

LibmanEducation  
Training for the 40180 Core/Workforce

**Coding Clinic for ICD-10-CM/PCS Update  
 Wolters Kluwer Law & Business  
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**Coordination & Maintenance**

March 9 & 10 2016  
 Session recordings on Youtube

CMS  
 FY 2017 - 3651 new PCS codes  
 487 revised code titles

NCHS  
 FY 2017 - 1943 new CM codes  
 422 revised code titles

**Coordination & Maintenance CEUs**

**Continuing Education Credits:** Continuing education credits **may be** awarded by the American Academy of Professional Coders (AAPC) or the American Health Information Management Association (AHIMA) for participation in CMS ICD-10 Coordination and Maintenance (C&M) Committee Meeting Conference Calls, Meetings and Webcasts.....

**Please note:** The statements above are standard language provided to CMS by the AAPC and the AHIMA. If you have any questions concerning either statement, **please contact the respective organization, not CMS.**

**Zika**

Zika Virus [www.cdc.gov/zika/](http://www.cdc.gov/zika/)

New code for FY 2017 A92.5

JAMA March 1, 2016 The Emerging Zika Pandemic  
 The **Zika virus** (ZIKV), a Flavivirus related to yellow fever, dengue, West Nile, and Japanese encephalitis, originated in the Zika forest in Uganda ...

NEJM May 12, 2016 The Zika Challenge

**IPPS FY 2017 Proposed Rule**

Federal Register April 27, 2016  
 Volume 81 Number 81

**Coding Clinic for ICD-10-CM/PCS**

Visit [www.CodingClinicAdvisor.com](http://www.CodingClinicAdvisor.com)

## ICD-10 Coding Clinic Guidance

### ICD-9 Coding Clinics (containing ICD-10 guidance)

Q4 2012  
Q1 2013  
Q2 2013  
Q3 2013  
Q4 2013

### ICD-10 Coding Clinics

Q1 2014  
Q2 2014  
Q3 2014  
Q4 2014  
Q1 2015  
Q2 2015  
Q3 2015 published October 7, 2015  
Q4 2015 published November 13, 2015

Q1 2016 published March 18, 2016  
Q2 2016 due any day now

## Coding Clinic transition

*Coding Clinic* first Quarter 2013

No plans to translate **all** previous issues of *Coding Clinic for ICD-9-CM* into ICD-10-CM/PCS since many of the questions published arose out of the need to provide clarification on the use of ICD-9-CM and would not be readily applicable to ICD-10-CM/PCS.

## Applying Past Issues of CC Q4 2015

In general, clinical information and information on documentation best practices published in *Coding Clinic* were not unique to ICD-9-CM, and remain applicable for ICD-10-CM with some caveats.

As far as previously published advice on documentation is concerned, documentation issues would generally not be unique to ICD-9-CM, and so long as there is nothing new published in *Coding Clinic for ICD-10-CM and ICD-10-PCS* to replace it, the advice would stand.

## Applying Past Issues of CC Q4 2015

Previously published ICD-9-CM advice that is still relevant and applicable to ICD-10 will continue to be re-published in *Coding Clinic for ICD-10-CM/PCS*.

## Hierarchy of Guidance

Conventions of the Classification  
Official Coding Guidelines  
Coding Clinic

Official Coding Guidelines page 1

"These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself. **The instructions and conventions of the classification take precedence over guidelines.** These guidelines are based on the coding and sequencing instructions in the Tabular List and Alphabetic Index of ICD-10-CM, but provide additional instruction.

**Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA).**"

## Coding Clinic Themes

*Coding Clinic* Guidance:

- .....guidance that is the same as in ICD-9-CM
- .....guidance that is drastically different
- .....corrections to the classification
- .....corrections to previous CCs
- .....empowerment – CCs allow coders to decide
- .....complex issues with multiple examples

## Today's topics

Excludes Notes  
 POA and Pressure Ulcers  
 New Index Entries  
 Hemorrhage due to Anticoagulant Therapy  
 Heart Failure  
 Diabetes Associated Conditions  
 Obstetric Perineal Laceration Repair  
 Sacral Dimple  
 Neoplasm Related Issues  
 Endarterectomy

## Excludes Notes

### 12. Excludes Notes

The ICD-10-CM has two types of excludes notes. Each type of note has a different definition for use but they are all similar in that they indicate that codes excluded from each other are independent of each other.

ICD-10-CM Official Guidelines for Coding and Reporting

**FY 2016**

Page 9 of 115

## Excludes Notes

**Excludes1** A type 1 Excludes note is a **pure excludes note**. It means "**NOT CODED HERE!**"

An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note.

An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

**Excludes2** A type 2 Excludes note represents "**Not included here**".

An excludes2 note indicates that the condition **excluded is not part of the condition represented by the code**, but a patient may have both conditions at the same time.

When an Excludes2 note appears under a code, it is **acceptable to use both the code and the excluded code together, when appropriate**.

## Interim Coding Advice Excludes 1 Q4 2015

The National Center for Health Statistics (NCHS), the Federal agency re-sponsible for use of the ICD-10-CM in the United States, has issued **interim advice** as it pertains to excludes 1 notes and unrelated conditions.

There are circumstances that have been identified where some conditions included in Excludes1 notes should be allowed to both be coded, and thus might be more appropriate for an Excludes2 note.

However, due to the partial code freeze, no changes to Excludes notes or revisions to the official coding guidelines can be made until October 1, 2016.

The new guidance concerning Excludes1 notes is intended to allow conditions to be reported together when appropriate even though they may currently be subject to an Excludes1 note.

## Excludes 1 COPD & Aspiration pneumonia

### J44 Other chronic obstructive pulmonary disease

#### Excludes1:

bronchiectasis (J47.-)  
 chronic bronchitis NOS (J42)  
 chronic simple and mucopurulent bronchitis (J41.-)  
 chronic tracheitis (J42)  
 chronic tracheobronchitis (J42)  
 emphysema without chronic bronchitis (J43.-)  
 lung diseases due to external agents (J60-J70)

## Interim Coding Advice Excludes 1 Q4 2015

### Question:

We have received several questions regarding the interpretation of Excludes1 notes in ICD-10-CM when the conditions are unrelated to one another.

### Answer:

If the two conditions are not related to one another, it is permissible to report both codes despite the presence of an Excludes1 note.

### Assigning Codes Using Prior Encounters Q3 2013

#### Question:

Is there a guideline or rule that indicates that you should only use the medical record documentation for that specific visit/admission for diagnosis coding purposes?

Does each visit or admission stand alone?

Would the coder go back to previous encounter records to assist in the coding of a current visit or admission?

### Assigning Codes Using Prior Encounters Q3 2013

#### Answer:

Documentation for the current encounter should clearly reflect those diagnoses that are current and relevant for that encounter.

Conditions documented on previous encounters may not be clinically relevant on the current encounter.

The physician is responsible for diagnosing and documenting all relevant conditions. A patient's historical problem list is not necessarily the same for every encounter/visit.

It is the physician's responsibility to determine the diagnoses applicable to the current encounter and document in the patient's record.

When reporting recurring conditions and the recurring condition is still valid for the outpatient encounter or inpatient admission, the recurring condition should be documented in the medical record with each encounter/admission.

### Assigning Codes Using Prior Encounters Q3 2013

#### Answer (continued):

However, if the condition is not documented in the current health record, it would be inappropriate to go back to previous encounters to retrieve a diagnosis without physician confirmation.

This is an area where coders and/or department managers may need to educate physicians and/or practice managers on the need to include complete diagnoses when outpatient services are ordered and to continue to document chronic or longstanding conditions on each admission/encounter record.

Please note this advice applies to both ICD-9-CM and ICD-10-CM.

### Review of a confusing POA Guideline

#### Combination Codes

Assign "N" if any part of the combination code was not present on admission

(e.g., COPD with acute exacerbation and the exacerbation was not present on admission; gastric ulcer that does not start bleeding until after admission; asthma patient develops status asthmaticus after admission)

### Pressure ulcer and POA CC Q1 2009

#### Clarification

#### Stage II Pressure Progressing to Stage III

#### Question:

Coding Clinic Fourth Quarter 2008, page 194 stated that a stage II pressure ulcer, which was present on admission, and progresses to become a stage III pressure ulcer during the stay is reported as "Yes" for the present on admission (POA) indicator.

However, the POA indicator is reported for conditions present at the time of inpatient admission.

It appears inconsistent to report a Stage III pressure ulcer as present on admission since the pressure ulcer gradually deteriorated during the hospital stay.

Could *Coding Clinic* please clarify this issue for coders and clinical teams that rely on this guidance?

### Pressure ulcer and POA CC Q1 2009

#### Answer:

In terms of coding and POA reporting, a pressure ulcer is only coded and reported once at the highest stage.

The information published in *Coding Clinic* Fourth Quarter 2008, page 194, instructing to report a Stage II pressure ulcer that progresses to a Stage III as present on admission is correct.

The pressure ulcer was present on admission; therefore, the POA should be yes.

### Pressure ulcer and POA CC Q1 2009

This advice is consistent with the National Quality Forum (NQF) endorsed measures. The NQF established a standardized set of serious reportable events also called never events. The list of serious reportable events excludes the progression of a pressure ulcer from stage II to stage III, if stage II was recognized upon admission.

The NQF is an organization created to develop and implement a national strategy for health care quality measurement and reporting.

Please refer to the NQF website for additional information about "Serious Reportable Events in Healthcare":  
<http://www.qualityforum.org/pdf/reports/sre/txsrepublic.pdf>

### Pressure ulcer staging CC Q4 2008

#### Frequently Asked POA Question

##### Question:

A patient is admitted to the hospital with a stage II pressure ulcer of the heel. During the hospitalization, the pressure ulcer worsens and becomes a stage III.

Based on the new *Official Coding Guidelines*, we would be assigning the code for the highest stage for that site.

What would be the correct POA indicator assignment for the stage III code?

##### Answer:

Assign "Y" to the pressure ulcer stage III code since this code is referring to a pressure ulcer that was present on admission rather than a new ulcer.

### Debridement Q3 2015

#### Question:

Can you clarify what determines that a debridement in ICD-10-PCS is excisional?

The progress note states: "I have debrided the abscess cavity, removing necrotic tissue and bone by sharp debridement."

Does the word "excision" need to be present as with ICD-9-CM?

### Debridement Q3 2015

#### Answer:

Yes, the documentation standard for coding excisional debridement in ICD-10-PCS is the same as it is for ICD-9-CM.

As with ICD-9-CM, the words "sharp debridement" are not enough to code the root operation Excision.

A code is assigned for excisional debridement when the provider documents "excisional debridement," and/or the documentation meets the root operation definition of "excision" (cutting out or off, without replacement, a portion of a body part).

### ICD-10-CM Index Deep Tissue Injury

DTI

Deep Tissue Injury

Synonym for Pressure Ulcer

#### Injury

--**deep tissue** – see Contusion, by site

----**meaning Pressure Ulcer** – see Ulcer, pressure, unstageable, by site

### ICD-10-CM Index Post-op Complication

ICD-10-CM Index

**Postoperative** (post procedural) – see Complication, postoperative

## Guideline – Complications of Care

### 16. Documentation of Complications of Care

Code assignment is based on the provider's documentation of the relationship between the condition and the care or procedure.

The guideline extends to any complications of care, regardless of the chapter the code is located in.

It is important to note that not all conditions that occur during or following medical care or surgery are classified as complications.

There must be a cause-and-effect relationship between the care provided and the condition, and an indication in the documentation that it is a complication.

Query the provider for clarification, if the complication is not clearly documented.

## ICD-10-CM Index

### Disorder

-- hemorrhagic NEC D69.9

---- **drug-induced** D68.32

---- **due to**

----- **extrinsic circulating anticoagulants** D68.32

## Hemorrhage due to Anticoag Rx Q1 2016

### Question:

What is the code assignment for duodenal ulcer with hemorrhage due to Coumadin therapy, initial encounter?

Is D68.32, Hemorrhagic disorder due to extrinsic circulating anticoagulant, assigned for bleeding that is due to anticoagulation therapy?

## Hemorrhage due to Anticoag Rx Q1 2016

### Answer:

Assign codes:

**K26.4**, Chronic or unspecified duodenal ulcer with hemorrhage,

**D68.32**, Hemorrhagic disorder due to extrinsic circulating anticoagulant, and

**T45.515-**, Adverse effect of anticoagulants.

Depending on the circumstances of the admission, it may be appropriate to sequence either K26.4 or D68.32 as the principal or first listed diagnosis.

An increased risk for bleeding is a side effect associated with anticoagulant therapy.

The adverse effect code is assigned for bleeding resulting from an anticoagulant that is properly administered.

## Hemorrhage due to Anticoag Rx Q1 2016

### Question:

Should bleeding due to therapeutic anticoagulant be coded as a hemorrhagic disorder (category D68)?

## Hemorrhage due to Anticoag Rx Q1 2016

### Answer:

For the most part, "hemorrhagic disorder" or "coagulation defects" must be specifically diagnosed and documented by the provider, in order to assign codes at category D68, Other coagulation defects.

However, for bleeding such as hemoptysis, hematuria, hematemesis, hematochezia, etc., that is associated with a drug, as part of anticoagulation therapy, assign code D68.32, Hemorrhagic disorder due to extrinsic circulating anticoagulants.

This is supported by the inclusion term at D68.32 of "Drug-induced hemorrhagic disorder."

The sequencing of code D68.32 and other codes describing the type or site of bleeding, (e.g., hemoptysis or hematuria), would be dependent on the circumstances of the admission.

### Hemorrhage due to Anticoag Rx Q1 2016

#### D68.32 Hemorrhagic disorder due to extrinsic circulating anticoagulants

Drug-induced hemorrhagic disorder  
Hemorrhagic disorder due to increase in anti-IIa  
Hemorrhagic disorder due to increase in anti-Xa  
Hyperheparinemia

Use additional code for adverse effect, if applicable, to identify drug (T45.515, T45.525)

### Inclusion Note versus Inclusion term

#### 10. Includes Notes

This note appears immediately under a three character code title to further define, or give examples of, the content of the category.

#### 11. Inclusion terms

List of terms is included under some codes.

These terms are the conditions for which that code is to be used.

The terms may be synonyms of the code title, or, in the case of "other specified" codes, the terms are a list of the various conditions assigned to that code.

The inclusion terms are not necessarily exhaustive. Additional terms found only in the Alphabetic Index may also be assigned to a code

### Hemorrhage due to Anticoag Rx Q1 2016

#### Question:

This patient underwent an emergency ileocecectomy. The patient's stay was complicated by postoperative coagulopathy and intra-abdominal hemorrhage due to prasugrel and aspirin taken as prescribed prior to admission.

What is the appropriate code for the acquired coagulopathy secondary to prasugrel and aspirin?

### Hemorrhage due to Anticoag Rx Q1 2016

#### Answer:

Assign codes:

**D68.32**, Hemorrhagic disorder due to extrinsic circulating anticoagulants

**T45.525A**, Adverse effect of antithrombotic, Initial encounter

**T39.015A**, Adverse effect of aspirin, Initial encounter, and

**K91.840**, Postprocedural hemorrhage and hematoma of a digestive system organ or structure following a digestive system procedure.

Prasugrel (Effient®) is a platelet inhibitor .....

### Heart Failure with... Q1 2016

#### Question:

Please reconsider the advice previously published in *Coding Clinic*, First Quarter 2014, page 25, stating that the coder cannot assume either diastolic or systolic failure or a combination of both, based on documentation of heart failure with preserved ejection fraction (HFpEF) or heart failure with reduced ejection fraction (HFrEF).

**Would it be appropriate to code diastolic or systolic heart failure when the provider documents HFpEF or HFrEF?**

### Heart Failure with... Q1 2016

#### Answer:

Based on additional information received from the American College of Cardiology (ACC), the Editorial Advisory Board for *Coding Clinic for ICD- 10-CM/PCS* has **reconsidered** previously published advice about coding heart failure with preserved ejection fraction (HFpEF), and heart failure with reduced ejection fraction (HFrEF).

**HFpEF** may also be referred to as heart failure **with preserved systolic function**, and this condition may also be **referred to as diastolic heart failure**.

**HFrEF** may also be called heart failure **with low ejection fraction**, or heart failure with reduced systolic function, or other similar terms **meaning systolic heart failure**.

These terms HFpEF and HFrEF are more contemporary terms that are being more frequently used, and can be further described as acute or chronic.

**Heart Failure with... Q1 2016**

Therefore, when the provider has documented HFpEF, HFrEF, or other similar terms noted above, the coder may interpret these as “diastolic heart failure” or “systolic heart failure,” respectively, or a combination of both if indicated, and assign the appropriate ICD-10-CM codes.

**Heart Failure with... Q1 2016**

HFpEF may also be referred to as heart failure with preserved systolic function, and this condition may also be referred to as diastolic heart failure.

**HFpEF = as diastolic heart failure**

HFrEF may also be called heart failure with low ejection fraction, or heart failure with reduced systolic function, or other similar terms meaning systolic heart failure.

**HFrEF = systolic heart failure**

**DM with Associated Conditions Q1 2016****Question:**

The ICD-10-CM Alphabetic Index entry for 'Diabetes with' includes listings for conditions associated with diabetes, which was not the case in ICD-9-CM.

Does the provider need to document a relationship between the two conditions or should the coder assume a causal relationship?

**DM with Associated Conditions Q1 2016****Answer:**

According to the ICD-10-CM Official Guidelines for Coding and Reporting, the term “with” means “associated with” or “due to,” when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List, and this is how it's meant to be interpreted when assigning codes for diabetes with associated manifestations and/or conditions.

**The classification assumes a cause-and-effect relationship between diabetes and certain diseases of the kidneys, nerves, and circulatory system.**

Assumed cause-and-effect relationships in the classification are not necessarily the same in ICD-9- CM and ICD-10-CM.

**DM with Associated Conditions Q1 2016****Answer (cont'd):**

However, if the physician documentation specifies diabetes mellitus is not the underlying cause of the other condition, the condition should not be coded as a diabetic complication.

When the coder is unable to determine whether a condition is related to diabetes mellitus, or the ICD-10-CM classification does not provide coding instruction, it is appropriate to query the physician for clarification so that the appropriate codes may be reported. (See ICD-10- CM Official Guidelines for Coding and Reporting, Section I.A.15.)

**DM with Associated Conditions Q1 2016****Guidelines Section I.A.15****“With”**

The word “with” should be interpreted to mean “associated with” or “due to” when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List.



### DM with Associated Conditions Q1 2016

#### Answer (cont'd):

In addition, the following advice published in *Coding Clinic*, Third Quarter 2012, page 3, also applies to ICD-10-CM:

"It is not required that two conditions be listed together in the health record. However, the provider needs to document the linkage, except for situations where the classification assumes an association (e.g., hypertension with chronic kidney involvement).

When the provider establishes a linkage or relationship between the two conditions, they should be coded as such. However, the entire record should be reviewed to determine whether a relationship between the two conditions exists. The fact that a patient has two conditions that commonly occur together does not necessarily mean they are related. A different cause may be documented by the provider. If it is not clear whether or not two conditions are related, query the provider."

### Diabetic Foot Ulcer

#### Question:

A patient, who is a type 2 diabetic, is admitted with a chronically infected ulcer of the left mid-foot.

The provider documented, "Diabetic foot ulcer with skin breakdown, positive for Methicillin resistant Staphylococcus aureus (MRSA) infection."

Also had been diagnosed with polyneuropathy, end-stage renal disease (ESRD), on hemodialysis maintenance.

Does ICD-10-CM assume a cause-and-effect relationship between the diabetes mellitus, the foot ulcer, polyneuropathy and ESRD?

How should this case be coded?

### Diabetic Foot Ulcer Q1 2016

#### Answer:

ICD-10-CM assumes a causal relationship between the diabetes mellitus and the foot ulcer, the polyneuropathy, as well as the chronic kidney disease.

Assign codes:

**E11.621**, Type 2 diabetes mellitus with foot ulcer, as the principal diagnosis. Also,

L97.421, Non-pressure chronic ulcer of left heel and midfoot limited to breakdown of skin;

**E11.42**, Type 2 diabetes mellitus with diabetic polyneuropathy;

B95.62, Methicillin resistant Staphylococcus aureus infection as the cause of disease classified elsewhere;

**E11.22**, Type 2 diabetes mellitus with diabetic chronic kidney disease;

N18.6, End stage renal disease; and Z99.2, Dependence on renal dialysis, should be assigned as additional diagnoses.

### Diabetes and Osteomyelitis Q4 2013

#### Question:

*Coding Clinic*, First Quarter 2004, pages 14-15, indicated that "ICD-9-CM assumes a relationship between diabetes and osteomyelitis when both conditions are present, unless the physician has indicated in the medical record that the acute osteomyelitis is totally unrelated to the diabetes."

Is the same relationship between diabetes and osteomyelitis true for ICD-10-CM?

### Diabetes and Osteomyelitis Q4 2013

#### Answer:

**No, ICD-10-CM does not presume a linkage between diabetes and osteomyelitis.**

The provider will need to document a linkage or relationship between the two conditions before it can be coded as such.

### Diabetes Mellitus Type 2 with Ketoacidosis Q1 2013

#### Question:

What is the correct code assignment for type 2 diabetes mellitus with diabetic ketoacidosis?

### Diabetes Mellitus Type 2 with Ketoacidosis Q1 2013

**Answer:**

Assign code E13.10, Other specified diabetes mellitus with ketoacidosis without coma, for a patient with type 2 diabetes with ketoacidosis.

**Given the less than perfect limited choices, it was felt that it would be clinically important to identify the fact that the patient has ketoacidosis.**

The National Center for Health Statistics (NCHS), who has oversight for volumes I and II of ICD-10-CM, has agreed to consider a future ICD-10-CM Coordination and Maintenance Committee meeting proposal.

### Index and Diabetes

**ICD-10-CM Index:**

**out of control** – code to Diabetes by type with hyperglycemia

**poorly controlled** – code to Diabetes by type with hyperglycemia

**inadequately controlled** – code to Diabetes by type with hyperglycemia

**ICD-9-CM Index:**

**poorly controlled** – code to Diabetes by type with 5<sup>th</sup> digit for not stated as uncontrolled

### DM with Hypoglycemia

What about hypoglycemia ?

**E11.64** Type 2 diabetes mellitus with hypoglycemia

**E11.641** Type 2 diabetes mellitus with hypoglycemia with coma

**E11.649** Type 2 diabetes mellitus with hypoglycemia without coma

### Obstetrical Perineal Laceration Repair Q1 2016

The repair of an obstetric perineal laceration is coded based on degree repaired.

The appropriate repair code is assigned depending on the degree of the tear and tissue repaired with the body part specifying the deepest layer repaired.

The ICD-10-PCS Official Guidelines for Coding and Reporting overlapping body layers (B3.5) states **“If the root operation Excision, Repair or Inspection are performed on overlapping layers of the musculoskeletal system, the body part specifying the deepest layer is coded.”**

For example, repair of a second-degree laceration requires repair of the perineal muscle, vaginal mucosa, and skin; therefore, it is coded to the body part “perineum, muscle.”

### Obstetrical Perineal Laceration Repair Q1 2016

**Guidelines**

**Overlapping body layers**

**B3.5**

If the root operations Excision, Repair or Inspection are performed on overlapping layers of the musculoskeletal system, the body part specifying the deepest layer is coded.

**Multiple procedures**

**B3.2**

During the same operative episode, multiple procedures are coded if:

- a. The same root operation is performed on different body parts as defined by distinct values of the body part character.

### Obstetrical Perineal Laceration Repair Q1 2016

Commonly coded prior to this CC Guidance:

**1st degree** perineal skin and subq tissue 0WQN0ZZ

**2nd degree** .....and muscle 0KQM0ZZ

**3rd degree** .....and anal sphincter 0KQM0ZZ  
0DQR0ZZ

**4th degree** .....and rectal mucosa 0KQM0ZZ  
0DQR0ZZ  
0DQP0ZZ

### Obstetrical Perineal Laceration Repair Q1 2016

#### First-degree perineal laceration

First-degree tears involve injury to the outermost layer of the perineum and vaginal mucosa. Assign code

**0HQ9XZZ**, Repair perineum skin, external approach, for repair of a first degree perineal laceration.

(commonly coded 0WQN0ZZ)

### Obstetrical Perineal Laceration Repair Q1 2016

#### Second-degree perineal laceration

Second-degree tears include injury to the vaginal wall and perineal muscle, but do not extend down into the anal sphincter muscle. Assign code

**0KQM0ZZ**, Repair perineum muscle, open approach, for repair of a second degree perineal laceration

(commonly coded 0KQM0ZZ)

### Obstetrical Perineal Laceration Repair Q1 2016

#### Third-degree perineal laceration

Third-degree tears extend to the anal sphincter, but the anal/ rectal mucosa beneath the anal sphincter are intact.

Assign code

**0DQR0ZZ**, Repair anal sphincter, open approach, for repair of a third degree perineal laceration

(commonly coded 0KQM0ZZ and 0DQR0ZZ)

### Obstetrical Perineal Laceration Repair Q1 2016

#### Fourth-degree perineal laceration

Fourth-degree tears consist of injury to the perineum, and the anal sphincter complex (external anal sphincter and internal anal sphincter), and the rectal mucosa. Assign code

**0DQP0ZZ**, Repair rectum, open approach, for the repair of the fourth-degree tear.

(commonly coded:

0KQM0ZZ, 0DQR0ZZ and 0DQP0ZZ)

### Obstetrical Perineal Laceration Repair Q1 2016

#### Question:

A patient had a completely normal delivery, except for an obstetric third-degree perineal laceration.

Is it correct to separately code each body part (i.e., perineum and anal sphincter) or should the repair only be coded to the deepest layer when multiple layers are involved (i.e., skin, subcutaneous, muscle, etc.)?

### Obstetrical Perineal Laceration Repair Q1 2016

#### Answer:

Assign code 0DQR0ZZ, Repair anal sphincter, open approach, for the repair of a third-degree obstetric perineal laceration.

ICD-10-PCS Guideline B3.5 states: "If the root operation Excision, Repair or Inspection is performed on overlapping layers of the musculoskeletal system, the body part specifying the deepest layer is coded."

In the context of a third degree obstetric laceration, the anal sphincter muscle is beneath the perineal muscle and is therefore the deepest layer in this scenario.

### Obstetrical Perineal Laceration Repair Q1 2016

#### Question:

A patient had a spontaneous vaginal delivery and experienced an obstetric fourth-degree perineal laceration. Is it correct to assign a code for each body part separately (i.e., perineum and anal sphincter) or should the repair only be coded to the deepest layer when multiple layers are involved (i.e., skin, subcutaneous, muscle, etc.)?

#### Answer:

Assign code

0DQP0ZZ, Repair rectum, open approach, for the repair of the fourth-degree tear.

As previously stated, code the deepest layer involved in the tear.

### Sacral Dimple Q1 2016

#### Question:

What is the appropriate code assignment for a newborn diagnosed with a sacral dimple?

#### Answer:

Assign code Q82.8, Other specified congenital malformations of skin, for sacral dimple. A sacral dimple is a congenital condition. Sacral dimples may be associated with a serious underlying abnormality of the spine or spinal cord. It is appropriate to code congenital anomalies when identified by the provider, since they can have implications for further evaluation.

### Sacral Dimple Q1 2016

#### Guideline – Coding Additional Perinatal Diagnoses

- 1) **Assigning codes for conditions that require treatment** Assign codes for conditions that require treatment or further investigation, prolong the length of stay, or require resource utilization.
- 2) **Codes for conditions specified as having implications for future health care needs** Assign codes for conditions that have been specified by the provider as having implications for future health care needs. **Note:** This guideline should not be used for adult patients.

### Bx of Neobladder Malignancy Q1 2016

#### Question:

A patient, who is status post creation of a neobladder due to invasive bladder cancer, presents with gross hematuria and undergoes surgical biopsy.

The biopsy of the neobladder is positive for poorly differentiated carcinoma.

Since a section of the small intestine was used to create the new bladder, would the diagnosis be coded as carcinoma of the intestine or bladder?

What is the appropriate "body part" for the biopsy, intestine or bladder?

### Bx of Neobladder Malignancy Q1 2016

#### Answer:

Assign code C67.9, Malignant neoplasm of bladder, unspecified, for the diagnosis of carcinoma of the neobladder. Since the intestine is functioning as a bladder, "Bladder" is the correct body part for the malignancy as well as the biopsy. Assign ICD-10- PCS code as follows:

**0TBB8ZX** Excision of bladder, via natural or artificial opening endoscopic, diagnostic, for biopsy of the neobladder

The ICD-10-PCS does not provide a body part value that distinguishes natural bladder from an artificially-created bladder.

### Biliary Obstruction due to HCC Q1 2016

#### Question:

A 69-year-old patient with nonresectable hepatocellular carcinoma (HCC), status post radioembolization, presented with two weeks of progressive hyperbilirubinemia. He underwent endoscopic retrograde cholangiopancreatography, which revealed biliary obstruction from HCC progression.

The provider performed biliary sphincterotomy and insertion of biliary stent into the common bile duct.

There is confusion as to whether it is appropriate to sequence the carcinoma as the principal diagnosis, since it is the underlying cause of the obstruction, or whether the obstruction is sequenced as the principal diagnosis, since it was the reason for the admission, and no treatment was directed to the carcinoma.

What is the correct sequencing of the biliary obstruction and the hepatocellular carcinoma for this encounter?

### Biliary Obstruction due to HCC Q1 2016

#### Answer:

**Assign code K83.1, Obstruction of bile duct, as the principal diagnosis.** The obstruction was the focus of treatment. Since therapy was only directed at the obstruction, and not the malignancy, the obstruction is sequenced as principal diagnosis.

Assign code C22.0, Liver cell carcinoma, as an additional diagnosis.

The ICD-10-CM Official Guidelines for Coding and Reporting (2.1.4.) state, "**When an encounter is for management of a complication associated with a neoplasm, such as dehydration, and the treatment is only for the complication, the complication is coded first, followed by the appropriate code(s) for the neoplasm.**"

The exception to this guideline is anemia."

### Iliofemoral Endarterectomy with Patch Repair Q1 2016

#### Question:

The patient presents for a left open iliofemoral endarterectomy with bovine patch repair.

The plaque extended from the femoral bifurcation up to the mid external iliac artery.

Since **the plaque extended through two distinct body parts, should there be two extirpation codes assigned for the endarterectomy and two supplement codes assigned for the bovine patch repairs to capture both the femoral and external iliac arteries?**

### Iliofemoral Endarterectomy with Patch Repair Q1 2016

#### Answer:

The lesion (plaque) extended from the femoral bifurcation to the mid external iliac artery, and **it is considered a continuation of a single lesion.**

**For coding purposes, choose the furthest anatomical site from the point of entry. In this case,** the dissection commenced at the bifurcation of the common femoral artery (where the common femoral splits to become the deep femoral and the superficial femoral) and was completed at the external iliac artery, so **the body part value assigned is the external iliac artery.**

When surgery is performed on an overlapping lesion in a tubular body part, assign the body part value describing the furthest site from the point of entry. Assign the following ICD-10-PCS codes:

**04CJ0ZZ** Extirpation of matter from left external iliac artery, open approach

**04UJ0KZ** Supplement left external iliac artery with nonautologous tissue substitute, open approach

### Axillary Lymph Node Resection with Modified Radical Mastectomy Q1 2016

#### Question:

A 39-year-old patient with invasive ductal cancer of the right breast, status post neoadjuvant chemotherapy, underwent modified radical mastectomy of the right breast.

During the axillary dissection, the provider removed level 1, level 2 and parts of level 3 lymph nodes.

We assigned a code for the modified radical mastectomy of the right breast, but are seeking clarification of whether each axillary lymph node level is considered a separate body part (4th character), and therefore, multiple codes are assigned?

### Axillary Lymph Node Resection with Modified Radical Mastectomy Q1 2016

#### Answer:

Each lymph node level is considered a chain.

When the intent is to remove an entire chain of lymph nodes, rather than isolated nodes, the root operation "Resection" is coded.

The axillary lymph nodes are all considered a single body part and therefore multiple procedure codes would not be assigned for the cutting out of various axillary lymph node levels.

Assign the following ICD-10-PCS code for the right axillary lymph node resection:

**07T50ZZ** Resection of right axillary lymphatic, open approach

### Axillary Lymph Node Resection with Modified Radical Mastectomy Q1 2016

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Coding note: Lymph nodes

When an entire lymph node chain is cut out, the appropriate root operation is Resection.

When a lymph node(s) is cut out, the root operation is Excision.

## Decompressive Laminectomy Q2 2015

### Question:

The patient presents for decompressive lumbar laminectomy. The surgeon performed an open complete decompressive laminectomy of L3-L4, as well as superior partial laminectomy of L5, and inferior partial laminectomy of L2.

What is the appropriate root operation, "Excision" or "Release?"

How is this surgery coded in ICD-10-PCS?

## Decompressive Laminectomy Q2 2015

### Answer:

Decompressive laminectomy is done to release pressure and free up the spinal nerve root.

Therefore the appropriate root operation is "Release."

Assign the following ICD-10-PCS code:

01NB0ZZ Release lumbar nerve, open approach

**Coding Clinic Fourth Quarter 2013, page 116, advised the assignment of the root operation "Excision" for decompressive laminectomy procedures.**

This advice was based on the ICD- 10-PCS' Index entry "Laminectomy," which instructs see Excision.

The Editorial Advisory Board for Coding Clinic revisited this advice and determined that the root operation "Release" is more appropriate.

## Questions?

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