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

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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)."

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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
-CCs that precede guideline changes
-corrections to previous CCs
-empowerment – CCs allow coders to decide
-reviews complex issues with multiple examples

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Today's topics

- DM & skin disorders
- Control of GI bleeding
- Encounter for Brachytherapy
- Unstageable pressure ulcer
- Omitting ICD-10-CM codes
- Coding of Social Determinants
- Uncertain Diagnosis "Concern for"
- Mechanical Vent using patient's own equipment
- Hyperplastic Rectal Polyp

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Today's topics

- IABP
- Diabetes with arthropathy
- DM with peripheral angiopathy
- Observation for suspected burn
- Carotid artery stenosis & TIA
- Takosubo Syndrome with hypertension
- Cocaine use during pregnancy
- Recreational marijuana use
- Prescribed opiates for pain management
- Sessile serrated polyp
- Degenerative changes

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Q4 2017 Diabetes and Cellulitis pg 100

Question:
 A patient with type 2 diabetes mellitus presented due to acute cellulitis of the left lower leg. The patient was admitted and started on broad-spectrum antibiotics.
 When assigning the diabetes code, would it be appropriate to report the code for diabetes "with skin complication NEC?"
 What is the appropriate code assignment for cellulitis in a patient with type 2 diabetes?

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Q4 2017 Diabetes and Cellulitis pg 100

Answer:
 In order to link the diabetes and the cellulitis, the provider would need to document cellulitis as a diabetic skin complication.
 When the causal relationship is unclear, query the provider regarding the linkage and whether cellulitis is a skin complication caused by the diabetes.
 Each case is patient specific, and the relationship between diabetes and cellulitis should be clearly documented by the provider.
 When the coder is unable to determine whether a condition is a diabetic complication, or the ICD-10-CM classification does not provide instruction, it is appropriate to query the physician for clarification so that the appropriate codes may be reported.

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Q4 2017 Diabetes and Cellulitis pg 100

"Diabetes with skin complication NEC," is indexed, but "diabetes with cellulitis" is not specifically indexed.
The "with" guideline does not apply to "not elsewhere classified (NEC)" index entries that cover broad categories of conditions.
 Specific conditions must be linked by the terms "with," "due to" or "associated with".
Coding professionals should not assume a causal relationship when the diabetic complication is "NEC."
 The ICD-10-CM classification presumes a cause and effect relationship with certain specific conditions when the Alphabetic Index links the conditions by the terms "with", "due to" or "associated with".

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Q4 2017 Diabetes and Skin Complication
Not Elsewhere Classified pg 101

Question:
 Could you please clarify the correct use of the diabetes subentry with "skin complication NEC?"
 Would the correct application of the entry with skin complication only pertain to provider documentation linking the skin complication to the diabetes or would any or all documented skin complications, such as cellulitis, bullous pemphigoid, disseminated granuloma annulare, eruptive xanthomatosis, or acne vulgaris, automatically be linked to the diabetes code with skin complication?

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Q4 2017 Diabetes and Skin Complication
Not Elsewhere Classified pg 101

Answer:
 The "with" guideline does not apply to "not elsewhere classified (NEC)" index entries that cover broad categories of conditions. Specific conditions must be linked by the terms "with," "due to" or "associated with".
 In order to link diabetes and a specific skin complication, the provider would need to document the condition as a diabetic skin complication.
 Each case is patient specific, and the relationship between diabetes and the skin complication should be clearly documented.
 Therefore, query the provider about the linkage, and if diabetes caused the specific skin complication.
 Coding professionals should not assume a causal relationship when the diabetic complication is "NEC."

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Q4 2017 Control of Gastrointestinal Bleeding
pg 105

Question:
 The patient underwent endoscopy due to upper gastrointestinal bleeding. A large duodenal ulcer with adherent clot was found and injected with epinephrine for hemostasis and 3 clips were placed.
 Is "Control" of bleeding appropriate for this procedure when there is no documentation of active bleeding?

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Q4 2017 Control of Gastrointestinal Bleeding pg 105

Answer:
 When a patient is seen for bleeding and a procedure is performed to control the hemorrhage and prevent a recurrent bleed, assign a code for control of bleeding.
Active bleeding does not need to be demonstrated during the encounter to diagnose and treat an acute hemorrhage.
 Assign the following ICD-10-PCS code:
0W3P8ZZ Control bleeding in gastrointestinal tract, via natural or artificial opening endoscopic

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Q4 2017 Encounter for Brachytherapy due to Cervical Malignancy pg 103

Question:
 A patient is admitted for brachytherapy due to cervical cancer. Intrauterine tandem and ovoids are placed and brachytherapy is provided.
 When coding encounters for brachytherapy, should code Z51.0, Encounter for antineoplastic radiation therapy, be assigned as the principal diagnosis, or should a code for the malignancy be assigned as the principal diagnosis?
 What is the appropriate code assignment for an encounter for brachytherapy due to cervical cancer?

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Q4 2017 Encounter for Brachytherapy due to Cervical Malignancy pg 103

Answer:
 Assign code C53.9, Malignant neoplasm of cervix uteri, unspecified, as the principal diagnosis for a patient who presents for brachytherapy due to cervical cancer.
Effective October 1, 2017, the Official Guidelines for Coding and Reporting, Section I.C.2 have been revised to clarify that code Z51.0, Encounter for antineoplastic radiation therapy, is intended for encounters for external beam radiation therapy.
 Further guidance has been added specifying that for admission/encounters for the insertion or implantation of radioactive elements (e.g., brachytherapy) sequence the appropriate code for the malignancy as the principal or first-listed diagnosis.

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Q4 2017 Unstageable Pressure Ulcer
pg 109

Question:
What are the correct ICD-10-CM codes and POA indicator for an unstageable pressure ulcer in which an eschar is removed during the patient's stay to reveal either stage III or stage IV pressure ulcer?

Answer:
If a patient is admitted with an unstageable pressure ulcer, and the eschar is removed to reveal the stage of the ulcer, assign the code for the ulcer site with the highest stage reported during the stay with a POA indicator of "Y".
Do not assign a code for unstageable pressure ulcer, as the true stage of an unstageable ulcer cannot be determined until the slough/eschar is removed.
The opening of the wound does not indicate a progression to a higher stage.
The code for unstageable pressure ulcer should only be assigned when it is not possible to stage the ulcer during the current encounter.

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Q4 2017 Omitting ICD-10-CM Codes
pg 110

Question:
Coding Clinic, Fourth Quarter 2016, page 149, states "A facility may require that a physician use a particular clinical definition or set of criteria when establishing a diagnosis".
Would it be appropriate for facilities to develop a policy to omit a diagnosis code based on the provider's documentation not meeting established criteria?

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Q4 2017 Omitting ICD-10-CM Codes
pg 110

Answer:
No.
It is not appropriate to develop internal policies to omit codes automatically when the documentation does not meet a particular clinical definition or diagnostic criteria.
Facilities may review documentation to clinically validate diagnoses and develop policies for querying the provider for clarification to confirm a diagnosis that may not meet particular criteria.
Facilities should also work with their medical staff to ensure conditions are appropriately diagnosed and documented.
If after querying, the attending physician affirms that a patient has a particular condition in spite of certain clinical parameters not being met, the facility should request the physician document the clinical rationale and be prepared to defend the condition if challenged in an audit.
The facility should assign the appropriate code(s) for the conditions documented.

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Guideline A.19.

19. Code assignment and Clinical Criteria

The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists.

The provider's statement that the patient has a particular condition is sufficient.

Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.

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**Q1 2018 Coding of Social Determinants...
Pg 18**

Question:

Is it appropriate to utilize nonphysician documentation to assign codes that provide information on social determinants of health?

For example, codes from categories Z55-Z65, Persons with potential health hazards related to socioeconomic and psychosocial circumstances, provide important information that is typically only found in nurses or social worker documentation.

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**Q1 2018 Coding of Social Determinants...
Pg 18**

Answer:

Categories Z55-Z65, Persons with potential health hazards related to socioeconomic and psychosocial circumstances, represent social information, rather than medical diagnoses.

As such, it is acceptable to report these codes based on information documented by other clinicians involved in the care of the patient.

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Q1 2018 Uncertain diagnosis “Concern for” pg 18

Question:
 The patient is admitted as an inpatient because of confusion. The patient had a computed tomography (CT) of the head, and the attending documented the findings on the discharge summary as follows: “CT head was concerning for subdural empyema.” The patient was empirically treated with antibiotics. The neurologist recommended transfer to an acute care facility for a higher level of care under neurosurgery and magnetic resonance imaging (MRI).
 Is “concern for” a term of uncertainty that allows the “subdural empyema” to be coded, since it was documented at the time of discharge?

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Q1 2018 Uncertain diagnosis “Concern for” pg 18

Answer:
 “Concern for” is a term that should be interpreted as an uncertain diagnosis and coded following the guideline for “uncertain diagnosis” in the inpatient setting.
 Codes are assigned for uncertain diagnoses in the hospital inpatient setting if the diagnosis documented at the time of discharge is qualified as “probable,” “suspected,” “likely,” “questionable,” “possible,” or “still to be ruled out,” or other similar terms indicating uncertainty.

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Q1 2018 Mechanical vent w pt’s own equip pg 13

Question:
 A patient with progressive muscular dystrophy, who is “vent dependent” at night and uses mechanical ventilation as needed during the day, is admitted to the hospital with acute on chronic respiratory failure.
 While in the hospital, the patient was connected to his own ventilator equipment via their tracheostomy tube. The respiratory therapist evaluated and monitored the patient throughout the hospitalization.
 Would it be appropriate to assign an ICD-10-PCS code for the use of the patient’s ventilator?

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Q1 2018 Mechanical vent w pt's own equip pg 13

Answer:
 It is appropriate to report mechanical ventilation, for patients who are admitted to the hospital on a home ventilator, since the patient is still being evaluated and monitored as well as receiving ventilator assistance.
 The patient is utilizing hospital resources, and ownership of the equipment has no bearing on code assignment in this case.
 Count the hours of ventilation according to established guidelines. Begin counting the duration of mechanical ventilation when ventilation starts. For example, if the patient receives mechanical ventilation for 18 hours, assign the following code:
5A1935Z Respiratory ventilation, less than 24 consecutive hours

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Q1 2018 CC Q3 2013 Mech vent w pt's equip

Question:
 We have a patient with progressive muscular dystrophy dependent on mechanical ventilation at night and as needed during the day, who was admitted to the hospital in acute on chronic respiratory failure with acute tracheobronchitis. While in the hospital, the patient was able to connect to his own ventilator via their tracheostomy tube.
 The respiratory therapist did follow the patient during his stay. Since the patient is using his own ventilator, should we report the ventilator procedure code?

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Q1 2018 CC Q3 2013 Mech vent w pt's equip

Answer:
 It would be appropriate to assign a code from subcategory 96.7, Other continuous mechanical ventilation, for patients admitted on a home ventilator, since the patient is still receiving mechanical ventilation and is utilizing significant hospital resources. Begin counting the duration from the time of the admission. The count ends at the time of discharge.
 Ownership of equipment has no bearing on code assignment. Code V46.11, Other dependence on machines, Respirator, should be assigned as an additional code to indicate the dependence on mechanical ventilation.

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Q1 2018 Hyperplastic rectal polyp...
pg 6

Question:
The patient presented for colon cancer screening due to increased risk secondary to family history of colon cancer. During the screening colonoscopy, a rectal polyp was found and removed via hot snare. The pathological findings revealed "hyperplastic polyp with focal adenomatous changes."
Should code
K62.1, Rectal polyp or code
D12.8, Benign neoplasm of rectum, be assigned for a hyperplastic rectal polyp with focal adenomatous changes?

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Q1 2018 Hyperplastic rectal polyp...
pg 6

Answer:
Assign code Z12.11, Encounter for screening for malignant neoplasm of colon, as the first-listed diagnosis.
Assign code D12.8, Benign neoplasm of rectum, as an additional diagnosis for the hyperplastic polyp with focal adenomatous changes.
Code Z80.0, Family history of malignant neoplasm of digestive organs, should also be assigned. This is a definitive finding of an adenomatous polyp. A mixed polyp would be treated clinically as an adenoma, which requires stricter surveillance and follow-up.

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Q1 2018 Hyperplastic rectal polyp...
pg 6

"hyperplastic polyp with focal adenomatous changes"

Index

Polyp, rectal, adenomatous see polyp adenomatous

Polyp, adenomatous see also Neoplasm, benign, by site

Assign code D12.8

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Q1 2018 CC Q1 2017 Hyperplastic polyp

Question:

Coding Clinic, Second Quarter 2015, page 14, advised to assign code K63.5, Polyp of colon, when the physician documents a hyperplastic colon polyp regardless of the location in the colon.

Therefore, would a hyperplastic polyp at any colonic site (e.g., ascending, descending, sigmoid, etc.) be assigned code K63.5, Polyp of colon, even though the ICD-10-CM subcategorizes specific locations of neoplastic polyps?

For example, a patient had a colonoscopy with removal of an ascending colon polyp. No additional information is available regarding histology. Would code D12.2, Benign neoplasm of ascending colon, or code K63.5, Polyp of colon, be reported?

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Q1 2018 CC Q1 2017 Hyperplastic polyp

Answer:

ICD-10-CM does not classify adenomatous (neoplastic) polyps of the colon the same as hyperplastic polyps.

Code K63.5 describes a hyperplastic polyp and is the default when the type of polyp is not specified as adenomatous/neoplastic.

Hyperplastic polyps, by definition, are not neoplastic, and are typically followed on a much different surveillance protocol than adenomatous polyps.

Category D12, Benign neoplasm of colon, rectum, anus and anal canal, classifies neoplastic polyps according to anatomic location.

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Q2 2018 Intra-aortic balloon pump pg 3

Coding Clinic provides an in depth clinical summary of IABP use

This Coding Clinic issue reminds us:

- ICD-10-PCS does not recognize an IABP as a device
- the root operation 'Assistance' is used to report the presence of an IABP rather than 'insertion' or 'removal'

3 questions and answers help explain current IAPB reporting

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Q2 2018 Intra-aortic balloon pump pg 4

Q:
 An IABP is used for cardiovascular support during a PCI procedure and removed at the conclusion of the procedure.
 Should we report the IABP that is used during the procedure and if so, what ICD-10-PCS procedure code best describes the procedure?

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Q2 2018 Intra-aortic balloon pump pg 4

A:
 In addition to the codes for the PCI procedure, the IABP use is reported:
5A02210 Assistance with cardiac output, continuous, IABP

5A0

Section	5 Extracorporeal or Systemic Assistance and Performance		
Body System	A Physiological Systems		
Operation	0 Assistance: Taking over a portion of a physiological function by extracorporeal means		
Body System	0 Donator	1 Function	0 Assayer
2 Cardiac	1 Incessant	1 Output	0 Portable Pump
	2 Continuous		5 Pulsatile Compression
			6 Core Pump
			0 Impactor Pump

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Q2 2018 IABP guidance update

Reminder:
 This CC advice updates guidance published in CC Q3 2013 pgs 18-19.

Q3 2013:
 Typically, auxiliary procedures done solely to support the performance of a surgical procedure are not coded separately. **Cardiopulmonary bypass is an exception.**

Q2 2018 pg 4 adds:
 Typically, auxiliary procedures done solely to support the performance of a surgical procedure are not coded separately. **However, cardiopulmonary bypass and IABP are exceptions.**

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Q2 2018 Intra-aortic balloon pump pg 4

Q:

An IABP remains in place at the conclusion of surgery and is removed later that day.

Is a code for Removal of the IABP assigned in addition to Assistance?

A:

Code the IABP as follows:

5A02210 Assistance with cardiac output using balloon pump, continuous

Removal of a device is not reported because as previously indicated an IABP is never classified as a device for ICD-10-PCS.

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Q2 2018 Intra-aortic balloon pump pg 5

Q:

A patient is transferred from Hospital A to Hospital B with an IABP in place. After a few days, the patient no longer requires this form of support and the IABP is removed.

Can Hospital B report the Assistance by IABP if the Assistance was initiated at Hospital A?

Should Hospital B also report the IABP removal?

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Q2 2018 Intra-aortic balloon pump pg 5

A:

The IABP Assistance should be reported by Hospital B using code:

5A02210 Assistance with cardiac output using balloon pump, continuous

Removal of a device is not reported because as previously stated an IABP is not classified as a device for ICD-10-PCS and therefore cannot be reported as a Removal of a device.

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Q2 2018 Diabetes with arthropathy pg 6

Q:
 How should we code the diagnosis of type 2 DM and arthritis where the provider's documentation does not link the two conditions?
 At the main term Diabetes, the ICD-10-CM Index provides an entry under the subterm 'with arthropathy NEC'.
 Arthritis is a form of arthropathy, therefore, is E11.618 the correct code to report this condition?

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Q2 2018 DM with arthropathy pg 6

A:
 No, E11.618 is not correct in this instance. Remember that the 'not elsewhere classified' (NEC) index entries are exempt from the application of the 'with' guideline.
 Use of the NEC code can only occur when a link is made in the documentation between the two conditions with phrases such as 'with,' 'due to' or 'associated with.'
 A causal relationship cannot be assumed when the diabetic complication is 'NEC.'
 Keep in mind that this advice was published in CC Q4 2017 pgs 100 and 101 pertaining to Diabetes and skin complications.

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Q2 2018 DM with peripheral angiopathy pg 7

Q:
 How should the diagnosis of type 2 DM and peripheral arteriosclerosis or peripheral vascular disease be coded when the provider has not linked the two conditions?
 Can the code for DM with peripheral angiopathy be assigned?
 We ask because this code is not an NEC code.

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Q2 2018 DM with peripheral angiopathy pg 7

A:
 Yes, the code for DM with angiopathy should be assigned.
 Peripheral vascular disease, peripheral arteriosclerosis and peripheral arterial disease are all forms of angiopathy and should be linked in a diabetic patient and reported using the code for Diabetes with angiopathy.

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Q2 2018 Observation for suspected burn injury pg 7 & pg 8

Q:
 A patient presents to the ER for a suspected burn injury that may have been caused by hot bathwater. The ER physician evaluated the patient and concluded that there was no burn injury.
 How should this encounter be coded?
 We are considering codes
 Z04.3, Encounter for examination and observation following other accident, or code
 Z04.8, Encounter for examination and observation for other specified reasons?
 Also, should an external cause code from Chapter 20 be reported to provide additional detail about the cause of the suspected injury?

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Q2 2018 Observation for suspected burn injury pg 7 & pg 8

A:
 Code Z04.3, Encounter for examination and observation following other accident should be reported as the first-listed diagnosis in this instance as this code best describes the circumstances of the encounter.
 No external cause code should be assigned because no injury, health condition or adverse effect was found.
 External cause codes are only reported when there is a documented injury.

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Guideline I.C.21.c.6.

Observation

There are three observation Z code categories. They are for use in very limited circumstances when a person is being observed for a suspected condition that is ruled out.

The observation codes are not for use if an injury or illness or any signs or symptoms related to the suspected condition are present.

In such cases the diagnosis/symptom code is used with the corresponding external cause code.

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Tabular list Z04 inclusion note

Z04 Encounter for examination and observation for other reasons

Includes: encounter for examination for medicolegal reasons

This category is to be used when a person without a diagnosis is suspected of having an abnormal condition, without signs or symptoms, which requires study, but after examination and observation, is ruled-out. This category is also for use for administrative and legal observation status.

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Guideline I.C.20.a.1.

Used with any code in the range of A00.0-T88.9 Z00-Z99

An external cause code may be used with any code in the range of A00.0-T88.9, Z00-Z99, classification that represents a health condition due to an external cause.

Though they are most applicable to injuries, they are also valid for use with such things as infections or diseases due to an external source, and other health conditions, such as a heart attack that occurs during strenuous physical activity.

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Q2 2018 Observation for suspected injury following MVA pg 7 & pg 8

Q:
 The car in which a one year old was a passenger was involved in a minor accident. The infant exhibited no symptoms as a result of the accident but parents felt it appropriate to have the child examined by a physician. The evaluation was negative for any injuries.
 What code or codes should be assigned to best describe this encounter?
 Is an External Cause code necessary?

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Q2 2018 Observation for suspected injury following MVA pg 7 & pg 8

A:
 Code Z04.1, Encounter for examination and observation following transport accident, should be reported as the first-listed diagnosis in this instance as this code best describes the circumstances of the encounter.
 No external cause code should be assigned because no injury, health condition or adverse effect was found.
 External cause codes are only reported when there is a documented injury.

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Q2 2018 Carotid artery stenosis & TIA pg 9

Q:
 A patient is admitted for evaluation of several neurological symptoms and after study is diagnosed with a TIA caused by bilateral carotid stenosis.
 The Excludes1 note under category I65-, Occlusion and stenosis of precerebral arteries, not resulting in cerebral infarction, requires that we report I65- and not assign an additional code for the TIA.
 Our facility's stroke team is troubled that without the TIA code, their efforts are not recognized.
 Despite the Excludes1 note explicit instructions that code I65- excludes G45- can we assign codes for both the carotid stenosis and the TIA?

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Q2 2018 Carotid artery stenosis & TIA
pg 9

A:
No.
Code only I65.23, Occlusion and stenosis of bilateral carotid arteries.
The Excludes1 note requires that the TIA not be reported with an additional code as the cause of the TIA is stated to be the carotid artery stenosis.

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Guidelines

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).

The diagnosis codes (Tabular List and Alphabetic Index) have been adopted under HIPAA for all healthcare settings.

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Q2 2018 Takosubo Syndrome with hypertension
pgs 9 & 10

Q:
A patient with known hypertension is admitted with cardiac symptoms.
The physician's final diagnosis states that the patient has Takosubo syndrome and hypertension.
Carefully following the conventions of the classification in the Index to Diseases and Tabular List, we are led to code I11.9, Hypertensive heart disease without heart failure because the Excludes1 note at category I51 indicates that Takosubo Syndrome I51.81 is classified as a form of hypertensive heart disease.
How can we correctly report Takosubo Syndrome and hypertension?

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Q2 2018 Takosubo Syndrome with hypertension pgs 9 & 10

A:
 Takosubo Syndrome and hypertension are correctly reported with codes I51.81 and I10.
 By definition, Takosubo Syndrome is caused by severe stress not hypertension.
 Therefore, documentation of Takosubo Syndrome means that the physician is stating that this cardiomyopathy is not caused by hypertension.
 For this reason, the 'with' guideline is not applied here.

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Excludes1 notes

I51 Complications and ill-defined descriptions of heart disease
Excludes1: any condition in I51.4-I51.9 due to hypertension (I11.-)

I11 Hypertensive heart disease
Includes: any condition in I50.-, I51.4-I51.9 due to hypertension

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Guideline I.A.15

“With”
 The word “with” or “in” 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**
 or when another guideline exists that specifically requires a documented linkage between two conditions (e.g., sepsis guideline for “acute organ dysfunction that is not clearly associated with the sepsis”).

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Q2 2018 Recreational marijuana use
pg 11

Q:
Should recreational marijuana use be coded when documented by the patient's provider?

A:
No, a code for the marijuana use is not assigned unless the provider documents an associated physical, mental, or behavioral disorder in accordance with Guideline I.C.5.b.3. This guideline states "As with all other diagnoses, the codes for psychoactive substance use (F10.9-, F11.9-, F12.9-, F13.9-, F14.9-, F15.9-, F16.9-) should only be assigned based on provider documentation and when they meet the definition of a reportable diagnosis (see Section III, Reporting Additional Diagnoses). The codes are to be used only when the psychoactive substance use is associated with a physical, mental or behavioral disorder, and such a relationship is documented by the provider."

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Q2 2018 Prescribed opiates for pain management pgs 11 & 12

Q:
Medical record documentation indicates the patient is taking opioids prescribed by their physician for treatment of chronic pain. Does Guideline I.C.5.b.3. mean that codes cannot be assigned for the opioid use unless there is a documented an associated physical, mental or behavioral disorder?

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Q2 2018 Prescribed opiates for pain management pgs 11 & 12

A:
A code for the use of prescription opiates would not be reported because there is no associated physical, mental or behavioral disorder.

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Guideline I.C.21.c.3.

Z79 Long-term (current) drug therapy

Codes from this category indicate a patient's continuous use of a prescribed drug (including such things as aspirin therapy) for the long-term treatment of a condition or for prophylactic use.

Assign a code from Z79 if the patient is receiving a medication for an extended period as a prophylactic measure (such as for the prevention of deep vein thrombosis) or as treatment of a chronic condition (such as arthritis) or a disease requiring a lengthy course of treatment (such as cancer).

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Q2 2018 Sessile serrated polyp pg 14

Q:
How is the diagnosis of sessile serrated polyp of the ascending colon coded?
Is this type of polyp considered to be hyperplastic or adenomatous?

A:
A sessile serrated polyp is a form of adenoma and is classified as a benign neoplasm.
The instructional term under the main term Adenoma says "see Neoplasm benign by site."
Code D12.2, Benign neoplasm of ascending colon, should be assigned for the diagnosis of a sessile serrated polyp of the ascending colon.

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Q2 2018 Degenerative changes of cervical spine pg 14

Q:
The final interpretation of an outpatient radiology report indicates a diagnosis of degenerative changes of the cervical spine.

How should this diagnosis be coded?

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Q2 2018 Degenerative changes of cervical spine pg 14

A:
 Code M47.812, Spondylosis without myelopathy or radiculopathy, cervical region should be reported per the ICD-10-CM Index to Diseases.

Degeneration, degenerative changes, spine or vertebrae - see Spondylosis
 Degeneration, degenerative joint disease - see Osteoarthritis
 Osteoarthritis spine - see Spondylosis

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Q2 2018 Degenerative changes of bilateral hips pg 15

Q:
 The final interpretation of an outpatient radiology report indicates a diagnosis of degenerative changes of hips bilaterally.
 How should this diagnosis be coded?

A:
 Code M16.0, Bilateral primary osteoarthritis of hip should be reported for this diagnosis.
 Degeneration, degenerative joint disease - see Osteoarthritis

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Q2 2018 Discogenic degenerative changes pg 15

Q:
 The final interpretation of an outpatient radiology report indicates a diagnosis of discogenic degenerative changes of the lumbar spine at level L3-L4.
 How should this diagnosis be coded?

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Q2 2018 Discogenic degenerative changes pg 15

A:
 Code M51.36, Other intervertebral disc degeneration, lumbar region should be reported for this diagnosis. The diagnosis of discogenic degenerative changes means there is degeneration of the intervertebral discs.
 Degeneration, degenerative
 intervertebral disc
 lumbar region M51.36

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“Changes”

Coding Clinic instructed us in the Q1 2017, pages 6 and 7, that a hyperplastic polyp with focal adenomatous changes is classified as an adenoma, indicating “changes” is considered diagnostic of a condition.

This guidance prompted the question: does this guidance apply to all diagnostic statements of “changes”.

By means of these three questions and answers Coding Clinic is telling us that the term “changes” should be interpreted to mean “diagnostic of” and coded as though the condition exists.

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Q2 2018 UTI with hydronephrosis due to obstructing ureteral calculus pg 21

Q:
 A patient is discharged from the hospital with a final diagnosis of UTI with hydronephrosis due to an obstructing ureteral calculus.
 How should this diagnosis be coded?

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Q2 2018 UTI with hydronephrosis due to obstructing ureteral calculus pg 21

A:
 Code N13.6, Pyonephrosis to correctly report final diagnosis of UTI with hydronephrosis due to an obstructing ureteral calculus.
 An additional code for the UTI is not reported per the inclusion terms under N13.6 stating this code includes an obstructive uropathy with infection and to use an additional code only to report the organism.

Hydronephrosis
 -with
 --obstruction
 ---ureteral NEC
 ----calculus
 -----with infection N13.6

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Tabular list N13.6

N13.6 Pyonephrosis
 Conditions in N13.0-N13.5 with infection
 Obstructive uropathy with infection

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

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Q2 2018 Kennedy terminal pressure ulcer pgs 21 & 22

Q:
 A full thickness pressure ulcer develops in a terminally patient. The progress notes and discharge summary indicate this pressure ulcer to be a Kennedy ulcer.
 The ICD-10-CM index does not have an entry for this condition.
 How should this Kennedy pressure ulcer be coded?

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Q2 2018 Kennedy terminal pressure ulcer pgs 21 & 22

A:
At the present time, a Kennedy pressure ulcer should be coded as any other pressure ulcer using a code from category L89.
This type of ulcer presents due to multiple organ failure in terminally ill patients.
Given its cause, this pressure ulcer is difficult to treat successfully.
Because Kennedy terminal pressure ulcers differ from other pressure ulcers in terms of etiology and outcome, there are hopes that the C&M committee will create a new code for this condition in upcoming years.

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Questions?

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