WELCOME TO CODING ROUND TABLE WEBINAR 147: AHA Coding Clinic Q2 2022 Highlights

The webinar will begin shortly

Round Table 147

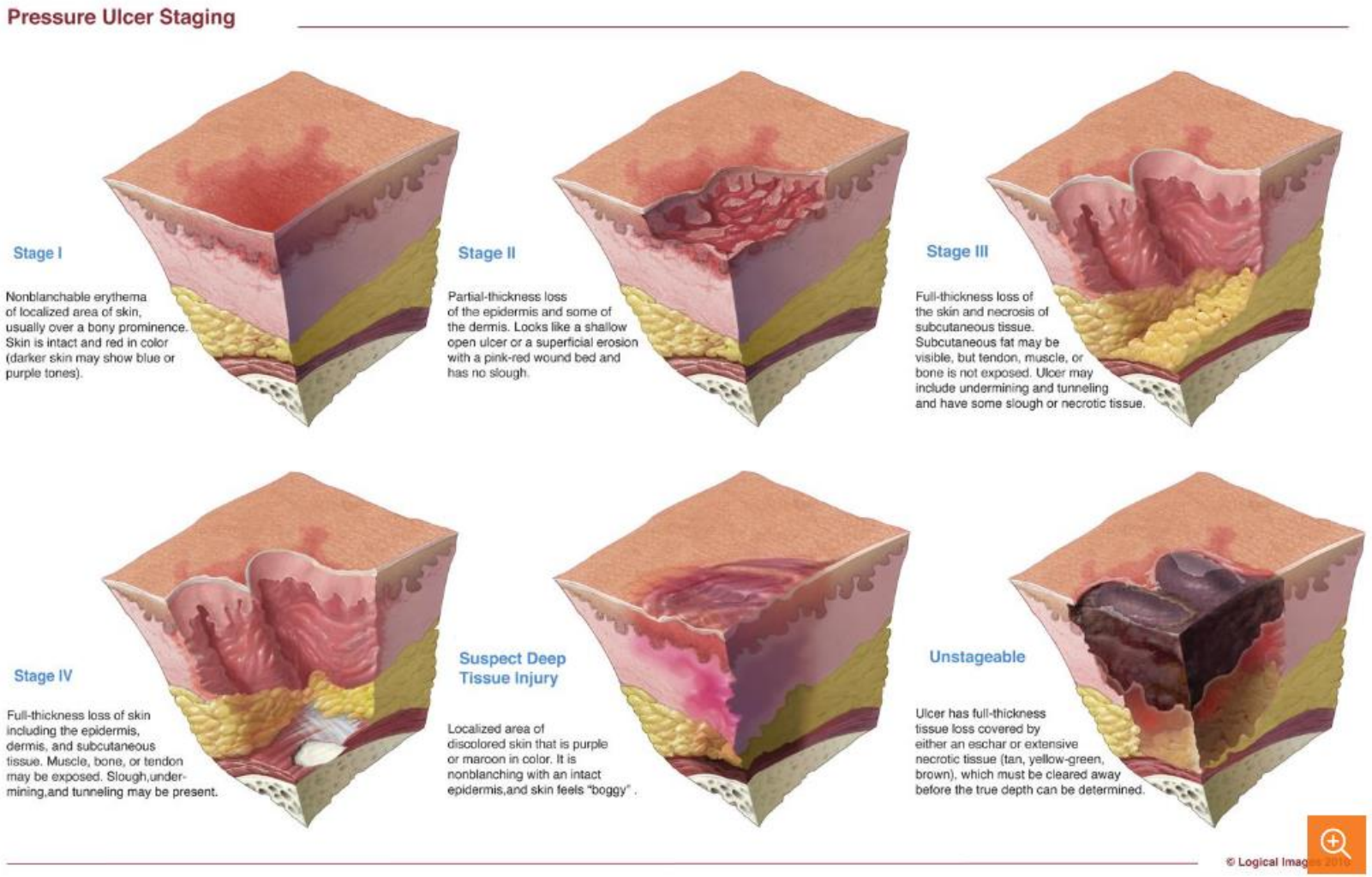
June 21, 2022

Deep Tissue Pressure Injury Revealed to be Stage IV Pressure Ulcer

Question:
A morbidly obese patient was admitted to the hospital with a deep tissue pressure injury (DTPI) to the bilateral gluteal region, which was revealed during the admission to be a stage IV pressure ulcer. On admission, wound care described the DTPI as bilateral inner gluteal folds with blanchable hyperpigmentation. During week one, the DTPI demonstrated areas of moist black eschar and subsequently, the two sites merged into one wound. On the discharge summary, the provider recorded, "Deep tissue pressure injury to the coccyx, present on admission, revealed to be Stage IV pressure ulcer." What is the correct ICD-10-CM code assignment and present on admission indicator (POA) for this case?

Answer:
Assign code L89.154, Pressure ulcer of sacral region, stage 4, with the POA indicator "Y," for the DTPI, which was revealed to be a stage 4 pressure ulcer. The stage IV pressure ulcer was not apparent until later in the hospital stay, and is not an ulcer that developed during the admission. In most deep tissue pressure injuries, the true extent of the injury is not known immediately. Typically, pressure ulcer staging is reliant on observable skin characteristics. However, since the extent of
DTPIs may be concealed, the color of the skin may not change right away, and necrosis may not be evident for several days, DTPIs can be easily misclassified. According to the National Pressure Ulcer Advisory Panel (NPUAP) "A pressure-related intact area of skin (PRIDAS), a classification that includes Stage 1 nonblanchable erythema can exist over or be a symptom of a more serious DTPI." A DTPI is the precursor of a Stage III and Stage IV pressure ulcer.

Deep Tissue Pressure Injury Revealed to be Stage IV Pressure Ulcer



Pressure Injury of Mucosal Lip

Question:
A patient was admitted for treatment of acute respiratory distress syndrome due to COVID-19. The patient was intubated on day 2 of the admission; later in the stay, the provider identified a mucosal lip pressure injury, which was attributed to the pressure from the endotracheal (ET) tube. What is the appropriate diagnosis code assignment for a mucosal pressure injury of the lip?

Answer:
Assign codes T88.8XXA, Other specified complications of surgical and medical care, not elsewhere classified, initial encounter, and K13.79, Other lesions of oral mucosa, for a mucosal pressure injury of the lip due to an ET tube. Code T85.79-, Infection and inflammatory reaction due to other internal prosthetic devices, implants and grafts, is not appropriate, because an ET tube is not considered an internal prosthetic device, implant, or graft.

Typically, mucosal pressure injuries occur on the mucous membrane, in which a medical device was used, and is an inflammatory reaction caused by the pressure of the device on the affected area.

Codes classified in Chapter 12, Diseases of the skin and subcutaneous tissue, are not appropriate for conditions involving the oral mucosa or mucous membrane.

Pressure Injury of Penile Mucosal Membrane

Question:
The provider's final diagnostic statement lists, "Pressure injury to mucosal membrane of penis from Foley catheter." There are no ICD-10-CM codes for mucosal membrane pressure injuries and these types of pressure injuries are not staged using the standard pressure injury staging system. What is the correct ICD-10- CM code assignment for a mucosal membrane pressure injury of the penis?

Answer:
Assign codes T83.511A, Infection and inflammatory reaction due to indwelling urethral catheter, initial encounter, and code N36.8, Other specified disorders of urethra. Code N36.8 is assigned because the pressure injury of the mucosal membrane involved the penile meatus (external end of urethra).

Determining Completed Weeks of Gestation

Question:
Please clarify “completed weeks of gestation” when assigning codes: O48.0, Post-term pregnancy, O48.1, Prolonged pregnancy, O75.82, Onset (spontaneous) of labor after 37 completed weeks of gestation but before 39 completed weeks gestation, with delivery by (planned) cesarean section, O02.1, Missed abortion, and O36.4, Maternal care for intrauterine death.

Answer:
In ICD-10-CM, “completed week of gestation” refers to a full week. For example, if the provider documents gestation at 39 weeks and 6 days, 39 weeks of gestation is assigned, as the patient has not yet reached 40 completed weeks.
When the provider’s documentation in the medical record indicates that the patient’s pregnancy is *over* 40 completed weeks to 42 completed weeks (40 weeks 1 day - 42 weeks 0 days), it is appropriate to assign code O48.0, Post-term pregnancy. If the documentation indicates that the pregnancy has advanced *beyond* 42 completed weeks of gestation (42 weeks 1 day), it would be appropriate to assign code O48.1, Prolonged pregnancy.

Code O75.82, Onset (spontaneous) of labor after 37 completed weeks of gestation but before 39 completed weeks of gestation, with delivery by (planned) cesarean section, may be assigned for a patient with weeks of gestation of 37 weeks 0 days up to 38 weeks and 6 days.

Code O02.1, Missed abortion, refers to fetal death that occurs prior to the completion of 20 weeks of gestation, thus including up to 19 weeks and 6 days.

Code O36.4, Maternal care for intrauterine death, is assigned for maternal care for intrauterine fetal death after completion of 20 weeks 0 days of gestation or later.

When assigning codes for obstetric conditions, assign also the appropriate code from category Z3A to indicate the weeks of gestation of the pregnancy.

Post-Term Pregnancy

Question:
An obstetrical patient is admitted to labor and delivery for a planned cesarean section due to breech presentation. The provider documents the gestational weeks as “40 weeks and 2 days.” Is it appropriate to assign code O48.0, Post-term pregnancy, based on the documentation of gestational weeks alone without documentation of “post-term” or “post-dates”?

Answer:
Yes. When provider documentation indicates the patient is over 40 completed weeks to 42 completed weeks gestation, it is appropriate to assign code O48.0, Post-term pregnancy, based on the inclusion term that specifically states: “Pregnancy over 40 completed weeks to 42 completed weeks gestation.” The provider does not have to document “post-term” or “post-dates.” Assign also the appropriate code from category Z3A, Weeks of gestation.

Postpartum Sepsis Due to Postpartum Urinary Tract Infection

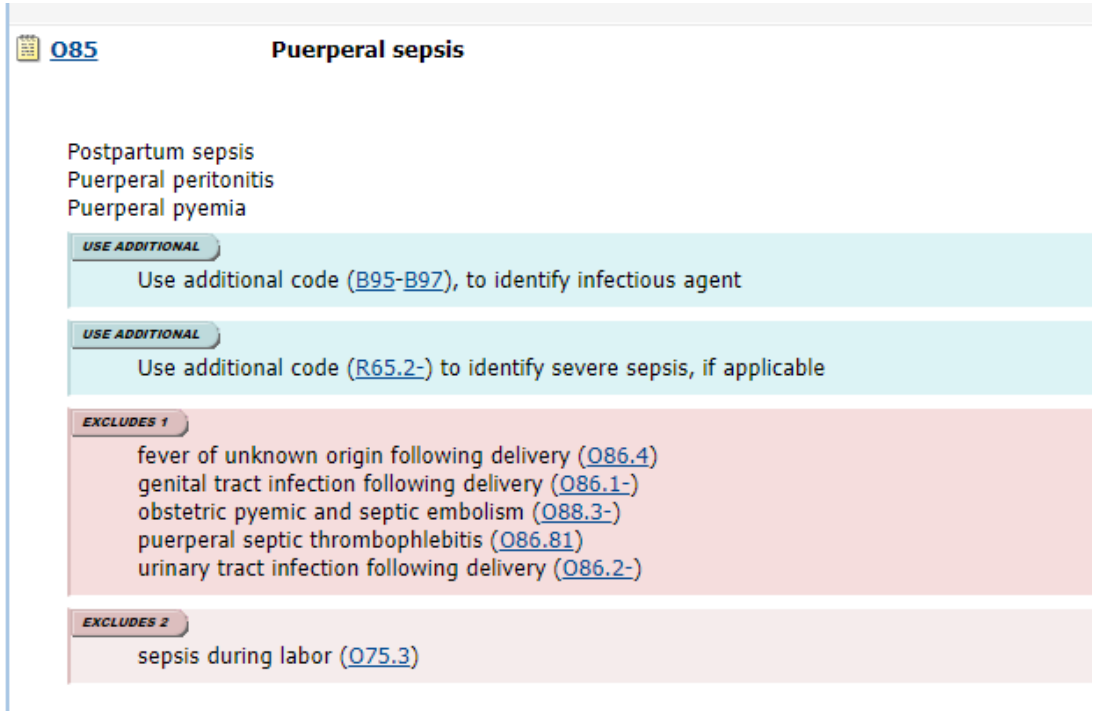
Question:

A 24-year-old patient was admitted with shortness of breath and fever due to postpartum sepsis and postpartum urinary tract infection (UTI). The patient had a history of spontaneous vaginal delivery one week ago. In the Tabular List an Excludes1 note under code O85, Puerperal sepsis, prohibits assigning code O86.20, Urinary tract infection following delivery, unspecified. What are the diagnosis codes for postpartum sepsis and UTI?

Answer:

Assign codes O98.83, Other maternal infectious and parasitic diseases complicating the puerperium, A41.9, Sepsis, unspecified organism, since the causal organism was not specified and O86.20, Urinary tract infection following delivery, unspecified, for postpartum sepsis and UTI. In this case, code O85, Puerperal sepsis, is not appropriate, as puerperal sepsis implies an infection of the genital tract, not an infection of the urinary tract.

The Centers for Disease Control and Prevention's National Center for Health Statistics (CDC/NCHS) is considering a future Coordination and Maintenance (C&M) proposal to expand code O85 to differentiate puerperal sepsis NOS (that is puerperal sepsis with infection of the genital tract) and postpartum systemic sepsis without infection of the genital tract, and other puerperal sepsis, as well as deleting the Excludes1 note.



O85 **Puerperal sepsis**

Postpartum sepsis
Puerperal peritonitis
Puerperal pyemia

USE ADDITIONAL
Use additional code (B95-B97), to identify infectious agent

USE ADDITIONAL
Use additional code (R65.2-) to identify severe sepsis, if applicable

EXCLUDES 1
fever of unknown origin following delivery (O86.4)
genital tract infection following delivery (O86.1-)
obstetric pyemic and septic embolism (O88.3-)
puerperal septic thrombophlebitis (O86.81)
urinary tract infection following delivery (O86.2-)

EXCLUDES 2
sepsis during labor (O75.3)

Light Meconium Stained Fluid

Question:
A pregnant patient underwent a low transverse cesarean section at 38 weeks due to placenta previa. During the delivery, the provider noted light meconium-stained fluid. The infant had no signs of fetal distress, with Apgar score of 9 at one minute and 9 at five minutes. What is the appropriate code assignment for light meconium-stained fluid? Is code O77.0, Labor and delivery complicated by meconium in amniotic fluid, only assigned when the presence of meconium stained fluid results in fetal distress and maternal care is affected?

Answer:
Assign code O77.0, Labor and delivery complicated by meconium in amniotic fluid, for the light meconium staining since the presence of any meconium staining may indicate fetal stress.

Hyperlipidemia Not Specified with Hypercholesterolemia

Question:
What is the appropriate ICD-10-CM code(s) for a diagnosis of unspecified hyperlipidemia and hypercholesterolemia?

Answer:
Assign code E78.00, Pure hypercholesterolemia, unspecified, for a diagnosis of unspecified hyperlipidemia and hypercholesterolemia. Do not assign code E78.5, Hyperlipidemia, unspecified, as the hypercholesterolemia identifies the specific blood lipid elevated.

Hypercholesterolemia is a high blood cholesterol level. Hyperlipidemia is high or elevated lipids/fats levels in the blood. Providers may use the terms hyperlipidemia and hypercholesterolemia interchangeably, as high blood cholesterol is a lipid disorder.

Mixed Hyperlipidemia with Hypercholesterolemia

Question:
What is the appropriate ICD-10-CM code(s) for a diagnosis of mixed hyperlipidemia with hypercholesterolemia?
Answer:
Assign code E78.2, Mixed hyperlipidemia, for a diagnosis of mixed hyperlipidemia with hypercholesterolemia. Do not assign code E78.00, Pure hypercholesterolemia, unspecified, as the hypercholesterolemia is included in code E78.2. Reference the Index to Diseases as follows:
Findings, abnormal, inconclusive, without diagnosis
high
cholesterol
with high triglycerides E78.2
Findings, abnormal, inconclusive, without diagnosis
high
triglycerides
with high cholesterol E78.2
High
cholesterol
with high triglycerides E78.2
High
triglycerides
with high cholesterol E78.2

Long-Term Use of Eliquis®

Question:
A patient was admitted for placement of a Watchman™ left atrial appendage device secondary to a history of chronic paroxysmal atrial fibrillation and persistent left atrial appendage (LAA) thrombus despite anticoagulation (Warfarin) therapy. The patient is being medically managed on Eliquis®. Is Eliquis® classified as an anticoagulant or an antithrombotic? What is the correct ICD-10-CM code assignment to capture the long-term use of Eliquis®?

Answer:
Assign code Z79.01, Long-term (current) use of anticoagulants, for long-term use of Eliquis®. Eliquis® is classified as an anticoagulant medication.

Metabolic Bone Disease

Question:
What is the appropriate ICD-10-CM code assignment for metabolic bone disease (MBD) when the condition meets requirements for coding as an additional/secondary diagnosis?

Answer:
Query the provider for clarification about the underlying cause of the metabolic bone disease. MBD is a broad term used to describe a group of bone disorders of bone strength usually caused by mineral abnormalities such as calcium, phosphorus, vitamin D, or magnesium. When MBD is a component of another disease process, code only the underlying condition (e.g., secondary hyperparathyroidism or renal osteodystrophy).

In the absence of documentation about the underlying condition, assign the appropriate code from subcategory M89.8X-, Other specified disorders of bone, for MBD.

Obesity Designated by Class

Question:
A patient presented for follow-up of multiple medical conditions. The provider documented Class 3 obesity as one of the patient's medical conditions. Would it be appropriate to assign code E66.01, Morbid (severe) obesity due to excess calories, based on the provider's diagnostic statement of "Class 3 obesity?"

Answer:
Assign code E66.01, Morbid (severe) obesity due to excess calories, for Class 3 obesity. Class 3 obesity is synonymous with morbid obesity, which is classified to code E66.01. For class 1 and 2 obesity, query the provider to determine the type or etiology of the obesity, if the documentation does not specify this information.

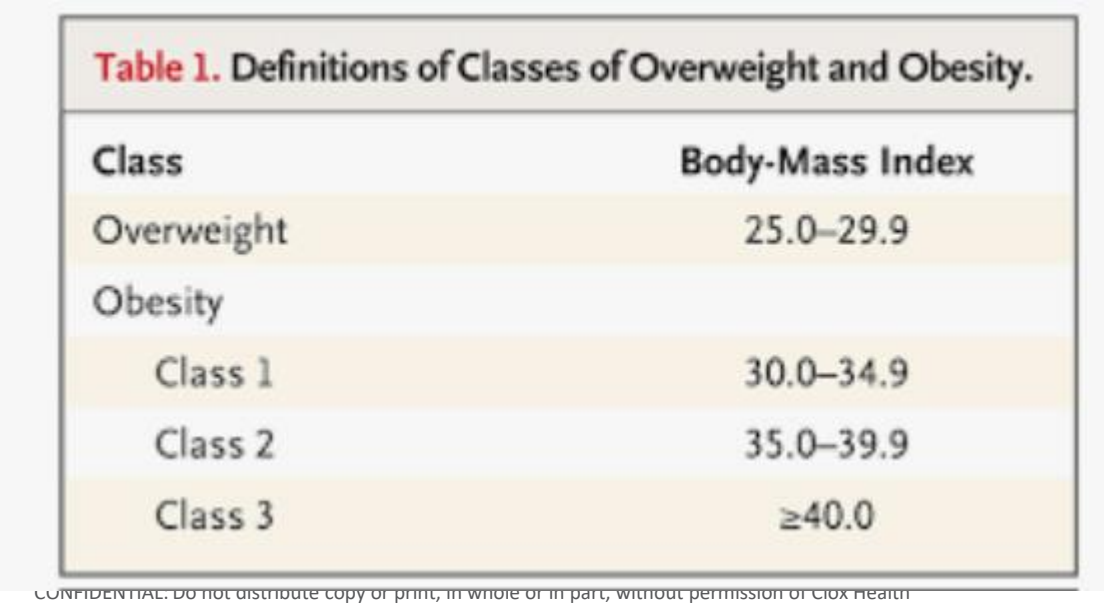


Table 1. Definitions of Classes of Overweight and Obesity.

Class	Body-Mass Index
Overweight	25.0–29.9
Obesity	
Class 1	30.0–34.9
Class 2	35.0–39.9
Class 3	≥40.0

Osmotic Demyelination Syndrome

Question:
A patient was admitted to the intensive care unit for monitoring of hyponatremia. Following treatment with intravenous fluids the sodium level normalized, however, the patient developed urinary incontinence and the inability to walk or follow commands. Neurology evaluation noted decreased alertness and ankle clonus. Magnetic resonance imaging (MRI) of the brain showed restricted diffusion and increased flair signal in the central pons, putamen, caudate, and thalamus bilaterally. The provider's documentation confirmed these findings as osmotic demyelination syndrome (ODS). The condition progressed and the patient is now in a locked-in state. What is the appropriate ICD-10-CM code assignment for osmotic demyelination syndrome?

Answer:
Assign code G37.2, Central pontine myelinolysis, for osmotic demyelination syndrome. Assign codes G83.5, Locked-in state, and T50.3X5A, Adverse effect of electrolytic, caloric and water-balance agents, initial encounter, for the locked-in state and the adverse effect. The decreased alertness and ankle clonus would not be coded separately, as they are integral to the disease process. Osmotic demyelination syndrome (ODS), also known as central pontine myelinolysis, is caused by the destruction of the myelin sheath layer covering nerve cells in the middle of the brainstem (pons). Treatment of hyponatremia/ hypernatremia may result in an increased risk of developing ODS. The following entry can be found in ICD-10-CM's Index to Diseases:
Myelinolysis, pontine, central G37.2

Osmotic demyelination syndrome is a well recognized complication of treatment of patients with severe and prolonged hyponatraemia, particularly when corrected too rapidly

Serotonin Syndrome

Question:

A patient was admitted with delirium and hallucinations secondary to serotonin syndrome. The provider was queried and clarified that the serotonin syndrome was due to the adverse effect of prescribed Risperdal and Paxil. What is the appropriate ICD-10-CM diagnosis code for the serotonin syndrome?

Answer:

Assign codes R41.0, Disorientation, unspecified, and R44.3, Hallucinations, unspecified, for the delirium and hallucinations. Assign codes T43.595A, Adverse effect of other antipsychotics and neuroleptics, initial encounter, and T43.225A, Adverse effect of selective serotonin reuptake inhibitors, initial encounter, for the adverse effects due to Risperdal and Paxil. As stated in the guideline found in Section I.C.19.e.5.a., when coding an adverse effect of a drug that has been correctly prescribed and properly administered, assign the appropriate code for the nature of the adverse effect followed by the appropriate code for the adverse effect of the drug (T36-T50).

Serotonin syndrome is not specifically classified in ICD-10-CM. When a syndrome is not classified in ICD-10-CM, follow section I.B.15 of the guidelines, which states, “In the absence of Alphabetic Index guidance, assign codes for the documented manifestations of the syndrome. Additional codes for manifestations that are not an integral part of the disease process may also be assigned when the condition does not have a unique code.”

Segmental and Subsegmental Pulmonary Emboli

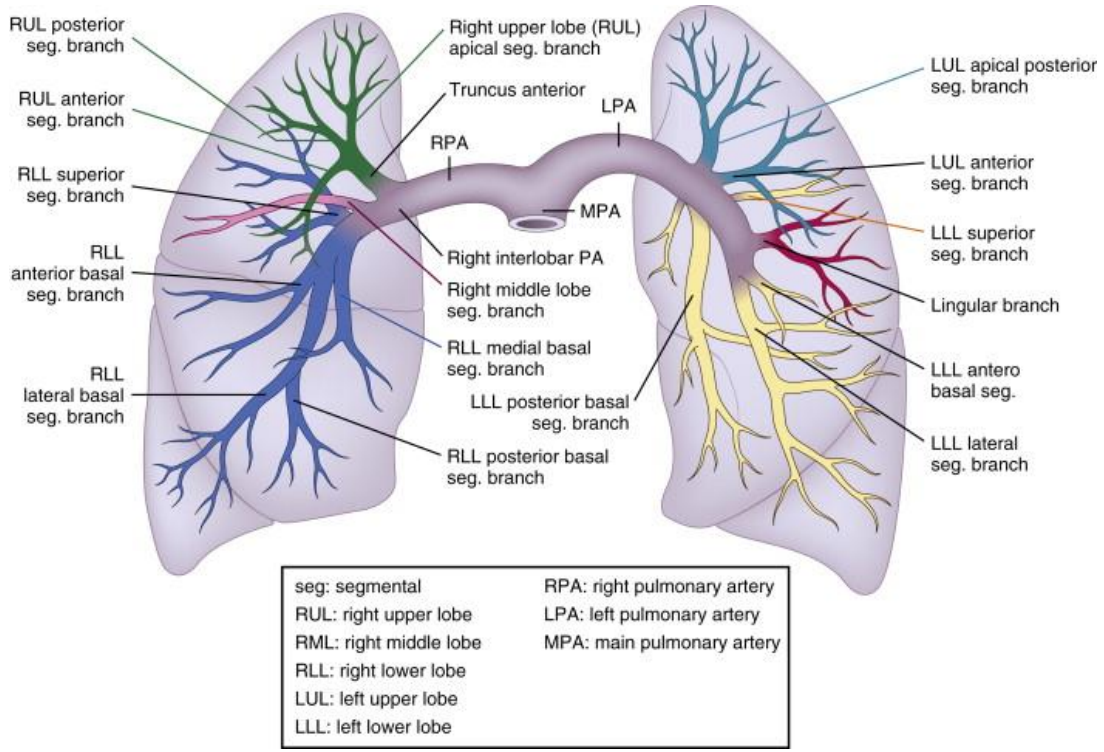
Question:

The patient had a chest computerized tomography angiography (CTA) which revealed pulmonary emboli in the segmental branches of the right middle and lower lobes of the lung. The radiologist also noted emboli in the subsegmental branches of the right and left lobes of the lung. The provider's final diagnostic statement listed "Segmental and subsegmental pulmonary emboli." How should segmental and subsegmental pulmonary emboli be coded?

Answer:

Assign codes I26.99, Other pulmonary embolism without acute cor pulmonale and I26.94, Multiple subsegmental pulmonary emboli without acute cor pulmonale, for documentation of segmental and multiple subsegmental pulmonary emboli.

In this case, the patient had segmental emboli in the proximal branches of the right middle and lower lobes as well as bilateral subsegmental emboli. Two codes are needed to fully capture the patient's condition.



Sternal Non-Union and Pseudoarthrosis Following Sternotomy

Question:
The patient is seen for complete sternal nonunion with pseudoarthrosis of a right lower hemisternotomy following mitral valve repair and Maze procedure. What is the diagnosis code assignment for nonunion of the sternum that is not related to a fracture?
Answer:
Assign codes M96.89, Other intraoperative and postprocedural complications and disorders of the musculoskeletal system, and M95.4, Acquired deformity of chest and rib.

Ventricular Fibrillation

Question:
A patient is admitted for multiple medical conditions and is status post automatic implantable cardioverter defibrillator (AICD) placement, for ventricular fibrillation. The cardiologist's documentation states, "Ventricular fibrillation remains quiet no flares no symptoms no firings of the AICD." Would ventricular fibrillation be considered a chronic condition that always meets reporting requirements? Previously published *Coding Clinic* advice clarified that for hospital reporting, it is appropriate to assign a code for a specific cardiac condition that is being controlled by the presence of a cardiac device. Would it be appropriate to report ventricular fibrillation in a patient who is status post AICD placement, if the condition did not occur during the admission?

Answer:
It would not be appropriate to assign a code for ventricular fibrillation (VF) in this scenario. However, codes Z86.79, Personal history of other disease of the circulatory system, and Z95.810, Presence of automatic (implantable) cardiac defibrillator, may be assigned to capture the presence of an AICD, in a patient with a history of ventricular fibrillation.
VF is an acute life-threatening condition that should only be reported when it is documented to occur during the admission. In this case, the patient is being followed by a cardiologist; however, he is not currently experiencing VF and the AICD is not firing. This is a different situation from a patient presenting to the Emergency Department because the device is firing due to the occurrence of VF. The advice previously published in *Coding Clinic* First Quarter 2019, pages 33-34, only applied to sick sinus syndrome (SSS), as it is a chronic condition, in which the device (pacemaker) is constantly functioning to increase the heart rate.

Radioembolization of Right Hepatic Lobe

Question:

A patient diagnosed with right lobe hepatocellular carcinoma and portal vein invasion, was admitted for low dose Yttrium-90 radioembolization of the right hepatic lobe. The right hepatic artery was selectively catheterized and a microcatheter was used to administer multiple small aliquots of Yttrium-90 microspheres into the right hepatic lobe via the hepatic artery, followed by sterile D5 water and contrast flushes. Imaging obtained following the radioembolization procedure demonstrated no extrahepatic uptake. What is the appropriate code assignment for Yttrium-90 radioembolization? Would two codes be required, one for the occlusion of the vessel and the other for introduction of radioactive material?

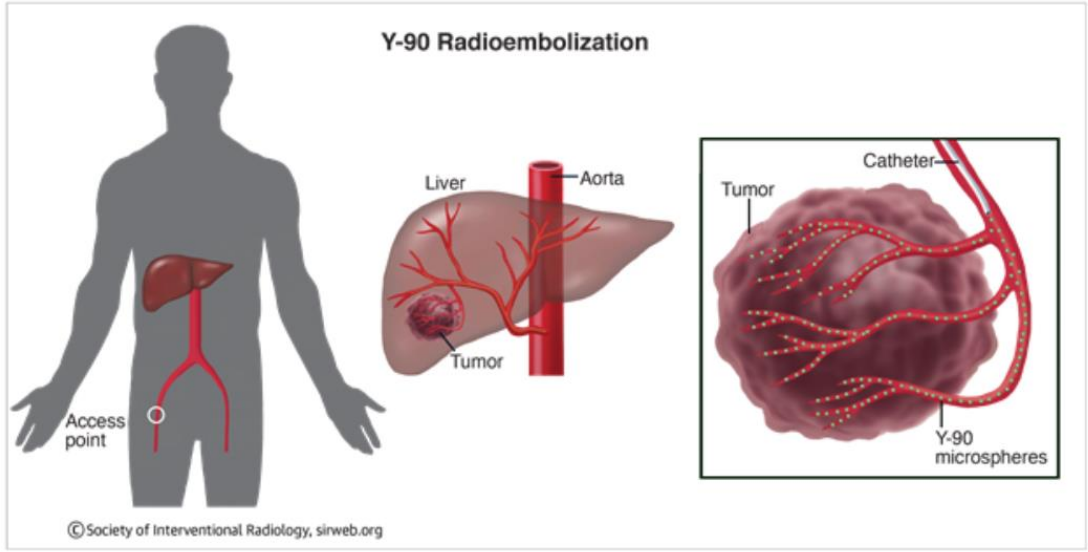
Answer:

Assign the following procedure codes:

0FH031Z Insertion of radioactive element into liver, percutaneous approach, for Yttrium-90 radioembolization.

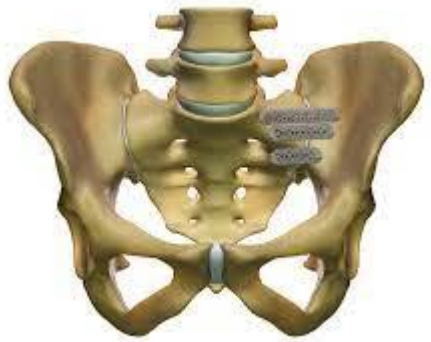
DF10BYZ Low dose rate (LDR) brachytherapy of liver using other isotope, for the Yttrium-90 microspheres.

In this case, the objective of the procedure is to deliver the radioactive element, not to occlude a vessel. By definition, embolization is introducing small particles into the circulation rather than just liquid. These particles can be used to deliver a therapeutic substance or to interrupt the blood supply. The health record documentation should state whether the objective is to block a vessel or deliver a radioactive element; however, when the objective of the procedure is not clear, query the provider for clarification



Sacroiliac Joint Fusion

Question:
A patient with left-sided joint instability and degeneration underwent a left-sided percutaneous sacroiliac joint fixation and fusion using three triangular fixation bone ingrowth devices. During the procedure, through a small incision, a dissection was made down through the skin to the fascia. The initial K-wire was advanced into position and a soft tissue dilator and a broach were used to implant the first triangular bony ingrowth stabilization and fusion cage. The same steps were achieved in placing the second and third triangular bony ingrowth stabilization devices. All three implants were noted to be placed in the appropriate positions; none were near the S1 or the S2 foramen, and all were well within the body of the sacral ala. What is the appropriate ICD-10- PCS code(s) for a sacroiliac joint fixation and fusion procedure using triangular fixation bone ingrowth devices?



Answer:
Assign the following ICD-10-PCS code:
0SG834Z Fusion of left sacroiliac joint with internal fixation device, percutaneous approach, for insertion of the sacroiliac joint fixation and fusion cage using triangular fixation bone ingrowth devices.
Triangular fixation bone ingrowth devices are designed to stabilize and fuse the sacroiliac joint by minimizing joint movement and rotation while the porous coating provides a favorable environment for bony ingrowth resulting in fusion. This minimally invasive procedure differs from more traditional fusion surgeries that can involve grafting or active packing of bone into the joint.
The root operation of “fusion” does not require the use of bone graft, except in cases describing spinal fusion. The ICD-10-PCS guidelines for Fusion are specific to spinal fusion and do not apply to fusion of other body parts.

Temporary-Permanent Pacemaker Placement

Question:
A patient had transcatheter aortic valve replacement (TAVR) for aortic stenosis. Following the TAVR procedure, the patient developed a complete heart block and junctional bradycardia. A temporary-permanent (T-P) pacemaker was placed into the right ventricle (RV), and was removed percutaneously a day later. The T-P pacemaker placement involved insertion of a fixated lead, unlike temporary transvenous pacemaker placement. Would an additional code be assigned for the lead insertion? What ICD-10- PCS code(s) are assigned?

Answer:
Assign the following ICD-10-PCS codes:
5A1223Z Performance of cardiac pacing, continuous,

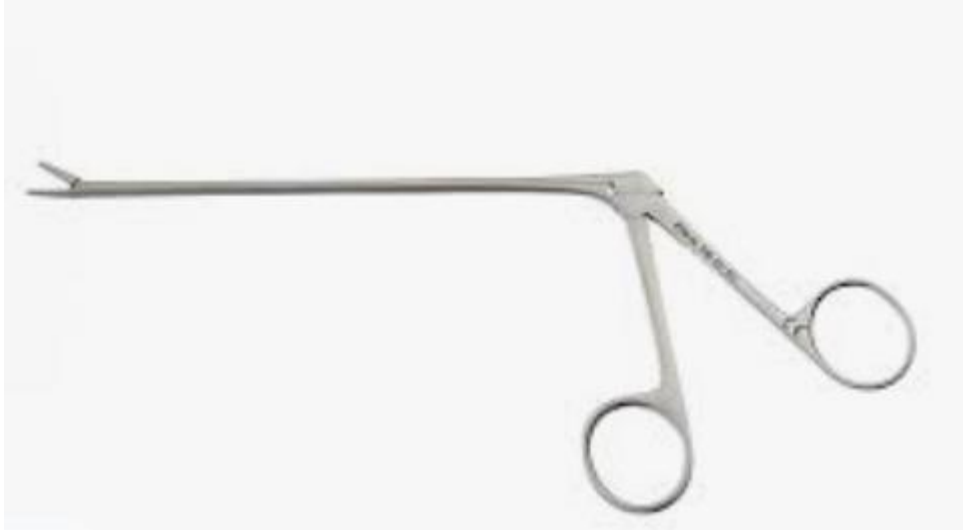
02HK3JZ Insertion of pacemaker lead into right ventricle, percutaneous approach, and

02PA3MZ Removal of cardiac lead from heart, percutaneous approach, for removal of the pacemaker lead from right ventricle

Transbronchial Lung Biopsy Using Alligator Forceps

Question:
A patient presented for transbronchial lung biopsy due to hilar lymphadenopathy and mediastinal adenopathy. Transbronchial biopsies of a lesion in the left upper lobe were performed using alligator forceps under fluoroscopic guidance. The sampling device penetrated the full thickness of the bronchial wall to obtain the biopsy of lung tissue. Four biopsy samples were obtained. The surgeon noted that the transbronchial biopsy technique was carried out because the sampling site was not visible endoscopically. It is not clear which root operation, Excision or Extraction, would be assigned. What is the correct root operation for a transbronchial biopsy of the left upper lung using alligator forceps?

Answer:
Assign the following procedure code:
0BBG8ZX Excision of left upper lung lobe, via natural or artificial opening endoscopic, diagnostic



Alligator forceps are a type of cutting tool. Typically, alligator forceps are used to remove an intact piece of tissue and the use of forceps is coded to the root operation Excision. On the other hand, the root operation Extraction is used to describe procedures such as needle aspirations in which a vacuum inside the syringe causes a collection of individual cells to be suctioned (aspirated) into the needle and syringe

Ankle Distraction Procedure

Question:

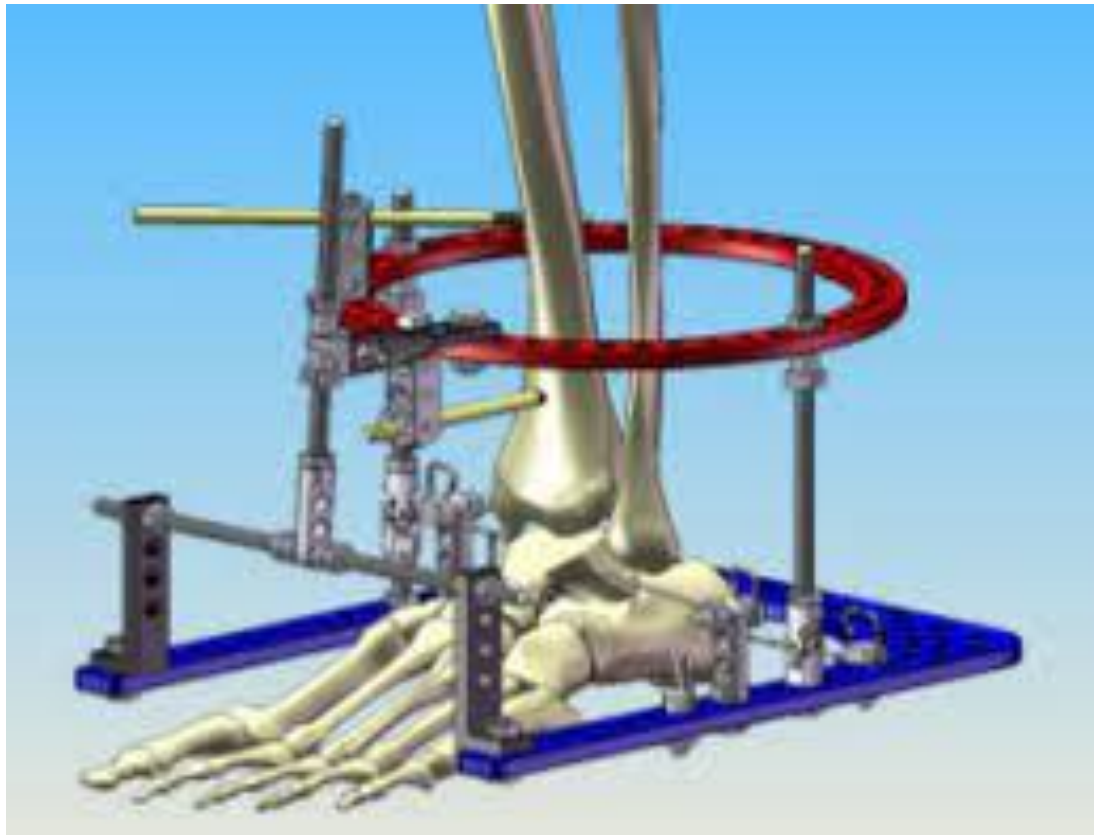
A patient with post-traumatic arthritis of the left ankle was admitted for distraction arthroplasty. An ankle distraction frame and ring were applied to the distal third of the tibia and stabilized with pins. A transmalleolar wire was placed through the talus to identify the center of rotation and guide the building of lateral and medial distraction hinges. A foot ring was attached to hinges and stabilized to the foot with wires through the calcaneus and talar neck. The wires were tensioned and an anterior locking rod was placed to hold the ankle in neutral position. Distraction was placed across the ankle at 4mm and bone marrow aspirate and stem cells were inserted into the ankle joint. What is the ICD-10-PCS code for distraction arthroplasty of the ankle with application of an external hinged fixator? Is the procedure a distraction of the ankle joint or tarsal joint?

Answer:

Assign the following ICD-10-PCS code:

0SSG35Z Reposition left ankle joint with external fixation device, percutaneous approach, for application of the external hinged fixator to distract the ankle.

The surgery is performed to move the ankle joint to a neutral position, to allow healing and repair. In the mechanical sense, in this case the distraction involved movement (reposition) of the ankle joint.



New Frequently Asked Questions Regarding Coding for COVID-19

Question:
A patient who had contracted COVID-19 infection during the second trimester of pregnancy delivered a healthy newborn at term. Would code Z20.822, Contact with and (suspected) exposure to COVID-19, be assigned to identify the newborn's exposure to COVID-19?

Answer:
Do not assign code Z20.822, Contact with and (suspected) exposure to COVID-19, since the provider's documentation does not indicate the infant was affected (e.g., small for gestational age) by the mother's COVID-19 infection and the criteria for secondary diagnosis has not been met. The *Official Guidelines for Coding and Reporting* general perinatal rules (16.a.6.) state, "All clinically significant conditions noted on routine newborn examination should be coded. A condition is clinically significant if it requires: clinical evaluation, or therapeutic treatment, or diagnostic procedures, or extended length of hospital stay, or increased nursing care and/or monitoring, or has implications for future health care needs."

Question:
What is the correct coding and sequencing for an immunocompromised patient with sickle cell disease (SCD) who presents in sickle cell crisis (SCC) triggered by a COVID-19 infection?

The sickle cell disease is not a manifestation of COVID-19 infection, but the acute sickle cell pain crisis is directly linked to a COVID-19 infection.

Answer:
Assign the appropriate code from category D57, Sickle-cell disorders, for the sickle cell crisis and code U07.1 for the COVID-19 infection. Sequencing would depend on the circumstances of the admission. While the COVID-19 infection triggered an acute sickle cell crisis, SCD is not a manifestation of COVID-19.

New Frequently Asked Questions Regarding Coding for COVID-19

Question:
A patient with end-stage liver disease is admitted for an orthotopic liver transplant. The donor organ came from a brain dead patient who was also COVID-19 positive. The recipient was contacted regarding the COVID-19 positive status of the donor prior to admission and elected to proceed with the liver transplant procedure.

Since the donor was COVID-19 positive, it was decided that anticoagulation was needed due to likely COVID-19 viremia and the patient was started on subcutaneous heparin. The donor organ was successfully transplanted and the patient was started on a daily dose of aspirin for a 3 month duration as well due to the COVID-19 positive organ donation. Is there an ICD-10-CM diagnosis code to capture that the recipient received a donor organ that was positive for COVID-19 at the time of donation?

Answer:
Assign code Z20.822, Contact with and (suspected) exposure to COVID-19, to identify that the recipient received a donor organ that was positive for COVID-19.

Question:
What is the correct diagnosis code assignment for an encounter for COVID-19 pre-exposure prophylactic treatment using long-acting monoclonal antibodies, such as tixagevimab and cilgavimab (EVUSHELD™)?

Answer:
Assign code Z29.8, Encounter for other specified prophylactic measures, for an encounter for pre-exposure prophylactic treatment with tixagevimab and cilgavimab (EVUSHELD™).

The Food and Drug Administration has issued an Emergency Use Authorization for investigational long-acting monoclonal antibodies tixagevimab and cilgavimab (EVUSHELD™ – AstraZeneca), to be administered for pre-exposure prophylaxis of COVID-19. The authorization applies to people 12 years of age and older, weighing greater than or equal to 40 kg, who do not have SARS-CoV-2 infection, who have not been recently exposed to an individual with SARS-CoV-2 infection, and who have either a history of severe allergy preventing them from being vaccinated against COVID-19, or are moderately or severely immune compromised and may have inadequate immune response to COVID-19 vaccination.

Reporting Additional Diagnoses in Outpatient Setting

Question:
We disagree with the advice published in *Coding Clinic* Third Quarter 2020, page 33, regarding not coding a mental disorder during an emergency department (ED) visit for an unrelated condition because the mental disorder was not treated during the current encounter, nor was there any documentation that the condition affected patient care or management. We are requesting clarification of this advice as it appears to conflict with existing outpatient guidelines.

Answer:
The advice published in Third Quarter 2020 does not conflict with the *Official Guidelines for Coding and Reporting* (Section IV.J.) as it utilized the same verbiage as the guideline that states "Code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care, treatment or management."

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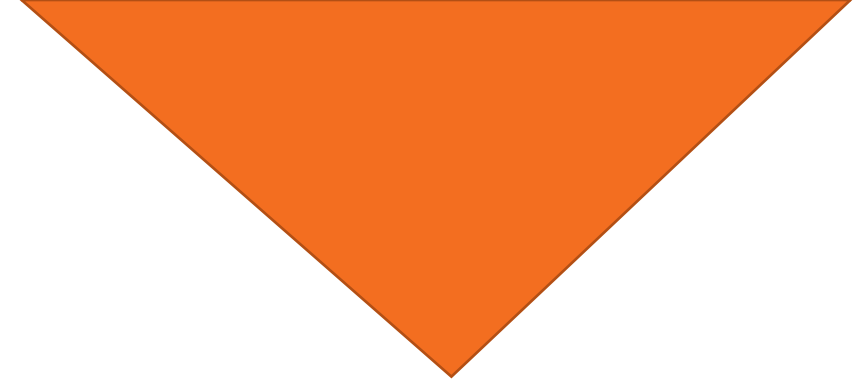
You have up to 2 weeks from today to download your CEU certificate before the link expires. We will not be re-issuing CEU certificates after this point.*

If you have any issues with downloading your CEU certificate, please contact us at CodingRoundTables@cioxhealth.com before the end of the 2-week period.

*Ciox Employees please refer to the Yammer group for guidelines.



Thank You