WELCOME TO CODING ROUND TABLE WEBINAR 144: Coding Clinic Q1 2022 Highlights

The webinar will begin shortly

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Round Table 144

Coding Clinic Q1 2022 Highlights

March 29th, 2022

****COVID related content will be discussed on RT 145 (April 12th)**

Acute Right Posterior Inferior Cerebral Artery Infarction

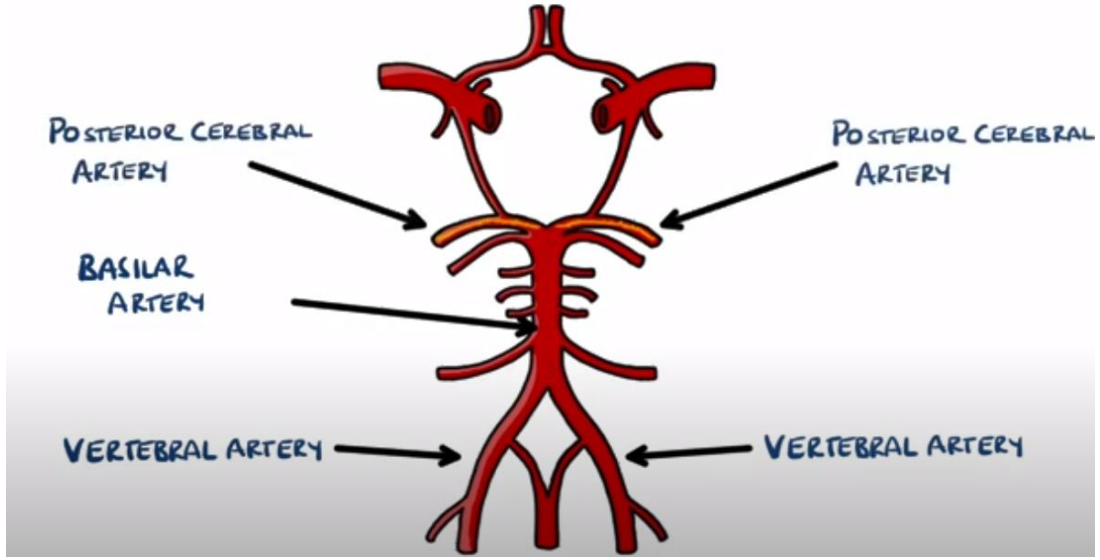
Question:

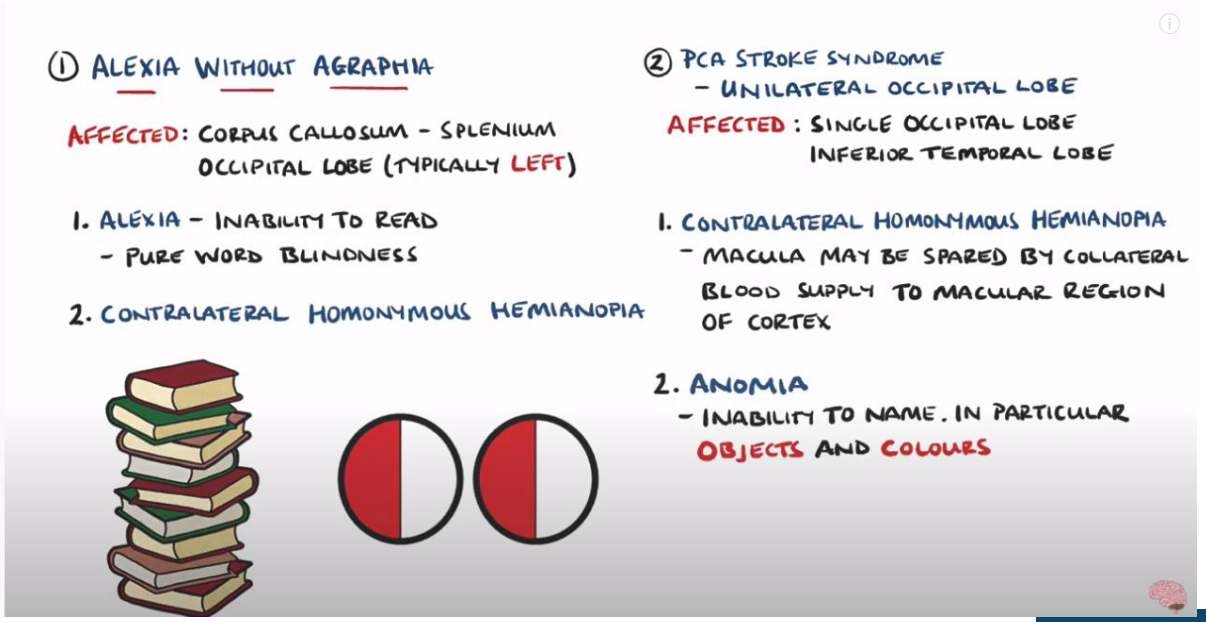
A patient presented to the hospital with complaints of dizziness with nausea and vomiting. Magnetic resonance imaging (MRI) of the head demonstrated a large right posterior inferior cerebral artery (PICA) infarction with no evidence of cerebral artery occlusion or high-grade stenosis and PICA origin is patent. Following diagnostic imaging, the provider's diagnostic statement listed, "Right posterior inferior cerebral artery (PICA) infarction." What is the appropriate ICD-10-CM code for an acute right PICA infarction when the location of the infarction is identified, without evidence of occlusion, stenosis, embolism or thrombus?

Answer:

Assign code I63.89, Other cerebral infarction, for the right PICA infarction since the location of the infarction is specified.

Reference





Admission for Consolidation Chemotherapy with Bone Marrow Biopsy

Question:
A patient with central nervous system 1a, B-cell acute lymphoblastic leukemia (B-ALL) is admitted for intrathecal consolidation chemotherapy. Immediately following chemotherapy, per protocol, an end of induction bone marrow biopsy is performed to evaluate the effectiveness of prior therapy and to determine whether the leukemia is in remission. The *Official Guidelines for Coding and Reporting* (I.C.2.a.) states, "When treatment is directed at a malignancy, the malignancy is sequenced as the principal diagnosis, except when the admission is solely for chemotherapy." In this case, the provider clearly documents the reason for admission is the administration of chemotherapy and the bone marrow biopsy was part of the treatment protocol. When a patient is admitted for chemotherapy but also has a diagnostic test such as a biopsy, is the neoplasm assigned as the principal diagnosis instead of code Z51.11, Encounter for antineoplastic chemotherapy? What is the principal diagnosis in this case?

Answer:
Assign code Z51.11, Encounter for antineoplastic chemotherapy, as the principal diagnosis. Assign code C91.00, Acute lymphoblastic leukemia not having achieved remission, as a secondary diagnosis.
In this case, an end of induction bone marrow biopsy was performed to evaluate the effectiveness of prior chemotherapy, measuring for minimal residual disease. Although a bone marrow biopsy was performed, the administration of intrathecal consolidation chemotherapy was the reason for the admission. Consolidation chemotherapy follows the induction (initial) phase of chemotherapy. The purpose is to destroy any remaining leukemia cells to "consolidate" the gains obtained and to prevent the cancer from returning.

Alcohol Abuse in Remission and Alcoholic Dementia

Question:
A patient with history of alcohol abuse diagnosed with alcoholic dementia presents to the clinic for a follow-up visit. The provider documented that the alcohol abuse is in remission and the patient's memory is impaired due to alcoholic dementia. ICD-10-CM does not provide a specific code for alcoholic dementia due to alcohol abuse. What are the appropriate code assignments to capture this patient's alcohol abuse in remission with alcoholic dementia?
Answer:
Assign codes F10.188, Alcohol abuse with other alcohol-induced disorder, and F02.80, Dementia in other diseases classified elsewhere without behavioral disturbance, for alcoholic dementia. Also assign F10.11, Alcohol abuse, in remission.

F10 Alcohol related disorders

Use additional code for blood alcohol level, if applicable (Y90.-)

F10.1 Alcohol abuse

Excludes1: alcohol dependence (F10.2-)
alcohol use, unspecified (F10.9-)

F10.10 Alcohol abuse, uncomplicated
Alcohol use disorder, mild

F10.11 Alcohol abuse, in remission
Alcohol use disorder, mild, in early remission
Alcohol use disorder, mild, in sustained remission

F10.12 Alcohol abuse with intoxication

F10.120 Alcohol abuse with intoxication, uncomplicated

F10.18 Alcohol abuse with other alcohol-induced disorders

F10.180 Alcohol abuse with alcohol-induced anxiety disorder

F10.181 Alcohol abuse with alcohol-induced sexual dysfunction

F10.182 Alcohol abuse with alcohol-induced sleep disorder

F10.188 Alcohol abuse with other alcohol-induced disorder

Anxiety with Alcohol Abuse

Question:
A patient was admitted for treatment of a malleolus fracture of the right ankle. The provider documented “Alcohol abuse - monitor for withdrawal symptoms.” The patient also had a history of anxiety and was prescribed Cymbalta during hospitalization. Based on the “with” convention, I.A.15, should we assume a link between anxiety and alcohol abuse and assign code F10.180, Alcohol abuse with alcohol-induced anxiety disorder?

Answer:
Do not assume a relationship between alcohol abuse and/or dependence and anxiety. Although the Alphabetic Index links “alcohol with anxiety disorder” and “alcohol-induced anxiety disorder” is part of the code narrative, an alcohol-induced anxiety disorder is not the same as having anxiety and alcohol use/abuse/ dependence. Further, **the Tabular narrative** for codes in subcategory F10.18-, Alcohol abuse with other alcohol-induced disorders, indicates these codes are assigned for “alcohol-induced disorders,” and such a relationship must be documented by the provider. While chronic alcohol dependence, abuse or use may lead to an alcohol induced anxiety disorder, there can be other underlying causes of anxiety. These conditions should not be linked, unless the provider clearly documents a relationship.

3) Psychoactive Substance Use, Unspecified

As with all other unspecified diagnoses, the codes for unspecified psychoactive substance use (F10.9-, F11.9-, F12.9-, F13.9-, F14.9-, F15.9-, F16.9-, F18.9-, F19.9-) should only be assigned based on provider documentation and when they meet the definition of a reportable diagnosis (see Section III, Reporting Additional Diagnoses). These codes are to be used only when the psychoactive substance use is associated with a **substance related** disorder (chapter 5 **disorders** such as sexual dysfunction, sleep disorder, or a mental or behavioral disorder) **or medical condition**, and such a relationship is documented by the provider.

4) Medical Conditions Due to Psychoactive Substance Use, Abuse and Dependence

Medical conditions due to substance use, abuse, and dependence are not classified as substance-induced disorders. Assign the diagnosis code for the medical condition as directed by the Alphabetical Index along with the appropriate psychoactive substance use, abuse or dependence code. For example, for alcoholic pancreatitis due to alcohol dependence, assign the appropriate code from subcategory K85.2, Alcohol induced acute pancreatitis, and the appropriate code from subcategory F10.2, such as code F10.20, Alcohol dependence, uncomplicated. It would not be appropriate to assign code F10.288, Alcohol dependence with other alcohol-induced disorder.

5) Blood Alcohol Level

A code from category Y90, Evidence of alcohol involvement determined by blood alcohol level, may be assigned when this information is documented and the patient’s provider has documented a condition classifiable to category F10, Alcohol related disorders. The blood alcohol level does not need to be documented by the patient’s provider in order for it to be coded.

Substance Abuse/ Dependence with Anxiety, Mood Disorder, Sleep Disorder, or Sexual Dysfunction

Question:
Should combination codes be assigned from categories F10-F19, Mental and behavioral disorders due to psychoactive substance use, any time a patient with a substance abuse or dependence diagnosis also has documented anxiety, mood disorder, sleep disorder, or sexual dysfunction based on the "with" guideline?

Answer:
Do not assume a relationship between substance abuse and/or dependence and anxiety, mood disorder, sleep disorder, or sexual dysfunction. Although these conditions are terms that are located under "with" in the Index, the narrative in the Tabular indicates these codes are reported when the condition is documented as an "alcohol-induced" disorder and such a relationship is documented by the provider.

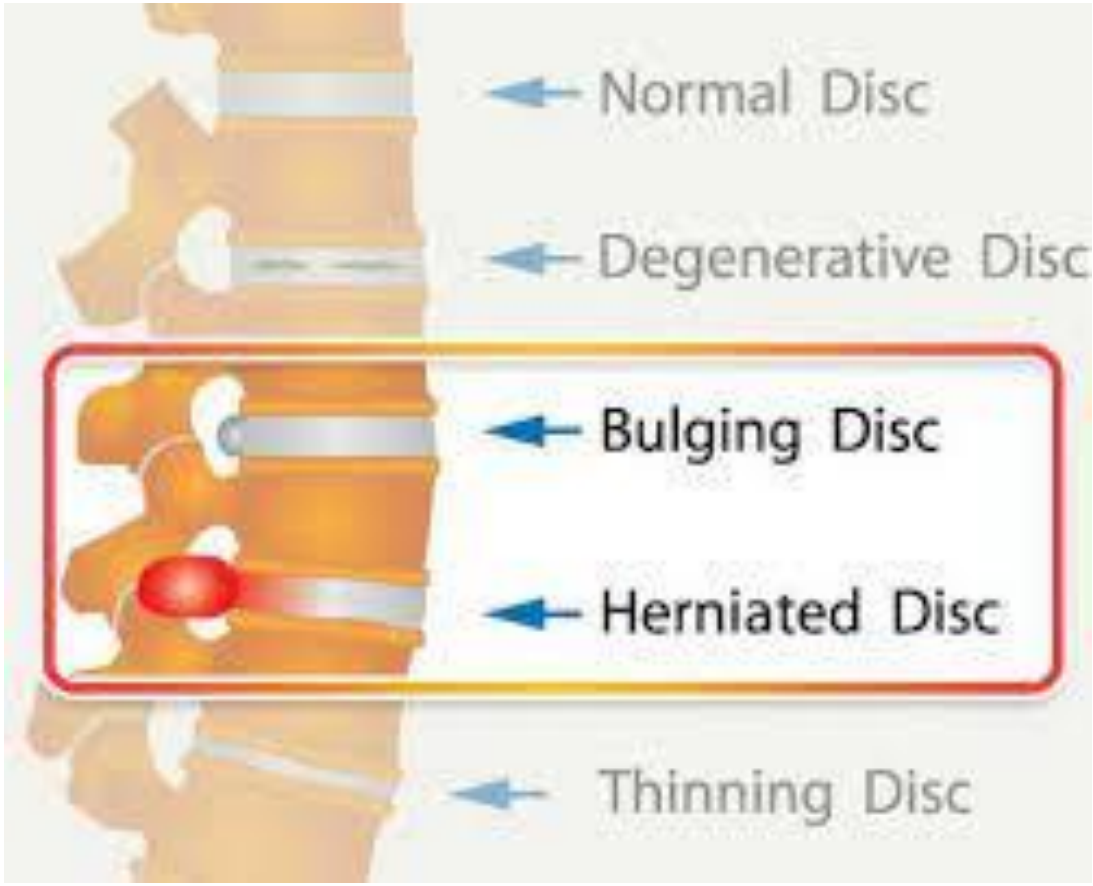
Bulging Disc

Question:

A patient presented for a spinal imaging exam and was diagnosed with a left far lateral disc bulge at level L5-S1. There is no Alphabetic Index entry for disc bulge. Is it appropriate to assume that disc bulge is the same as a herniated or displaced disc? What is the appropriate code assignment for a left L5-S1 far lateral disc bulge?

Answer:

Assign code M51.37, Other intervertebral disc degeneration, lumbosacral region, for a left L5-S1 far lateral disc bulge. A bulging disc is not the same as a herniated or displaced disc. A bulging disc happens over time, due to degeneration of the disc.



Diverticulitis with Intra-Abdominal Abscess

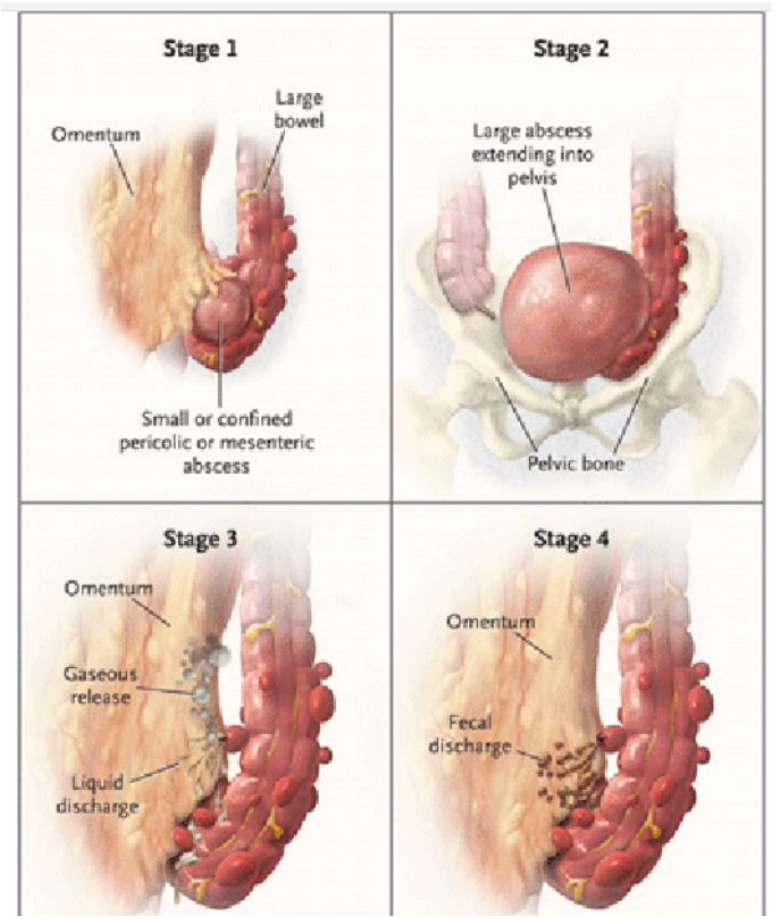
Question:

When a patient is admitted with diverticulitis of the colon and an intra-abdominal abscess, is code K65.1, Peritoneal abscess, assigned along with code K57.20, Diverticulitis of large intestine with perforation and abscess without bleeding?

Answer:

Yes. Assign code K57.20, Diverticulitis of large intestine with perforation and abscess without bleeding, followed by K65.1, Peritoneal abscess, to further specify the location of the abscess.

This code assignment is supported by the “code also” note located under both code categories. The note under category K57, Diverticular disease of intestines, instructs the coding professional to code peritonitis if applicable, and the note under category K65, Peritonitis, instructs to code if applicable diverticular disease of intestine (K57-).



Sigmoid Diverticulitis with Peritonitis and Perforation

Question:

A patient is admitted with peritonitis likely secondary to perforated sigmoid diverticulitis. Is code K65.9, Peritonitis, unspecified, assigned with code K57.20, Diverticulitis of large intestine with perforation and abscess without bleeding?

Answer:

Yes. Assign codes K57.20, Diverticulitis of large intestine with perforation and abscess without bleeding, and K65.9, Peritonitis, unspecified.

Please note, effective October 1, 2020, the inclusion term at subcategory K57.2- has been deleted. Therefore, it would be appropriate to report both codes for discharges on and after October 1, 2020.

K57 Diverticular disease of intestine

Code also if applicable peritonitis K65.-

Excludes1: congenital diverticulum of intestine (Q43.8)
Meckel's diverticulum (Q43.0)

Excludes2: diverticulum of appendix (K38.2)

K57.0 Diverticulitis of small intestine with perforation and abscess

Excludes1: diverticulitis of both small and large intestine with perforation and abscess (K57.4-)

K57.00 Diverticulitis of small intestine with perforation and abscess without bleeding

K57.01 Diverticulitis of small intestine with perforation and abscess with bleeding

K57.1 Diverticular disease of small intestine without perforation or abscess

Excludes1: diverticular disease of both small and large intestine without perforation or abscess (K57.5-)

K57.10 Diverticulosis of small intestine without perforation or abscess without bleeding
Diverticular disease of small intestine NOS

K57.11 Diverticulosis of small intestine without perforation or abscess with bleeding

K57.12 Diverticulitis of small intestine without perforation or abscess without bleeding

K57.13 Diverticulitis of small intestine without perforation or abscess with bleeding

K57.2 Diverticulitis of large intestine with perforation and abscess

Excludes1: diverticulitis of both small and large intestine with perforation and abscess (K57.4-)

K57.20 Diverticulitis of large intestine with perforation and abscess without bleeding

K57.21 Diverticulitis of large intestine with perforation and abscess with bleeding

K57.3 Diverticular disease of large intestine without perforation or abscess

Excludes1: diverticular disease of both small and large intestine without perforation or abscess (K57.5-)

K57.30 Diverticulosis of large intestine without perforation or abscess without bleeding
Diverticular disease of colon NOS

History of HIV Managed by Medication

Question:
My facility has interpreted new HIV coding guideline I.C.1.a.2.i "History of HIV managed by medication" to mean that code B20, HIV disease, should be reported for any HIV positive patient on antiretrovirals, regardless of whether the documentation states the patient has ever had an HIV-defining illness or has HIV disease. Could you please clarify if this was the intent of this new guideline?

Answer:
The intent of the guideline is to provide guidance that code B20 is appropriate for patients documented with HIV disease on antiretrovirals and to align with the guidance published in *Coding Clinic,* Fourth Quarter 2020, pages 97-98, that clarified HIV disease is specifically classified to code B20. It would not be appropriate to report code B20 without provider documentation of an HIV related illness, HIV disease or AIDS. A diagnosis of "HIV" or "HIV positive" without documentation of HIV disease, an HIV related illness, or AIDS should be assigned code Z21, Asymptomatic human immunodeficiency virus [HIV] infection status." However, the provider should be queried for clarification when the documentation is unclear regarding the patient's HIV status. This is also consistent with the advice published in *Coding Clinic*, First Quarter 2019, pages 8-11.

(d) **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.

(i) **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.

Medical Treatment/Stabilization of Severe Malnutrition due to Anorexia Nervosa

Question:

A 51-year-old patient with severe protein calorie malnutrition due to extreme anorexia nervosa, binge-eating purging type, is admitted to the hospital for stabilization of her acute medical conditions and weight restoration, before being transferred to a residential treatment program specializing in eating disorders. The provider also documented that the patient's end stage renal disease, dehydration and kidney stones are complications caused by the anorexia nervosa. Some coding professionals are questioning whether it is appropriate to sequence anorexia nervosa as the principal diagnosis when the admission is for medical stabilization. What is the appropriate principal diagnosis?

Answer:

Assign code E43, Unspecified severe protein-calorie malnutrition, as the principal diagnosis, as this condition is the reason for the admission. Code F50.02, Anorexia nervosa, binge eating/purging type, should be assigned as a secondary diagnosis. Since the admission was for treatment/ stabilization of the patient's acute medical conditions, it would not be appropriate to sequence anorexia nervosa as the principal diagnosis.

The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

F50 Eating disorders

Excludes1: anorexia NOS (R63.0)
feeding problems of newborn (P92.-)
polyphagia (R63.2)

Excludes2: feeding difficulties (R63.3)
feeding disorder in infancy or childhood (F98.2-)

F50.0 Anorexia nervosa

Excludes1: loss of appetite (R63.0)
psychogenic loss of appetite (F50.89)

F50.00 Anorexia nervosa, unspecified

F50.01 Anorexia nervosa, restricting type

F50.02 Anorexia nervosa, binge eating/purging type

Excludes1: bulimia nervosa (F50.2)

F50.2 Bulimia nervosa
Bulimia NOS
Hyperorexia nervosa

Excludes1: anorexia nervosa, binge eating/purging type (F50.02)

Newborn Tight Nuchal Cord

Question:
What is the appropriate ICD-10-CM code assignment for a diagnosis of “tight nuchal cord” on the newborn record? Does “tight” nuchal cord” indicate “with compression” or must the provider document “with compression” in order to assign code P02.5, Newborn affected by other compression of umbilical cord?

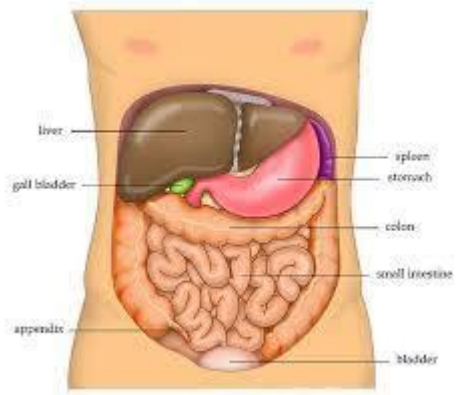
Answer:
A tight nuchal cord does not necessarily imply compression. When coding the newborn’s record, the health record documentation should indicate the infant was affected in some way by the tight nuchal cord (e.g., metabolic acidosis, late decelerations, low Apgar score, etc.). If the documentation is not clear whether the newborn was affected, query the provider for clarification.

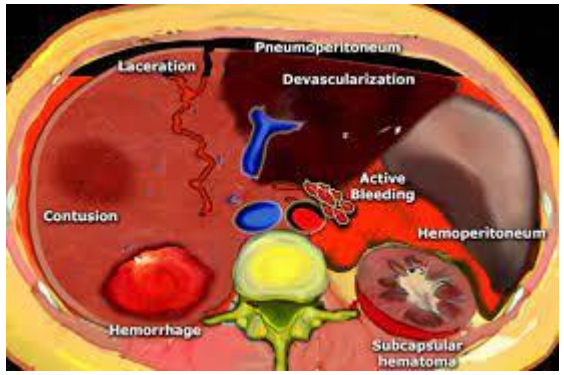
A diagnosis of “tight nuchal cord” documented on the maternal record is not applicable to the newborn, since the provider would need to document the condition on the newborn’s record, as well as the fact that the infant has been affected by this condition.

Hemoperitoneum with Splenic Laceration

Question:
A patient was admitted three hours following a colonoscopy with left upper quadrant (LUQ) pain and was found to have a grade 3 splenic laceration with hemoperitoneum, due to the colonoscopy. Is it appropriate to assign a code for the hemoperitoneum when it is associated with a splenic laceration or is the hemoperitoneum considered integral to the laceration and not coded separately?

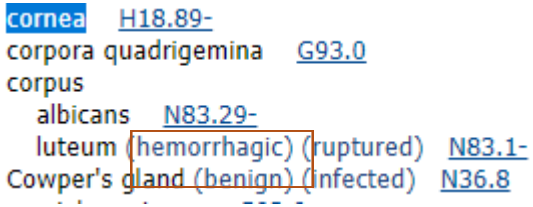
Answer:
Assign codes D78.12, Accidental puncture and laceration of the spleen during other procedure, K66.1, Hemoperitoneum, and Y65.8, Other specified misadventures during surgical and medical care. Code D78.12 is assigned for the splenic laceration and code K66.1 is assigned to capture the hemoperitoneum. Both codes are needed to fully capture the patient's diagnoses. Code S36.031A, Moderate laceration of spleen, initial encounter, is not appropriate, because a traumatic injury code should not be assigned for injuries that occur during, or as a result of, a medical intervention.

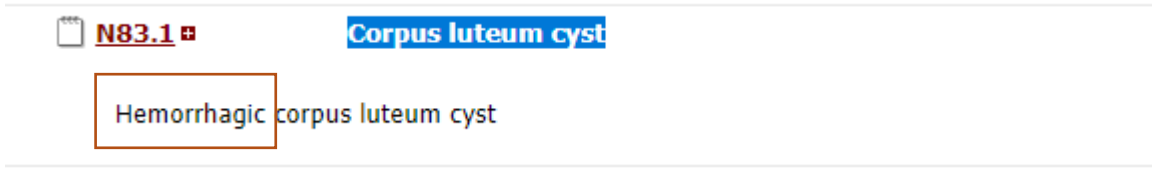




Ruptured Corpus Luteum Cyst and Hemoperitoneum

Question:
A patient presented with lower abdominal pain due to left-sided ruptured corpus luteum cyst that resulted in a hemoperitoneum and acute blood loss anemia. Is it appropriate to assign code K66.1, Hemoperitoneum, when it is associated with a ruptured corpus luteum ovarian cyst?
Answer:
Assign codes N83.12, Corpus luteum cyst of left ovary, and K66.1, Hemoperitoneum. While “hemorrhagic” is a nonessential modifier when referencing corpus luteum cyst in the Index, both codes are needed to capture the severity of this patient’s condition.

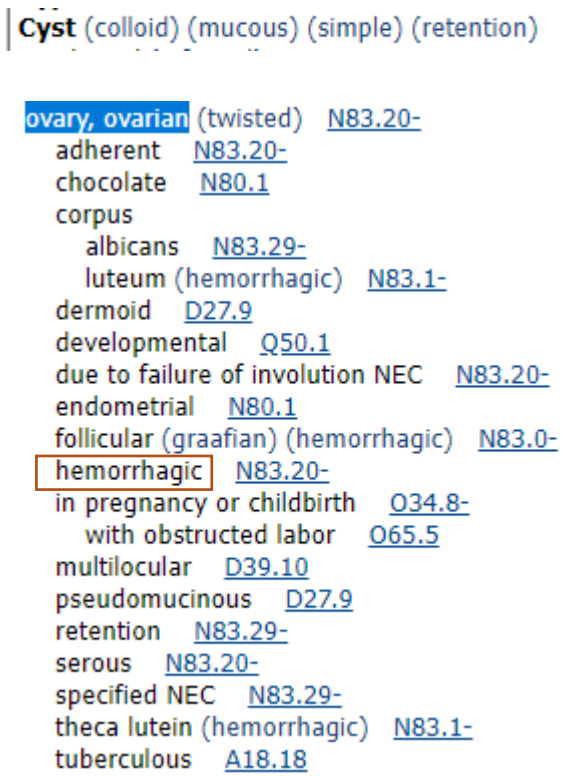




Ruptured Ovarian Cyst with Hemoperitoneum

Question:
A patient presented with severe pelvic pain due to ruptured left ovarian cyst with hemoperitoneum. Is it appropriate to assign code K66.1, Hemoperitoneum, when it is associated with a ruptured ovarian cyst?

Answer:
Assign code N83.202, Unspecified ovarian cyst, left side and code K66.1, Hemoperitoneum. A code from subcategory N83.20-, Unspecified ovarian cyst, does not fully capture the condition; therefore, code K66.1 is needed to identify the hemoperitoneum.



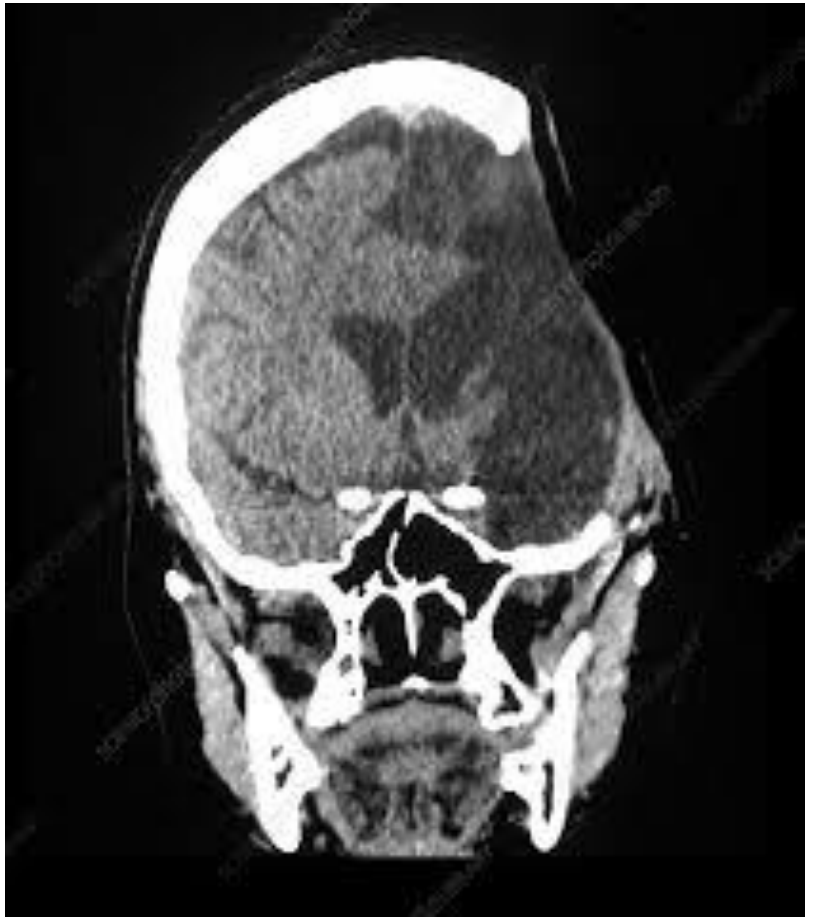
Sunken Flap Syndrome

Question:

A patient with a history of traumatic brain injury, status post bilateral craniectomies is admitted for skull reconstruction due to bilateral frontoparietal cranial defects. Cranioplasty was performed on the right side, however during the recovery phase the patient became obtunded, encephalopathic and bradycardic. The physician noted the previous left-sided skull flap appeared sunken, consistent with sunken flap syndrome and paradoxical brain shift, which required left-sided reconstruction. What are the correct code assignments for sunken flap syndrome?

Answer:

Assign codes G97.82, Other postprocedural complications and disorders of nervous system, and M95.2, Other acquired deformity of head, for post craniectomy sunken flap syndrome. Based on the “use additional code” note located at subcategory G97.8, Other intraoperative and postprocedural complications and disorders of nervous system, assign additional codes to further specify the condition.



Type 1 Diabetic Hyperglycemic Hyperosmolar Syndrome

Question:
A patient is diagnosed with uncontrolled type I diabetes mellitus (DM), hyperglycemia, and acute hyperglycemic hyperosmolar syndrome (HHS). Both hyperglycemia and hyperosmolarity are respective subterms at the Index entry for Diabetes, type 2, under the subterm “with.” However, only hyperglycemia appears as a subterm at the Index entry for Diabetes, type 1, under the subterm “with.” What is the correct code assignment for uncontrolled Type 1 DM with HHS?

Assign codes E10.69, Type 1 diabetes mellitus with other specified complication, E10.65, Type I diabetes mellitus with hyperglycemia, and E87.0, Hyperosmolality and hypernatremia, for HHS. Since ICD-10- CM does not provide a specific code for type 1 diabetes with hyperosmolarity, code E10.69 is assigned. Further, code E10.65 captures the hyperglycemia, but not the hyperosmolality; therefore each code is needed to completely capture the patient’s condition. Although HHS most often affects individuals who have type 2 diabetes, it can also affect people with type 1 diabetes.

Type 2 Diabetic Hyperosmolar Ketotic State without Acidosis

Question:
A patient is diagnosed with hyperglycemic hyperosmolar ketotic state without acidosis, and new onset type 2 diabetes. *Coding Clinic,* Third Quarter 2013, page 20, states “Any combination of the diabetes codes can be assigned together, unless one diabetic condition is inherent in another.” Is code E11.65, Type 2 diabetes mellitus with hyperglycemia assigned as an additional diagnosis? What is the correct code assignment for this patient?
Answer:
Assign code E11.00, Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC). Hyperglycemia is inherent to code E11.00; therefore, do not separately report code E11.65

Underdosing with No Change in Patient's Condition

Question:
A patient stopped taking his prescribed dose of Amlodipine after running out of the antihypertensive medication several days ago. The provider documented that the patient's blood pressure was stable. Would it be appropriate to assign a code for underdosing of Amlodipine when there is no documentation of an exacerbation or an issue with the patient's chronic hypertension?

Answer:
Assign codes T46.5X6A, Underdosing of other antihypertensive drugs, initial encounter, I10, Essential (primary) hypertension, and Z91.14, Patient's other noncompliance with medication regimen, to capture the fact that the patient was not taking the medication as prescribed.
The underdosing guideline (I.C.19.e.5.c) does not preclude the assignment of underdosing codes if the health record documentation does not specifically state a change in the patient's condition. Documentation that the patient had discontinued the prescribed medication on his/ her own is sufficient for code assignment.

(c) **Underdosing**

Underdosing refers to taking less of a medication than is prescribed by a provider or a manufacturer's instruction. Discontinuing the use of a prescribed medication on the patient's own initiative (not directed by the patient's provider) is also classified as an underdosing. For underdosing, assign the code from categories T36-T50 (fifth or sixth character "6").

Codes for underdosing should never be assigned as principal or first-listed codes. If a patient has a relapse or exacerbation of the medical condition for which the drug is prescribed because of the reduction in dose, then the medical condition itself should be coded.

Noncompliance (Z91.12-, Z91.13- and Z91.14-) or complication of care (Y63.6-Y63.9) codes are to be used with an underdosing code to indicate intent, if known.

Intraoperative Serosal Tear

Intraoperative Serosal Tear
Question:
Please clarify the advice published in *Coding Clinic* Second Quarter 2021, page 8, regarding intraoperative serosal tear. The advice appears to conflict with the *Official Guidelines for Coding and Reporting* for documentation of complication of care (1.B.16.) since the provider explicitly documented that no complication occurred. In addition, because the tear occurred during a laparoscopic salpingo-oophorectomy, code K91.72, Accidental puncture and laceration of a digestive system organ or structure during other procedure, should have been assigned, rather than code K91.71, Accidental puncture and laceration of a digestive system organ or structure during a digestive system procedure.

Answer:
The advice previously published in *Coding Clinic* Second Quarter 2021, page 8, does not conflict with the *Official Guidelines for Coding and Reporting* for documentation of complication of care (1.B.16.) since a cause and effect relationship was documented between the surgery and the serosal tear. This guideline was not intended to mean that the surgeon must specifically document the term "complication." The surgeon's documentation of the serosal tear and the subsequent procedure for repairing the tear is sufficient documentation to report a complication code. Furthermore, the term "complication" does not imply inappropriate/inadequate care, and/or an unplanned outcome. Some issues or conditions occurring as a result of surgery are classified by ICD-10-CM as a complication whether stated or not. Although the surgeon stated that the serosal tear was unavoidable, it does not mean that the tear is not a surgical complication. For example, a serosal tear can range from a small nick requiring no treatment at all, to a major tear requiring removal of a portion of the small intestine. Serosal tears alone do not qualify as reportable diagnoses. If, however, the degree of a serosal tear alters the course of the surgery as supported by the medical record documentation, then the tear should be reported.

Although not explicitly stated in the Q&A, the patient had undergone multiple procedures including salpingo-oophorectomy, reduction and repair of an incarcerated ventral hernia with mesh and lysis of adhesions. The serosal tear occurred during the part of the surgery to repair the ventral hernia and lysis of adhesions of the small intestine. Therefore, code K91.71, Accidental puncture and laceration of a digestive system organ or structure during a digestive system procedure, is the correct code assignment.

Toxic Metabolic Encephalopathy due to Hepatic Encephalopathy

Question:
Coding Clinic, First Quarter 2021, page 13, states that it is appropriate to assign code G92, Toxic encephalopathy, for toxic metabolic encephalopathy (TME) due to acute on chronic hepatic encephalopathy. However, this advice does not seem correct since the provider did not document an associated toxic substance or an adverse effect of medication. Is it appropriate to assign code G92, when there is no external agent associated with the encephalopathy? It would appear that toxic metabolic encephalopathy or any other specified type of encephalopathy should only be reported when linked to another condition besides hepatic encephalopathy or hepatic failure. In this case, it appears that the encephalopathy should be inherent and not separately reported since it is linked to the liver encephalopathy.

Answer:
The encephalopathy that occurs with liver failure is metabolic in nature from toxins generated within the body, not from external toxins. When the provider has confirmed the diagnosis of toxic metabolic encephalopathy, assign code G92.8, Other toxic encephalopathy. This code assignment does not imply external toxins and a toxin does not have to come from outside the body in order to assign this code.

The Alphabetic Index for Encephalopathy, toxic, metabolic, leads to code G92.8 and the inclusion term “Toxic metabolic encephalopathy” confirms that this is the correct code assignment. Code assignment is based on the provider’s documentation of the condition, and is not based on a particular clinical definition or criterion.

A “code first” note instructs that two codes may be required to fully describe this condition, if applicable. Toxic metabolic encephalopathy is not inherent to hepatic encephalopathy, therefore code G92.8 should be assigned separately to specifically capture the TME.
Code K72.90, Hepatic failure, unspecified without coma, should be assigned if the only documentation in the medical record is “hepatic encephalopathy,” without any further specification of the underlying cause. In this case, the underlying cause of the toxic metabolic encephalopathy was acute on chronic hepatic encephalopathy.

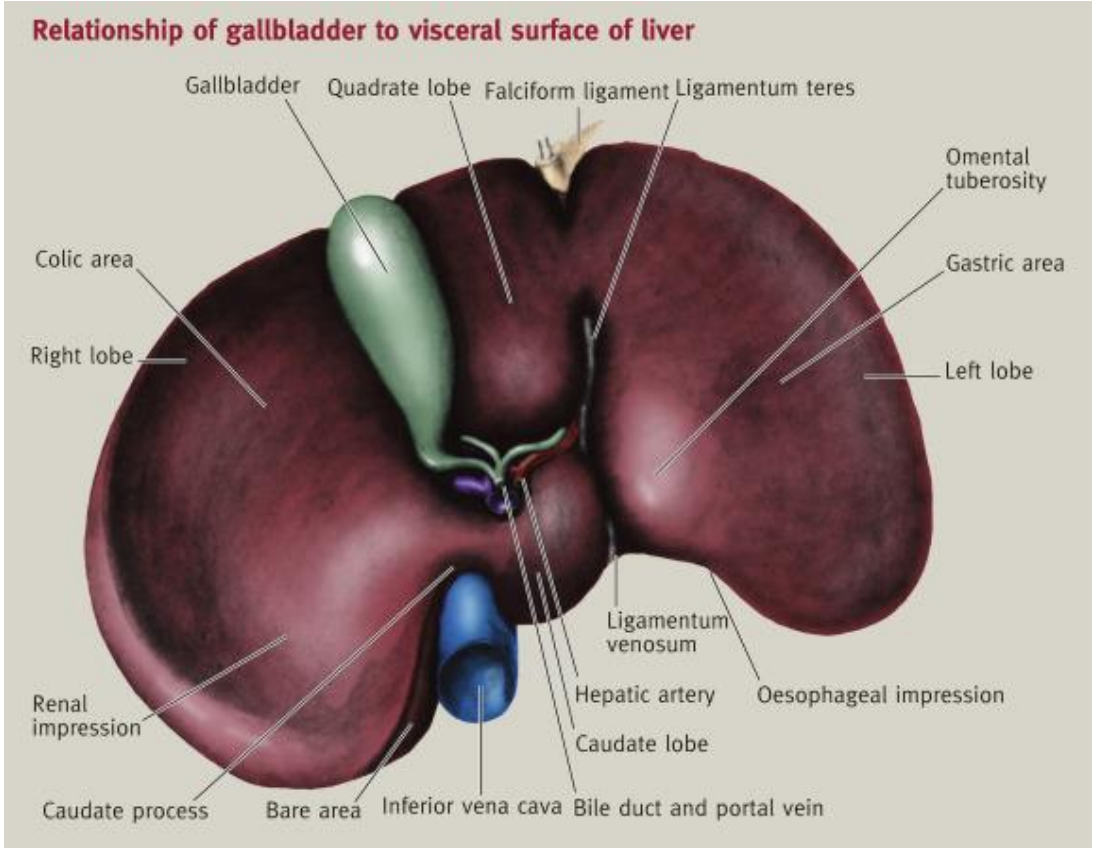
Postsurgical Hematoma of Gallbladder Fossa

Question:

A patient status post laparoscopic cholecystectomy for chronic biliary disease, was readmitted due to abdominal distention with nausea and vomiting. A computerized tomography scan of the abdomen demonstrated a large hematoma of the gallbladder fossa. Surgical exploration revealed no active bleeding and the liver bed was hemostatic. A large hematoma was found within the gallbladder fossa, and the space between the liver and duodenum, along with old blood in the abdomen. Evacuation of hematoma and old blood was performed. The postoperative diagnosis listed, "Postoperative accumulation of intra-abdominal hematoma with hemoperitoneum." What are the correct code assignments to capture these conditions?

Answer:

Assign code K91.870, Postprocedural hematoma of a digestive system organ or structure following a digestive system procedure. Do not assign a separate code for the hemoperitoneum, because the documentation does not support a diagnosis of hemoperitoneum. The operative report did not describe any active bleeding (hemoperitoneum), only hematoma and old blood, which was essentially part of the hematoma. Although the postoperative diagnosis recorded "Postoperative hemoperitoneum," coding professionals should review the full body of the operative note, rather than coding strictly from the title of the report. A hematoma is a collection of clotted or partially clotted blood in an organ, tissue or body space, which is typically due to inadequate hemostasis; whereas a hemoperitoneum is internal bleeding that accumulates in the peritoneum.



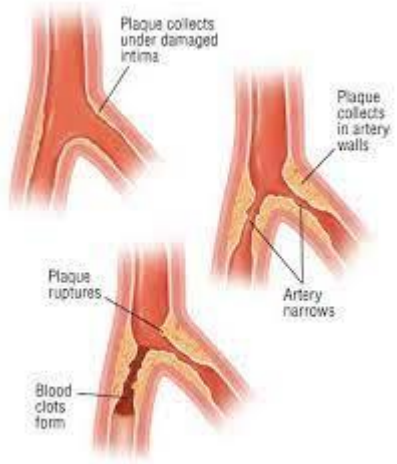
Present on Admission Indicator for Palliative Care

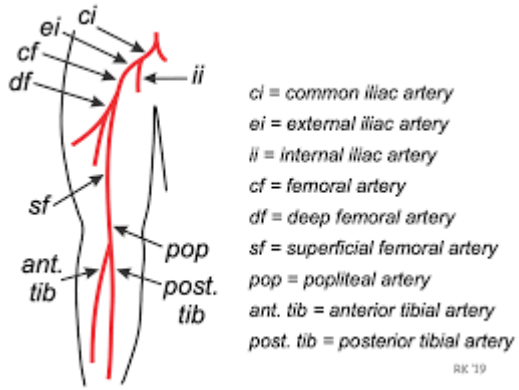
Question:
Quality measures at our facility may be affected when a patient is receiving palliative care and the present on admission (POA) indicator “N” (No) is reported. We are seeking official guidance from *Coding Clinic* regarding the appropriate POA indicator for patients receiving palliative care.

Answer:
Effective October 1, 2021, code Z51.5, Encounter for palliative care, was added to the Exempt from POA Reporting List by the Centers for Disease Control and Prevention’s National Center for Health Statistics.

Procedures Performed on a Continuous Vessel, ICD-10-PCS Guideline B4.1c

AHA's Central Office on ICD-10-CM/PCS has received numerous questions regarding the revised ICD-10-PCS guideline pertaining to a tubular body part (B4.1c). The guideline states, "If a procedure is performed on a continuous section of a tubular body part, code the body part value corresponding to the anatomically most proximal (closest to the heart) portion of the tubular body part." For 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 external iliac artery is also coded to the external iliacartery body part. The following questionsand answers are provided to assist coding professionals in applying the guideline.





Question:
According to the updated guideline B4.1c, if a carotid endarterectomy is performed on a single continuous lesion involving both the common carotid artery and internal carotid artery, the common carotid artery would be the only body part coded, because it is closest to the heart. We are concerned that data involving carotid endarterectomies would be skewed and procedures performed on both the common carotid and internal carotid arteries would not reflect the complexity involved in the surgery. We are requesting that Coding Clinic clarify this issue.

Answer:
The procedure code would identify the common carotid artery only if it were a single procedure performed on one continuous lesion. If, however, the documentation states that separate lesions in separate vessels were identified and treated, multiple codes would be assigned to specify distinct procedures performed on multiple body parts.

Procedures Performed on a Continuous Vessel, ICD-10-PCS Guideline B4.1c

Question:
The updated ICD-10-PCS Official Guidelines for Coding and Reporting, Guideline B4.1c, pertaining to procedures performed on a continuous section of a tubular body part appears to conflict with the multiple procedures guideline B3.2a. This guideline (B3.2a) states, "During the same operative episode, multiple procedures are coded if the same root operation is performed on different body parts as defined by distinct values of the body part character." Guideline B4.1c does not indicate that it only applies to certain body parts/body systems. Could you please clarify?

Answer:
The updated guideline (B4.1c) does not conflict with the guideline for multiple procedures (B3.2a). However, guideline B4.1c will be clarified further by adding the terms "vascular" and "arterial/ venous" as well as "single" procedure.

Question:
Since the updated *ICD-10-PCS Official Guidelines for Coding and Reporting* guideline B4.1c specifies "tubular body part," does this guideline apply to any tubular body part, such as the esophagus, stomach, large and small intestines, etc.?

Answer:
No, the *ICD-10-PCS Official Guidelines for Coding and Reporting,* Guideline B4.1c only applies to the vasculature, such as arteries and veins, not other tubular organs, such as esophagus, stomach, large and small intestines.

Question:
When applying the ICD-10-PCS Official Guidelines for Coding and Reporting, Guideline B4.1c, does the surgery need to involve a single lesion that spans across multiple body parts?
Answer:
Yes, this guideline (B4.1c) only applies to surgeries that involve a single lesion that spans across multiple body parts.

Question:
When assigning codes for procedures involving separate lesions, such as thrombus, clots, plaque, etc., within multiple body parts, rather than a single continuous lesion, should each procedure be coded separately?
Answer:
Yes, procedures involving separate lesions found in/on multiple body parts should be coded separately. The ICD-10-PCS Official Guidelines for Coding and Reporting, Guideline B3.2 states, "During the same operative episode, multiple procedures are coded if the same root operation is performed on different body parts as defined by distinct values of the body part character."

Procedures Performed on a Continuous Vessel, ICD-10-PCS Guideline B4.1c

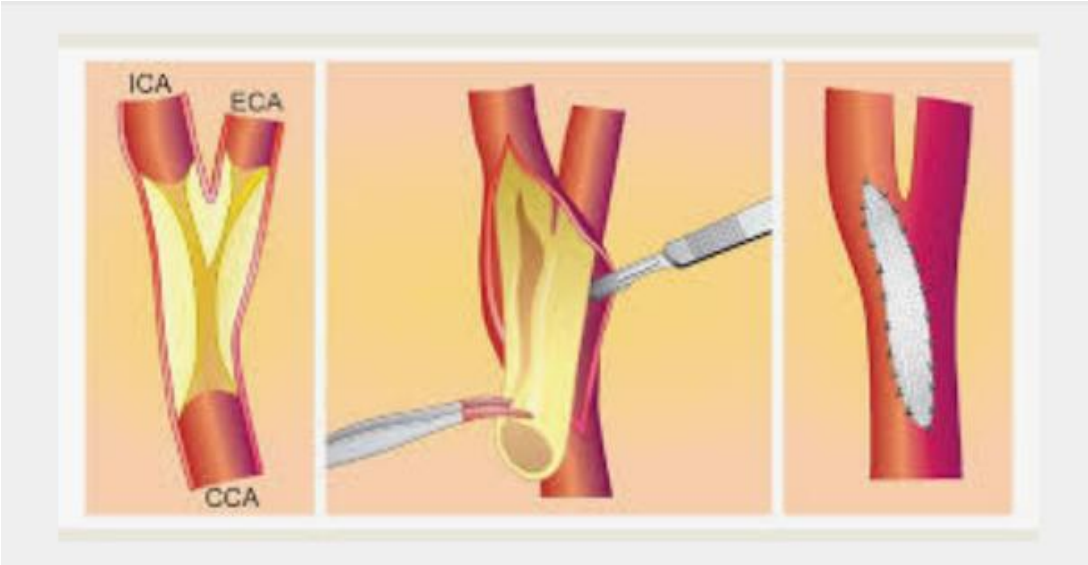
Question:

According to the updated guideline B4.1c, if a carotid endarterectomy is performed on a single continuous lesion involving the common carotid artery and an internal carotid artery, only the

body part closest to the heart is coded. Based on this guideline, what body part is assigned when an endarterectomy is performed on one continuous lesion involving both the common carotid and internal carotid arteries?

Answer:

If the endarterectomy is performed on one continuous lesion involving the common carotid artery and an internal carotid artery, the body part identified in the procedure code assigned is the common carotid artery, which is closest to the hear.



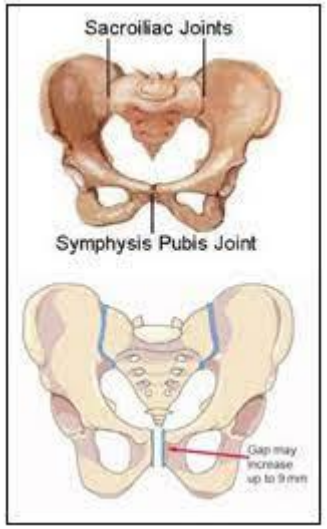
Umbilical Cord Blood Sampling

Question:
An infant had umbilical cord blood collected for blood typing and testing of blood gases shortly following birth. Would it be appropriate to assign code 6A550ZT, Pheresis of cord blood stem cells, single, for the collection of umbilical cord blood for sampling? If not, what is the appropriate ICD-10-PCS code assignment?
Answer:
It is not appropriate to assign code 6A550ZT, Pheresis of cord blood stem cells, single, for umbilical cord blood sampling. Collection of umbilical cord blood is a routine part of the newborn's care and an ICD-10-PCS code is not assigned. This is not the same as pheresis of cord blood stem cells, and is not a separately reportable service.

Septic Arthritis/ Osteomyelitis of Pubic Symphysis and Aspiration Biopsy

Question:
A patient presents with possible recurrent E. coli urinary tract infection, bacteremia and ongoing left hip/groin pain. A pubic symphysis aspirate demonstrated E. coli, likely the same E. coli in the blood. The provider confirmed a diagnosis of septic arthritis/osteomyelitis of pubic symphysis/ pubic bone. What are the ICD-10-CM diagnosis code assignments for pubic symphysis osteomyelitis and septic arthritis?

Answer:
Assign codes M86.8X8, Other osteomyelitis, other site, for osteomyelitis of the pubic symphysis joint, and B96.20, Unspecified Escherichia coli [E. coli] as the cause of diseases classified elsewhere, to identify the infectious agent. Currently, ICD-10-CM does not have a specific code for septic arthritis of the pubic symphysis joint. The Centers for Disease Control and Prevention's National Center for Health Statistics has agreed to consider a future ICD-10 Coordination and Maintenance (C&M) proposal to create a new code for septic arthritis, affecting other joints.



Question:
This same patient underwent an aspiration fluid biopsy of the pubic symphysis joint. During the procedure, a guide needle was passed percutaneously under CT guidance into the pubic symphysis joint. Aspiration was attempted; however, there was no return of fluid. After approximately 2cc's of sterile saline was administered into the pubic symphysis joint, the joint was re-aspirated and serous sinus fluid was retrieved for analysis. What is the appropriate root operation and body part value for an aspiration fluid biopsy of the pubic symphysis joint?

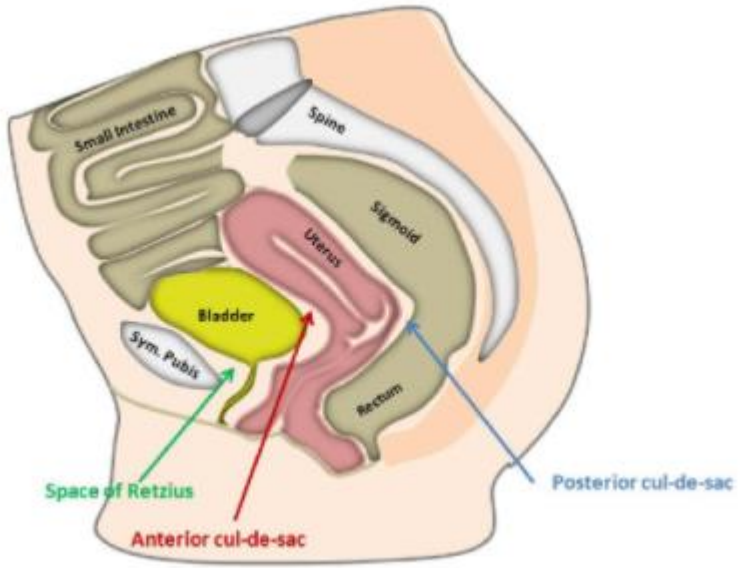
Assign the following procedure codes:
0Q933ZX Drainage of left pelvic bone, percutaneous approach, diagnostic, and
0Q923ZX Drainage of right pelvic bone, percutaneous approach, diagnostic, for aspiration biopsy of the pubic symphysis joint.

In ICD-10-PCS, there is no specific body part value for drainage of the "pubic symphysis joint". The pubic symphysis lies midline to the right and left pubic bones. Therefore, the body part values "3", Pelvic bone, left, and "2", Pelvic bone, right, would be appropriate in this case. When the physician describes the pelvic symphysis as the body part, assign codes for both the left and right pelvic bones.

Removal of Fat Necrosis from Retroperitoneum and Space of Retzius

Question:

A woman with a pelvic abscess and pancreatic head necrosis presented for surgery. A flank incision was made with division into the retroperitoneum. Malodorous semi-solid material typical of fat necrosis was found. The area of the retroperitoneum up toward the head of the pancreas was gently debrided with fingers and sponge stick. A resectional debridement was carried out until all remaining necrotic fat and tissue were removed. For the pelvic abscess, a lower midline incision was made near the symphysis pubis until the abscess cavity was entered. This too looked like fat necrosis in the space of Retzius. This was scooped out with fingers and a sponge stick. What are the root operations and body part values for removal of fat necrosis near the pancreas and within the pelvic abscess cavity?

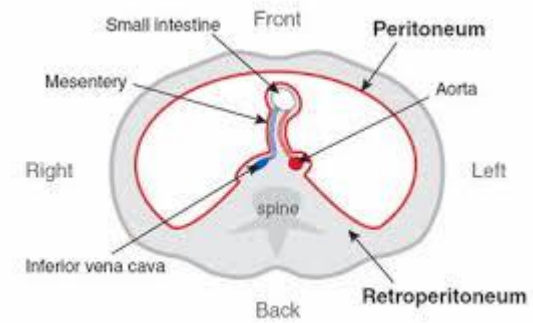


Answer:

Assign the following procedure codes:

0WCH0ZZ Extirpation of matter from retroperitoneum, open approach, for the removal of fat necrosis from the retroperitoneum near the pancreatic head and surrounding tissue.

0WCJ0ZZ Extirpation of matter from pelvic cavity, open approach, for the fat necrosis removal from the abscess cavity. Per the ICD-10- PCS body part key, the space of Retzius is a retropubic space, classified to the pelvic cavity.



The provider documented that the necrotic tissue was semi-solid material and removed by use of fingers and sponge stick. This meets the definition of Extirpation - taking or cutting out solid material from a body part.

Provisional Total Hip Arthroplasty

Question:
A patient with a femoral neck fracture underwent an open left total hip arthroplasty. Following removal of the femoral head, trial femoral head and neck metal on polyethylene components were placed. At the acetabulum, a shell was trialed for fit, followed by placement of the acetabular component. A temporary acetabular liner was placed in addition. Suddenly, the patient decompensated and was not stable to continue the surgery. The temporary acetabular liner and femoral trials were left in place, to be exchanged for final implants at a later date. Would ICD-10-PCS codes be assigned for placement of the trial joint components, not intended to remain at the end of the procedure? If so, what are the correct root operations and device values?

Answer:
Assign the following ICD-10-PCS code:
0SRB02A Replacement of left hip joint with metal on polyethylene synthetic substitute, uncemented, open approach, for the provisional total hip arthroplasty.

In this case, a total hip replacement procedure was performed, as both the acetabular and the femoral portions of the joint were replaced with prosthetic components.

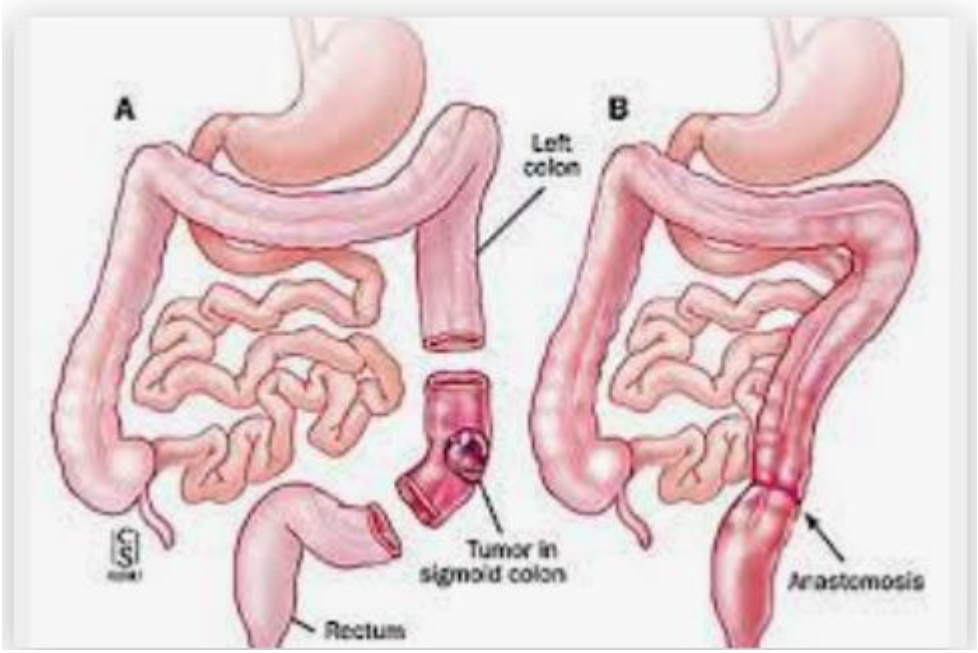
Robotic-Assisted Low Anterior Resection of Colon

Question:

A patient underwent robotic-assisted low anterior colon resection for treatment of cancer. At surgery, pneumoperitoneum was established; robotic ports were placed; and the splenic flexure was mobilized laparoscopically, followed by robotic excision. A Pfannenstiel incision was made; the sigmoid colon was pulled through the incision; and skeletonized extracorporeally. Anastomosis was then performed and inspected via proctoscope. What is the appropriate approach value for this procedure?

Answer:

Assign the approach value “4, Percutaneous Endoscopic” for the robotic-assisted sigmoid colectomy with primary anastomosis. In this case, surgery was performed laparoscopically; towards the end of the procedure, a small Pfannenstiel incision was made to divide, skeletonize and remove the specimen. According to the ICD-10-PCS guideline B5.2b, “Procedures performed using the percutaneous endoscopic approach, with incision or extension of an incision to assist in the removal of all or a portion of a body part or to anastomose a tubular body part to complete the procedure, are coded to the approach value Percutaneous Endoscopic.”



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