. The robot was brought in and ports were docked for robotic assisted laparoscopic surgery. A cholecystectomy was performed. Then, the right portal vein was isolated and a Hem-o-lock clip was placed, completely occluding portal flow. Next, the hepatic parenchyma between segments 4 and 3 was divided using a scalpel. Segment 4 pedicle was identified, clipped and divided followed by stage 1 ALPPS procedures. Approximately 50% parenchyma dissection was performed. The liver splitting sites were then sprayed with FloSeal® for homeostasis. How should this procedure coded in ICD-10-PCS? Are the portal vein occlusion and cholecystectomy procedures coded separately?

Answer:
Assign the following ICD-10-PCS codes:
0F824ZZ Division of left lobe liver, percutaneous endoscopic approach, for the ALPPS of the liver to create hypertrophy in the left lobe of the liver;
0FT44ZZ Resection of gallbladder, percutaneous endoscopic approach, for the cholecystectomy;

06L84CZ Occlusion of portal vein with extraluminal device, percutaneous endoscopic approach, for the portal vein occlusion using a clip; and
8E0W3CZ Robotic assisted procedure of trunk region, percutaneous approach, for the robotic assisted laparoscopy.

ALPPS is most accurately classified as a Division procedure. If the gallbladder had been removed as part of an excision or resection of the right lobe of the liver, the gallbladder resection would not be coded separately. However, in this case the right lobe of the liver was not excised or resected, so it is appropriate to code the gallbladder removal.

Disclaimer

All materials have been prepared for general information purposes only to permit you to learn more about coding and coding-related subject matter. Except where referenced, the information presented is not official coding advice, is not to be acted on as such, may not be current and is subject to change without notice. The directives in the ICD-10-CM/PCS manuals take precedence over advice published in Coding Clinic.