

LibmanEducation
Training the Health Care Professionals

Coding Clinic for ICD-10-CM/PCS Update CTHIMA September 17, 2017

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AHA Coding Clinic for ICD-10-CM/PCS

Visit www.CodingClinicAdvisor.com

Access to complete text of AHA Coding Clinic for ICD-10-CM and ICD-10-PCS is essential

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	Q1 2016
Q2 2014	Q2 2016
Q3 2014	Q3 2016
Q4 2014	Q4 2016
Q1 2015	Q1 2017
Q2 2015	Q2 2017
Q3 2015	Q3 2017
Q4 2015	

Applying Past Issues of CC Q4 2015

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.

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:

-educational points
-new guidance
-guidance that is the same as in ICD-9-CM
-reinforces new guidelines
-corrections to the classification
-corrections to previous CCs
-empowerment – CCs allow coders to decide
-complex issues with multiple examples

Coding Clinic Q3 2017 Topics

Persistent Postoperative Fistula
 Delivery of Placenta
 GI Bleeding Secondary to Gastric Ulcer
 Lumbar Spinal Stenosis and Neurogenic Claudication
 Skin Necrosis at Mastectomy
 Therapeutic and Diagnostic Paracentesis
 Skin Necrosis at Mastectomy Site
 Ureteral Stent Placement for Urinary Leakage
 Intra-Aortic Balloon Pump Removal

Coding Clinic Q2 2017 Topics

Adverse effect of tPA
 Cerebral Infarction with Hemorrhagic Conversion
 Encephalopathy associated with CVA
 Encephalopathy due to Sepsis
 Intestinal obstruction due to peritoneal carcinomatosis
 Gross hematuria associated with a malignancy
 Decompression of spinal canal and placement of spinal instrumentation
 Newborn transfers

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Q3 2017 Persistent Postoperative Fistula pg 3

Question:

How is a persistent postoperative fistula coded? When referencing the Alphabetic Index, the coder is instructed as follows:

Fistula

postoperative, persistent T81.83
 specified site—see Fistula, by site

and

Complication(s) (from) (of)

surgical procedure (on)
 fistula (persistent postoperative) T81.83

Does this mean that if the site is known, code T81.83X-, Persistent postoperative fistula, is not necessary?

For example, would a postoperative uterovaginal fistula be assigned to codes T81.83X- and N82.1, Other female urinary-genital tract fistulae, or only code N82.1?

Q3 2017 Persistent Postoperative Fistula pg 3

Answer:

Assign code T81.83X-, Persistent postoperative fistula, with the appropriate 7th character depending on whether active treatment is still being provided, and code N82.1, Other female urinary-genital tract fistulae, for a postsurgical uterovaginal fistula.

Both codes are needed to indicate the specific site of the fistula and the fact that it is a postsurgical complication.

Persistent Postoperative Fistula

Complications of surgical and medical care, not elsewhere classified (T80-T88)

Use additional code for adverse effect, if applicable, to identify drug (T36-T50 with fifth or sixth character 5)

Use additional code(s) to identify the specified condition resulting from the complication

Q3 2014 Persistent Postoperative Fistula pg 4

Question:

The patient has a history of bowel perforation and obstruction, and is status post complex abdominal surgery due to intestinal anastomotic leak.

The patient was transferred to the long-term care hospital (LTCH) for ongoing care of her abdominal wound. The patient presented with an enterocutaneous fistula with a large open abdominal wound and surgical wound dehiscence.

Should the fistula be coded as a persistent postoperative fistula or according to the site of the fistula?

Q3 2014 Persistent Postoperative Fistula pg 4

Answer:
 Assign codes T81.83X-, Persistent postoperative fistula, and K63.2, Fistula of intestine, for the enterocutaneous postsurgical fistula.
 Both codes are needed to show the postoperative complication and the specific site of the fistula. Assign also code T81.32X-, Disruption of internal operation (surgical) wound, not elsewhere classified, for the wound dehiscence.
 The assignment of the 7th character "A" depends on whether active treatment is still being provided.
 The postoperative fistula is considered "persistent," because it is a continuing problem requiring care. "Postoperative fistula" can be referenced as follows:
Complication(s)
 surgical procedure
 fistula (persistent postoperative) T81.83

Q3 2017 Delivery of Placenta pg 5

Question:
 The patient delivers a baby outside of the hospital. She is admitted to the obstetric unit and expels the placenta at the hospital. How is the expulsion of the placenta captured in ICD-10-PCS?

Answer:
 The placenta is part of the products of conception. Assign the following ICD-10-PCS code:
10E0XZZ Delivery of products of conception, external approach, for the delivery of the placenta
 The ICD-10-PCS does not differentiate between the delivery of the baby and the placenta.
 However, the ICD-10-CM diagnosis code will capture the fact that the baby was born outside the hospital.

Delivery of Placenta

10E

Section	1	Obstetrics
Body System	0	Pregnancy
Operation	E	Delivery, Assisting the passage of the products of conception from the genital canal
Body Part		
Approach		
Device		
Qualifier		
0 Products of Conception	X	External
	Z	No Device
	Z	No Qualifier

Coding note: Delivery
 Delivery applies only to manually-assisted, vaginal delivery and is defined as assisting the passage of the products of conception from the genital canal. Cesarean deliveries are coded in this section to the root operation Extraction.

Q3 2017 GI Bleeding Secondary to Gastric Ulcer pg 27

Question:
 A patient presents due to acute gastrointestinal bleed (GI). An esophagogastroduodenoscopy (EGD) was performed, which showed gastric ulcers as well as portal hypertension. The physician does not link the bleeding to the ulcer nor is it documented that these conditions are unrelated. Under the revised "With" guideline, it appears that we may assume a relationship between the gastrointestinal bleed and the ulcer. How should we report gastric ulcer in a patient with gastrointestinal bleeding?

Q3 2017 GI Bleeding Secondary to Gastric Ulcer pg 27

Answer:
 It would be appropriate to assign code K25.4, Chronic or unspecified gastric ulcer with hemorrhage.
 As stated in the ICD-10-CM Official Guidelines for Coding and Reporting, (I.A.15) the classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List.
 Unless the provider documents a different cause of the bleeding or states that the conditions are unrelated, it is appropriate to assign the combination code for these conditions.

Q2 2007 / CC Q3 2005 no longer in effect

Clarify - gastrointestinal bleeding with a single finding
 ICD-9-CM Coding Clinic, **Second Quarter 2007** Page: 13 Effective with discharges: June 30, 2007

Clarifications
Gastrointestinal (GI) Bleeding with a Single Finding

Question:
 In the **Third Quarter 2005 issue of Coding Clinic**, it was advised that "the combination codes describing hemorrhage should not be assigned unless the physician identifies a causal relationship."
 This information superseded previous advice provided in Second Quarter 1992. If, however, a patient presents with GI bleeding where only one possible source is found, can the coder assume a causal relationship between the GI bleeding and the single finding (ulcer, gastritis, diverticulitis, etc.) or must the physician explicitly state that the GI bleeding is due to the single finding?

Answer:
 The coder should not assume a causal relationship between gastrointestinal bleeding and a single finding such as a gastric ulcer, gastritis, diverticulitis, etc. The physician must identify the source of the bleeding and link the clinical findings from the colonoscopy or upper endoscopy, since these findings may be unrelated to the bleeding.

Guideline “with”

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. The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated. For conditions not specifically linked by these relational terms in the classification, provider documentation must link the conditions in order to code them as related.

ICD-10-CM Official Guidelines for Coding and Reporting
FY 2017
Page 12 of 134

In other words...

if a subterm in the index says "with" the documentation in the medical record does not have to link the two conditions

Q3 2017 Lumbar Spinal Stenosis and Neurogenic Claudication pg 24

Question:

A patient is admitted for treatment of spinal stenosis of the lumbar region with neurogenic claudication.

How is neurogenic claudication due to lumbar spinal stenosis coded?

Answer:

Assign only code M48.06, Spinal stenosis, lumbar region, for spinal stenosis of the lumbar region with neurogenic claudication.

Currently, spinal stenosis with neurogenic claudication is not classified in ICD-10-CM.

A new code describing this condition will become effective October 1, 2017, with the code set update.

Lumbar Spinal Stenosis and Neurogenic Claudication

FY 2017

Stenosis, stenotic (cicatricial) -see also Stricture

- spinal M48.00
- - cervical region M48.02
- - cervicothoracic region M48.03
- - lumbar region M48.06
- - lumbosacral region M48.07
- - occipito-atlanto-axial region M48.01
- - sacrococcygeal region M48.08
- - thoracic region M48.04
- - thoracolumbar region M48.05

Lumbar Spinal Stenosis and Neurogenic Claudication

FY 2018

M48.062 Spinal stenosis, lumbar region with neurogenic claudication

- spinal M48.00
- - cervical region M48.02
- - cervicothoracic region M48.03
- - lumbar region (NOS) (without neurogenic claudication) M48.061
- - with neurogenic claudication M48.062
- - lumbosacral region M48.07
- - occipito-atlanto-axial region M48.01
- - sacrococcygeal region M48.08
- - thoracic region M48.04
- - thoracolumbar region M48.05

Lumbar Spinal Stenosis and Neurogenic Claudication

Claudication (intermittent) I73.9

- cerebral (artery) G45.9
- spinal cord (arteriosclerotic) G95.19
- - syphilitic A52.09
- venous (axillary) I87.8

Q3 2017 Skin Necrosis at Mastectomy Site pg 6

Question:

A patient, who had recently undergone right mastectomy with immediate breast reconstruction using a tissue expander and AlloDerm, is readmitted for treatment of skin necrosis at the mastectomy site. The surgeon also noted early onset ecchymosis and ischemic changes, and the patient underwent excision of demarcated necrotic skin, subcutaneous tissue, and fat at the right mastectomy site. What is the correct diagnosis code assignment for this condition?

Answer:

Assign codes L76.82, Other postprocedural complications of skin and subcutaneous tissue, and I96, Gangrene, not elsewhere classified, for the skin necrosis (gangrene) of the right mastectomy site.

Q3 2017 Therapeutic and Diagnostic Paracentesis pg 12

Question:

A 64-year-old patient with new onset ascites presents for abdominal paracentesis.

An ultrasound guided diagnostic and therapeutic paracentesis are both performed via a catheter.

Is it appropriate to report two procedure codes for the diagnostic and therapeutic paracentesis?

Q3 2017 Therapeutic and Diagnostic Paracentesis pg 12

Answer:

Assign only the following code:

0W9G3ZZ Drainage of peritoneal cavity, percutaneous approach, for the diagnostic and therapeutic paracentesis

If there is a therapeutic component to the procedure, only the qualifier "Z" is used, rather than the qualifier "X."

The qualifier "X" is exclusively used for diagnostic procedures only.

If there are two separate procedures, one diagnostic and the other therapeutic, then both procedures are code separately.

For example, a diagnostic drainage procedure that uses a different approach or samples a different site from the therapeutic drainage procedure requires two separate codes to capture both the diagnostic procedure (biopsy) and the therapeutic procedure.

Therapeutic and Diagnostic Paracentesis

0W9

Section	0	Medical and Surgical	
Body System	W	Anatomical Regions, General	
Operation	9	Drainage: Taking or letting out fluids and/or gases from a body part	
Body Part	Approach	Device	Qualifier
0 Head	0 Open	Z No Device	X Diagnostic
1 Cranial Cavity	3 Percutaneous		Z No Qualifier
2 Face	4 Percutaneous Endoscopic		
3 Oral Cavity and Throat			
4 Upper Jaw			
5 Lower Jaw			
6 Neck			
8 Chest Wall			
9 Pleural Cavity, Right			
B Pleural Cavity, Left			
C Mediastinum			
D Pericardial Cavity			
F Abdominal Wall			
G Peritoneal Cavity			
H Retroperitoneum			
J Pelvic Cavity			
K Upper Back			
L Lower Back			
M Perineum, Male			
N Perineum, Female			

Therapeutic and Diagnostic Paracentesis

In other words,

if a paracentesis that is both diagnostic and therapeutic in nature is performed, only one procedure code is required to report the procedure.

The 7th character (the qualifier) is reported as "Z" (no qualifier) as "X" (diagnostic) is reported when the procedure is only diagnostic in nature.

It is reasonable to assume that this logic may be applied to other similar circumstances (thoracentesis).

PCS Guideline B3.4b

Biopsy followed by more definitive treatment
B3.4b

If a diagnostic Excision, Extraction, or Drainage procedure (biopsy) is followed by a more definitive procedure, such as Destruction, Excision or Resection at the same procedure site, both the biopsy and the more definitive treatment are coded.

Example: Biopsy of breast followed by partial mastectomy at the same procedure site, both the biopsy and the partial mastectomy procedure are coded.

Q3 2017 Skin Necrosis at Mastectomy Site pg 6

Question:

A patient, who had recently undergone right mastectomy with immediate breast reconstruction using a tissue expander and AlloDerm, is readmitted for treatment of skin necrosis at the mastectomy site.

The surgeon also noted early onset ecchymosis and ischemic changes, and the patient underwent excision of demarcated necrotic skin, subcutaneous tissue, and fat at the right mastectomy site.

What is the correct diagnosis code assignment for this condition?

Answer:

Assign codes L76.82, Other postprocedural complications of skin and subcutaneous tissue, and I96, Gangrene, not elsewhere classified, for the skin necrosis (gangrene) of the right mastectomy site.

ICD-10-CM Index Necrosis/Gangrene

Necrosis, necrotic (ischemic) -see also Gangrene
- skin or subcutaneous tissue NEC I96

Gangrene, gangrenous (connective tissue) (dropsical) (dry)
[moist] (skin) (ulcer) -see also Necrosis I96

Q3 Ureteral Stent Placement for Urinary Leakage 2017 pg 19

Question:

A 73-year-old patient, who is status post partial right nephrectomy due to renal cell carcinoma, presented due to a urine leak with a urinary fistula and retroperitoneal fluid collection.

Urinary diversion was performed by placing a right ureteral stent.

A double J ureteral stent was placed with the proximal curl in the upper pole calyx and the distal curl in the bladder.

What is the appropriate root operation for this procedure?

Q3 Ureteral Stent Placement for Urinary Leakage 2017 pg 19

Answer:

The stent was placed to keep the ureteral valve between the bladder and the ureter open.

This helps facilitate normal drainage of the urine, into the bladder rather than out the urinary fistula.

Assign the following ICD-10-PCS code:

0T9680Z Drainage of right ureter with drainage device, via natural or artificial opening endoscopic, for the insertion of the urinary stent for urinary leakage

Q3 2017 Intra-Aortic Balloon Pump Removal pg 18

Question:

A patient was transferred to our facility status post placement of an intra-aortic balloon pump (IABP) due to persistent cardiogenic shock. The patient subsequently underwent bedside removal of the IABP. The IABP was disconnected and the catheter and sheath were withdrawn. A Fem-Stop was then applied. What is the appropriate ICD-10-PCS code assignment for removal of an IABP performed at bedside?

Q3 2017 Intra-Aortic Balloon Pump Removal pg 18

Answer:

Facilities are not required to report the non-operative removal of an intra-aortic balloon pump separately. In ICD-10-PCS, the use of an IABP is classified in the Extracorporeal Assistance and Performance sections (5A0) where a device value does not exist. It would be inappropriate to report the removal of a device code from the Medical and Surgical section within ICD-10-PCS for an IABP when it is not specifically identified as a device in the classification.

Q2 2017 Adverse Effect of tPA pg 9**Question:**

A patient was started on tissue plasminogen activator (tPA) after presenting to the emergency department with expressive aphasia and was diagnosed with an ischemic stroke. A repeat **CT scan showed left stroke with hemorrhagic transformation.**

The provider was queried regarding the hemorrhagic transformation, and stated that the **tPA therapy had caused hemorrhagic conversion of the ischemic stroke.**

What is the diagnosis code assignment for the hemorrhagic conversion of the ischemic stroke?

Q2 2017 Adverse Effect of tPA pg 9**Answer:**

In this case, the patient had an ischemic stroke, and after tPA was administered as prescribed, he developed hemorrhaging into the area of the infarct.

Therefore, the cerebral hemorrhage is coded as an adverse effect of the medication (tPA), rather than as a complication.

Assign code I63.8, Other cerebral infarction, for the initial ischemic stroke.

In addition, assign the appropriate code from category I61, Nontraumatic intracerebral hemorrhage, along with code T45.615A, Adverse effect of thrombolytic drugs, initial encounter, for the hemorrhagic transformation following administration of tPA.

Q2 2017 Adverse Effect of tPA pg 9

I63.8 Other cerebral infarction, for the initial ischemic
I61- Nontraumatic intracerebral hemorrhage,
T45.615A Adverse effect of thrombolytic drugs, initial encounter

Q2 2017 Cerebral Infarction with Hemorrhagic Conversion pg 10**Question:**

A patient was given tPA after being admitted through the emergency department ED for sudden onset of weakness and difficulty speaking. **The provider diagnosed ischemic infarction of the left posterior cerebral artery. A repeat CT scan showed hemorrhagic conversion** of the left posterior cerebral artery ischemic stroke. When the provider was queried regarding cause and effect between the tPA and the hemorrhagic conversion, he responded that there was **no relationship**; the hemorrhage occurred after the tPA had worn off.

What is the diagnosis code assignment for the hemorrhagic conversion?

Q2 2017 Cerebral Infarction with Hemorrhagic Conversion pg 10**Answer:**

In this case, the provider has confirmed that **the hemorrhagic conversion is not an adverse effect** of tPA.

Assign code I63.532, Cerebral infarction due to unspecified occlusion or stenosis of left posterior cerebral artery, for the initial infarction as the principal diagnosis and

Assign the appropriate code from category I61-, Nontraumatic intracerebral hemorrhage, for the hemorrhagic conversion as an additional diagnosis.

Q2 2017 Cerebral Infarction with Hemorrhagic Conversion pg 10

Raising the question about how to code sequela(e) of cerebral infarction with hemorrhagic conversion ??

Not addressed by Coding Clinic

Q2 2017 Encephalopathy associated with CVA pg 9

Question:

A patient is admitted to the hospital due to altered mental status, and is **diagnosed with an acute lacunar infarct and encephalopathy** secondary to the lacunar infarction.

Would the encephalopathy be coded separately or is it considered inherent to the acute lacunar infarct?

Answer:

Assign code G93.49, Other encephalopathy, for encephalopathy that occurs secondary to an acute cerebrovascular accident/stroke.

Although the encephalopathy is associated with an acute lacunar infarct, it is not inherent, and therefore is coded when it occurs.

Q2 2017 Encephalopathy d/t sepsis pg 8

Question:

A patient is admitted with mental status changes and is diagnosed with severe sepsis secondary to urinary tract infection, acute renal failure and acute encephalopathy.

The provider documented "sepsis associated encephalopathy."

How should the encephalopathy be coded (G94 vs. G93.41)?

Q2 2017 Encephalopathy d/t sepsis pg 8

Answer:

Assign code G93.41, Metabolic encephalopathy, for sepsis-associated encephalopathy. This code assignment can be found in the Index under:

Encephalopathy (acute) septic G93.41

Code G94, Other disorders of brain in diseases classified elsewhere, should only be assigned for those conditions with Index entries that directly point to code G94 for certain etiologies; otherwise assign code G93.40, Encephalopathy, unspecified, if the type of encephalopathy is not documented.

Assign a more specific code, when the type of encephalopathy is documented.

R65.2- Severe sepsis

Use additional code to identify specific acute organ dysfunction, such as:

- acute kidney failure (N17.-)
- acute respiratory failure (J96.0-)
- critical illness myopathy (G72.81)
- critical illness polyneuropathy (G62.81)
- disseminated intravascular coagulopathy [DIC] (D65)
- encephalopathy (metabolic) (septic) (G93.41)
- hepatic failure (K72.0-)

....other things you learn from reading the codebook

L89 Pressure ulcer

Includes: bed sore
decubitus ulcer
plaster ulcer
pressure area
pressure sore

Code first any associated gangrene (I96)

My new favorite code....

Z92.8 Personal history of other medical treatment

Z92.81 Personal history of extracorporeal membrane oxygenation (ECMO)

Q2 2017 Intestinal obstruction due to peritoneal carcinomatosis pg 12

Question:

How is bowel obstruction due to peritoneal carcinomatosis coded?

Answer:

Assign only code C78.6, Secondary malignant neoplasm of retroperitoneum and peritoneum, as instructed by the Excludes 1 notes found under codes K56.60, Unspecified intestinal obstruction, and K56.69, Other intestinal obstruction, which state:

“intestinal obstruction due to specified condition-code to condition.”

K56.6- Other and unspecified intestinal obstruction

K56.6 Other and unspecified intestinal obstruction

K56.60 Unspecified intestinal obstruction

Intestinal obstruction NOS

Excludes1: intestinal obstruction due to specified condition-code to condition

K56.69 Other intestinal obstruction

Enterostenosis NOS
Obstructive ileus NOS
Occlusion of colon or intestine NOS
Stenosis of colon or intestine NOS
Stricture of colon or intestine NOS

Excludes1: intestinal obstruction due to specified condition-code to condition

I.12.a. Excludes 1 notes pg 11 of 114

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.

An exception to the Excludes1 definition is the circumstance when the two conditions are unrelated to each other.....

I.12.a. Excludes 2 notes pg 11 of 114

b. 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.

I.C.2.I.4. pg 31 of 114

Encounter for complication associated with a neoplasm

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.

When the admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate code for the malignancy is sequenced as the principal or first-listed diagnosis followed by code D63.0, Anemia in neoplastic disease.

Q1 2017 Gross hematuria associated with a malignancy pg 17

Question:

Coding Clinic for ICD-9-CM, Second Quarter 2010, page 3, provided advice to sequence gross hematuria as the principal diagnosis for a patient, who was currently under treatment for prostate cancer and was admitted for gross hematuria with a significant drop in hemoglobin.

The patient had been unable to pass urine and was only passing frank blood and clots. While in the hospital, 12 units of blood were transfused, and bladder irrigation was done.

Now that hematuria is a Chapter 18 (Signs, symptoms..) code in ICD-10-CM does the guideline in Section II.A., regarding codes for symptoms, signs, and ill-defined conditions apply, and change the previously published advice in regards to the principal diagnosis?

Q1 2017 Gross hematuria associated with a malignancy

Answer:

The Official Guidelines for Coding and Reporting state, "Codes for symptoms, signs, and ill-defined conditions from Chapter 18 are not to be used as principal diagnosis when a related definitive diagnosis has been established."

Based on this guideline and the fact that hematuria is classified as a symptom in ICD-10-CM, code C61,

Malignant neoplasm of prostate, would now be assigned as the principal diagnosis.

Code R31.0, Gross hematuria, would be assigned as a secondary diagnosis.

This advice is also consistent with the neoplasm guidelines regarding symptoms, signs, and abnormal findings listed in Chapter 18 associated with neoplasms.

The previously published advice was based on the application of the guideline regarding the selection of principal diagnosis as ICD-9-CM did not classify hematuria in the symptom chapter.

This advice is an example of differences in the ICD-10-CM classification compared to ICD-9-CM.

Q2 2017 Infusion of tPA into the pleural cavity

Question:

The patient had a Streptococcal empyema and received an infusion of tissue plasminogen activator (tPA) via his chest tube into the pleural cavity to break up thickened pleural effusion in order for it to easily drain.

In ICD-10-PCS, under the root operation "Introduction" of thrombolytic there is no body part value for pleural cavity.

What is the appropriate code assignment for tPA infusion into the pleural cavity?

Answer:

Assign the following ICD-10-PCS code:

3E0L3GC Introduction of other therapeutic substance into pleural cavity, percutaneous approach, for the infusion of tPA into the pleural cavity

Q2 2017 Decompression of spinal canal and placement of spinal instrumentation

Question:

The health record documentation states that the patient underwent

laminectomy C3 through C7,

decompression of the spinal cord,

placement of posterior instrumentation and spinal fusion, due to cervical spondylosis.

After decompression of the spinal cord, lateral mass screws were placed from C3-C6 bilaterally with connecting rods.

Would placement of instrumentation be coded as a pedicle based stabilization device?

What device value is assigned for the spinal fusion?

Would the decompression of the spinal cord be coded separately or is it considered inherent to the total surgery?

Q2 2017 Decompression of spinal canal and placement of spinal instrumentation

Answer:

In this case, a spinal fusion was not carried out.

There was no documentation of bone graft or a bone graft substitute being utilized; only spinal cord decompression and insertion of rods and screws (instrumentation) were accomplished.

Instrumentation alone does not constitute a spinal fusion.

Spinal fusion involves the use of bone graft or bone graft substitute, which can be done with or without instrumentation.

Also, the insertion of rods and screws is not the same as the placement of a pedicle based stabilization device.

The device value "Spinal stabilization device, pedicle based" is not used, because that device value is only used for specific stabilization systems.

The root operation "Release" is coded separately when decompression is documented, and there is a distinct surgical objective, not just incidental removal of the lamina to reach the site of the procedure. Assign the following procedure codes:

0RH104Z Insertion of internal fixation device into cervical vertebral joint, open approach

00NW0ZZ Release cervical spinal cord, open approach

Q2 2017 Newborn Transferred from Hospital A to Hospital B

pg 7

Question:

A 34-week premature infant, who was delivered via cesarean section at Hospital A, was transferred to Hospital B for continued treatment.

What code would the receiving facility (Hospital B) report?

How would the attending physician at Hospital B report his/her services; code

Z38.01, Single liveborn infant, delivered by cesarean, or code

P07.37, Preterm newborn, gestational age 34 completed weeks?

Q2 2017 Newborn Transferred from Hospital A to Hospital B

pg 7

Answer:

Both the attending physician and the receiving hospital would report code P07.37, Preterm newborn, gestational age 34 completed weeks.

When a newborn is transferred to another facility for treatment, neither the receiving hospital nor the attending physician should report codes from category Z38.

Questions?

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