BILATERAL LOWER SACROILIAC DJD

Question:

A patient is diagnosed with bilateral lower sacroiliac degenerative joint disease (DJD). When referencing the Index to Diseases under Degenerative, joint disease, ICD-10-CM directs the coding professional to see "Osteoarthritis." However, the Index to Diseases does not specifically classify osteoarthritis (OA) of the sacroiliac joint. What is the appropriate code assignment for bilateral lower sacroiliac degenerative joint disease (DJD)?

Answer:

Assign code M46.1, Sacroiliitis, not elsewhere classified. DJD of the sacroiliac joint is caused by degeneration, leading to inflammation of the sacroiliac joint. Currently, the ICD-10-CM does not have a unique code for DJD of the sacroiliac joint; therefore, code M46.1 is the closest available alternative. The National Centers for Health Statistics has agreed to consider a future ICD-10 Coordination and Maintenance (C&M) proposal for creation of a new code for DJD/osteoarthritis of the sacroiliac joint.

LONG TERM USE OF TOPICAL/INTRANASAL STEROID

Question:

What is the appropriate diagnosis code for long-term (current) use of a topical intranasal steroid, such as Flonase®? Even though it is administered intranasal, would Flonase® be considered an inhaled steroid?

Answer:

Assign code Z79.899, Other long-term (current) drug therapy, for the long-term use of a topical/ local intranasal steroid, such as Flonase®.

While Flonase® is classified as a corticosteroid, it is not considered an inhaled steroid (administrated by an inhaler or nebulizer into lungs), nor a systemic steroid (given orally or by injection and distributed throughout the body).

OMMAYA RESERVOIR WITH VENTRICULAR CATHETER

Question:

A patient with a history of acute myeloblastic leukemia presented with an intracranial recurrence. An Ommaya reservoir with ventricular catheter was placed for the intrathecal delivery of medication. A previous twist drill hole in the skull was expanded around the Ommaya reservoir and was able to fit into a bony pocket but the inner cortical bone was not expanded beyond the twist drill hole. Next, a ventricular catheter was attached to the reservoir and the other end was navigated via the drill hole into the foramen of Monro. What is the appropriate ICD-10-PCS code for insertion of an Ommaya reservoir intra-cranially for delivery of medication?

OMMAYA RESERVOIR WITH VENTRICULAR CATHETER

Answer:

Assign the following ICD-10-PCS codes

00H633Z Insertion of infusion device into cerebral ventricle, percutaneous approach, for the insertion of the catheter portion of the Ommaya into the cerebral ventricle; and

0JHS33Z Insertion of infusion device into head and neck subcutaneous tissue and fascia, percutaneous approach, for the placement of the Ommaya reservoir portion into the bony pocket of the skull.

Although the reservoir was placed in the skull, there is no specific device value for infusion device that corresponds to the body part value describing skull bone; therefore, the **closest available equivalent is head and neck subcutaneous tissue and fascia**.

An Ommaya reservoir is a surgically implanted dome-shaped device that provides direct access to the cerebrospinal fluid (CSF) for the administration of medication, such as chemotherapy and antibiotics. The device also enables sampling of CSF and consists of a small port that is placed underneath the skull, which is attached to a catheter and threaded into the ventricle of the brain.

SEQUENCING SEPSIS DUE TO VAP

Question:

A patient with a complicated past medical history is admitted for severe sepsis due to ventilator-associated pneumonia (VAP). The VAP is due to Escherichia coli and methicillin susceptible Staphylococcus aureus. Would VAP be considered a complication or a localized infection? What are the appropriate code assignments and sequencing of sepsis due to VAP?

Answer:

The VAP is the localized infection, which is sequenced after the underlying systemic infection, sepsis.

In this case, sequence either code A41.51, Sepsis due to Escherichia coli [E. coli], or A41.01, Sepsis due to Methicillin susceptible Staphylococcus aureus, as the **principal diagnosis**.

Codes J95.851, Ventilator associated pneumonia, and R65.20, Severe sepsis without septic shock, should be assigned as **additional diagnoses**.

The *Official Guidelines for Coding and Reporting,* Section I.C.1.d.4, states, "**If the reason for admission is sepsis or severe sepsis and a localized infection, such as pneumonia or cellulitis, a code for the underlying systemic infection should be assigned first and the code for the localized infection should be assigned as a secondary diagnosis**."

FOURNIER'S GANGRENE

Question:

The patient, who is a type 2 diabetic, presents with Fournier's gangrene. The Alphabetic Index under the main term "diabetes" provides a subentry "with gangrene." Does this subentry include Fournier's gangrene? What are the appropriate code assignments for Fournier's gangrene in a diabetic patient?

Answer:

No, **Fournier's gangrene is not a type of diabetic gangrene**. In this case, there is no documentation of a peripheral angiopathy (circulatory disorder). The Alphabetic Index under diabetes with gangrene leads to code E11.52, Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene. Although diabetes may predispose some patients to develop Fournier's gangrene, this is not a diabetic gangrene nor a peripheral angiopathy, which progresses more slowly and occurs secondary to circulatory issues. Fournier's is a bacterial necrotizing soft tissue infection, which can occur due to trauma, postoperative complications, or other causes.

Assign codes **N49.3, Fournier gangrene, and E11.9, Type 2 diabetes mellitus without complications**. Assign an additional code from categories B95-B97 to identify the infectious agent, if known.

CHRONIC NON PRESSURE ULCER AND LEVEL OF EXPOSURE

Question:

A patient with Type 2 diabetes mellitus presents to outpatient wound care for debridement of a chronic non-pressure ulcer of the right heel. The provider documented that the ulcer was necrotic with exposed subcutaneous tissue. For the purposes of code assignment, should documentation of "subcutaneous tissue exposure" be interpreted to mean fat level exposure?

Answer:

Yes. The subcutaneous tissue includes the fat layer. Assign codes E11.621, Type 2 diabetes mellitus with foot ulcer, and L97.412, Non-pressure chronic ulcer of right heel and midfoot with fat layer exposed, for the right heel non-pressure ulcer.

OUTPATIENT SETTING: CODING PRESSURE ULCERS TO HIGHEST DEGREE OF CERTAINTY

Question:

A patient presented to wound care for debridement of a non-pressure chronic ulcer of the left lateral foot. The ulcer is documented as having visible skin breakdown prior to debridement and visible subcutaneous tissue without necrosis, post-debridement. In the outpatient setting, when a non-pressure chronic ulcer is documented as one severity pre-debridement and a different severity post-debridement, are one or two codes reported? If one, which severity level is assigned?

Answer:

Assign only code, L97.512, Non-pressure chronic ulcer of other part of right foot with fat layer exposed. The subcutaneous tissue includes the fat layer. **In the outpatient setting, codes are assigned to the highest degree of certainty for that encounter/visit, which is similar to coding the post-operative diagnosis**.

Excisional debridement is typically done layer-by-layer to excise all devitalized tissue until all non-viable tissue has been removed. Therefore, **following debridement, the true depth of the ulcer can appear deeper, as its full extent will be uncovered**. This is not the same as ulcer progression and does not indicate the ulcer has progressed or worsened.

The guideline requiring two codes for ulcers that progress to another severity **does not apply to the outpatient setting**. The guideline was intended for inpatient hospital reporting to allow the most accurate reporting of the present on admission (POA) indicator in order to track the change in severity during an inpatient admission.

HISTORY RECURRENT DVT AND ANTICOAGULANT TREATMENT

Question:

A 79-year-old patient presents for a follow-up visit for multiple conditions, including personal history of recurrent deep vein thrombosis (DVT) of the lower extremity. The patient was initially anticoagulated with Coumadin but was switched to Xarelto®.

Some coding professionals at our facility feel that a diagnosis of history of recurrent DVT in a patient on anticoagulation therapy should be coded as a chronic DVT. However, other coding professionals believe that history of recurrent DVT without any further specification should be reported with the default code assignment of acute DVT. What is the appropriate code assignment for personal history of recurrent deep vein thrombosis of the lower extremity?

Answer:

Based on the health record documentation, assign codes **Z86.718**, Personal history of other venous thrombosis and embolism, and **Z79.01**, Long term (current) use of anticoagulants, for history of recurrent deep vein thrombosis of the lower extremity on long term use of anticoagulant medication. In this case, the patient presented for a follow-up visit and had no evidence of an acute, current or recurrent DVT nor complications from the thrombus.

Chronic DVT is a thrombus that is one month to several months old and usually involves symptoms, such as chronic swelling, ulceration, cellulitis, or other complication.

Recurrent DVT indicates the condition has occurred more than once. The provider would need to document recurrent or chronic DVT, to code it as such.

RETROLISTHESIS

Question:

How is a diagnosis of retrolisthesis coded? Retrolisthesis is not indexed in ICD-10- CM; however, it appears to be a form of spondylolisthesis.

Answer:

Assign the appropriate code from subcategory **M43.1**, Spondylolisthesis. Retrolisthesis refers to backward slippage of a vertebra, and ICD- 10-CM classifies any slippage of the vertebra as a spondylolisthesis.

PICC LINE DISPLACEMENT

Question:

A 61-year-old patient was recently admitted for chronic osteomyelitis and abscess of the left distal femur. During that previous admission, she underwent incision and drainage of the abscess and placement of a peripherally inserted central catheter (PICC). The patient was discharged to a skilled nursing facility, where she pulled out the PICC line. She was transported to the emergency department and the provider documented "PICC line displacement." The patient was readmitted, and Interventional Radiology replaced the PICC line. What is the correct diagnosis code assignment for a displaced PICC line?

Answer:

Assign code **T82.524A**, Displacement of infusion catheter, initial encounter, for the displaced PICC line. Although the patient displaced her own catheter, it is not positioned in the intended vessel, and is appropriately coded as a complication. Code **Z45.2**, Encounter for adjustment and management of vascular access device, would not be assigned, as this code assignment is only used for routine encounters for catheter care.

STRANGULATED RECURRENT INCISIONAL HERNIA WITH NECROTIC BOWEL AND PERFORATION

Question:

What are the appropriate diagnosis codes for a strangulated recurrent incisional hernia with necrotic bowel and perforation? Would multiple codes be assigned to capture the patient's conditions?

Answer:

Assign codes **K43.1**, Incisional hernia with gangrene, and **K63.1**, Perforation of intestine (nontraumatic), for the recurrent incisional hernia with necrotic small bowel and perforation, to fully capture the patient's condition.

ANASTOMOTIC DEHISCENCE OF THE SMALL BOWEL TO THE TRANSVERSE COLON

Question:

A patient who is status post colectomy presents with chills, abdominal pain, and fever. On examination, he was found to have feculent wound drainage and was diagnosed with anastomotic dehiscence of the small bowel to the transverse colon. Coding professionals can arrive at different codes, based on how the condition is referenced in the Index (Dehiscence-internal operation wound vs. Complication-anastomosis). What is the appropriate code assignment for an anastomotic dehiscence of the small bowel to the transverse colon?

Answer:

Assign codes **K91.89**, Other postprocedural complications and disorders of digestive system, and **T81.32XA**, Disruption of internal operation (surgical) wound, not elsewhere classified, initial encounter, for the dehiscence of the intestinal anastomosis.

Both codes are needed to fully describe the patient's condition. The note found at code K91.89 instructs to use an additional code to further specify the disorder.

Although guideline I.C.19.g.5 indicates complications specifically indexed to a T code in chapter 19 would not be assigned a complication code from a body system chapter, in this case, code **K91.89 provides information about the body system involved that is not captured in the T code.**

CODING SINUS BRADYCARDIA AND PREMATURE VENTRICULAR BEATS

Question:

A patient presented with palpitations and presyncopal symptoms, which he experienced while going from a sitting to standing position. The provider diagnosed sinus bradycardia and multiple premature ventricular contractions. Code I49.3, Ventricular premature depolarization, cannot be assigned with code R00.1, Bradycardia, unspecified, based on the Excludes1 note at category I49-, Other cardiac arrhythmias. However, there is an Excludes 2 note at category R00-, Abnormalities of heart beat, which allows the reporting of codes in that category with specified arrhythmias (I47-I49). Should codes for sinus bradycardia and premature ventricular contractions be assigned together?

Answer:

Assign **both** code **I49.3**, Ventricular premature depolarization, and code **R00.1**, Bradycardia, unspecified.

Although there is an Excludes1 note at category I49-, Other cardiac arrhythmias, for sinus bradycardia, these are distinct (unrelated) cardiac conditions, which **can exist independently**. **In order to convey the complete clinical picture, code both conditions**.

UNRESPONSIVENESS DUE TO DILAUDID

Question:

The patient became unresponsive after receiving intravenous Dilaudid. The provider documented "Unresponsiveness due to Dilaudid." How is this diagnosis coded?

Answer:

Assign codes **R40.4,** Transient alteration of awareness, and **T40.2X5A**, Adverse effect of other opioids, initial encounter.

LEPTOMENINGEAL CYSTS

Question:

A 15-year-old male presented with a growing mass on the right side of his head.   After diagnostic workup, the provider documented "Craniofacial deformity secondary to leptomeningeal cyst/growing skull fracture." He underwent frontotemporal craniotomy with periosteal dural graft for repair of growing skull fracture. What are the appropriate diagnosis code assignments for leptomeningeal cyst/ growing skull fracture?

Answer:

Assign code **G93.89**, Other specified disorders of brain, for leptomeningeal cyst. Also, assign code **S02.91XS**, Unspecified fracture of skull, sequela, since the leptomeningeal cyst/growing skull fracture is a late effect of the fracture.

Leptomeningeal cysts, also called growing skull fractures, are **expanding skull fractures that develop near post-traumatic encephalomalacia**. The term "leptomeningeal cyst" is a misnomer, because it is not a cyst, but an extension of the encephalomalacia, and is typically seen several months post-trauma, and usually develops following linear fracture with an underlying dural tear, and may result in herniation of the brain.

FOR TRANSORAL ZENKER'S DIVERTICULECTOMY

Question:

A patient is admitted for transoral Zenker's diverticulectomy. During surgery, the scope was positioned, and an endovascular gastrointestinal stapler was passed transorally with the staple load in the true esophagus and the anvil in the diverticulum pouch. The stapler was engaged and fired. Repeat endoscopy confirmed the common channel had been appropriately managed with resolution of the Zenker's diverticulum. What is the ICD-10-PCS code assignment for this procedure?

Answer:

Assign the following procedure code:

0K844ZZ Division of tongue, palate, pharynx muscle, percutaneous endoscopic approach, for division of the cricopharyngeus muscle.

In Zenker's diverticulum, the pharyngeal muscle is too tight and squeezes the pharynx, so that it bulges above the esophagus and forms a pouch. The goal of surgery is to sever the common wall between the esophageal lumen and the diverticulum containing the cricopharyngeus muscle in order to create a common cavity between the esophagus and the diverticulum. Stapling of the common wall results in cricopharyngeal myotomy and fusion of the pouch lumen and esophagus.

The percutaneous endoscopic approach value is assigned because the approach value, via natural or artificial opening endoscopic, is not available in the ICD-10-PCS table 0K8, Division of Muscles.

EXCISIONAL AND NONEXCISIONAL DEBRIDEMENT OF THE SAME SITE AND DEPTH

Question:

A patient, who is diagnosed with a stage IV sacral decubitus ulcer and wet gangrene, underwent excisional and nonexcisional debridement, down to and including muscle, fascia, and bone. Since debridement of necrotic gangrenous tissue appears to be the sole objective of the procedure, the multiple procedure guideline does not appear to apply. What is the appropriate code assignment for excisional and nonexcisional debridement of the same site and depth?

Answer:

Assign the following procedure code:

0QB10ZZ Excision of sacrum, open approach, for excisional and nonexcisional debridement of the sacrum down to and including muscle, fascia, and bone.

Excision is the definitive treatment performed at the site, and when both excisional and nonexcisional debridement of the same site are performed, only the excisional debridement code is reported.

NON-EXCISIONAL DEBRIDEMENT OF THE KNEE

Question:

A patient presents with a painful knee, status post right total knee replacement. In the operative suite, arthroscopic manipulation of the right knee was performed under anesthesia to break up the adhesions. Next, arthroscopic inspection revealed peripatellar, suprapatellar, medial, and lateral gutter scar tissue, which was removed by non-excisional debridement. How should non-excisional debridement of the knee be coded since there is no body part value for joint in the root operation Extraction?

Answer:

Assign the following procedure code:

0SNC4ZZ Release right knee joint, percutaneous endoscopic approach, for the release of scar tissue in the knee joint.

Based on the documentation in the operative report, the **procedure was done to release the knee joint**.   In this case, scar tissue was removed to free the joint.

NUVASIVE® VERSATIE® POLYETHYLENE TETHER

Question:

A patient with multiple spinal conditions, including previous fusion, severe kyphoscoliosis, and severe spinal and foraminal stenosis, presents for corrective surgery. Prior fusion instrumentation was removed, new instrumentation was placed, and a new fusion was performed in the lumbar spine.

In addition to the multiple spinal procedures performed, a NuVasive® VersaTie® polyethylene tether was woven through the interspinous ligaments via drill holes that were placed at the base of T8. The tether was returned in a weave fashion and after full tension was achieved, the tie was locked into place to the VersaTie® connectors that were placed at T11-T12. What is the appropriate root operation for placement of tether from T8-T12?

Answer:

Do not assign an additional code for the placement of the VersaTie® tether. **Fixation instrumentation is integral to the fusion procedure and no additional code is assigned.**

SEPSIS DUE TO ASPIRATION PNEUMONIA

Question:

When the provider documents "sepsis due to aspiration pneumonia," is a code for the sepsis, or the aspiration pneumonia assigned as the principal diagnosis?

Answer:

Assign code **A41.9** Sepsis, unspecified organism, as the **principal diagnosis**.

Codes **J18.9**, Pneumonia, unspecified organism, and J69.0, Pneumonitis due to inhalation of food and vomit, should be assigned as **additional diagnoses**.

Sepsis indicates infection and the body's response to it. Aspiration pneumonia may be just from the direct effect of inhaled material, such as a chemical effect, or it may involve infection; however, for sepsis to result, it would need to involve an infectious pneumonia. Therefore, codes J18.9 and J69.0 are both needed to show the presence of a localized infection (pneumonia and unspecified organism) as well as pneumonia due to aspiration.

When sepsis and aspiration pneumonia are related (i.e., sepsis due to aspiration pneumonia or sepsis related to aspiration pneumonia) and present on admission, sepsis should be sequenced as the principal diagnosis.

SEPSIS DUE TO GRAM-NEGATIVE PNEUMONIA

Question:

A patient was discharged with the following diagnoses: 1. sepsis secondary to aspiration pneumonia, 2. aspiration pneumonia secondary to probable gram-negative bacteria. Both diagnoses were present on admission. Should this be coded as sepsis due to gram-negative pneumonia?

Answer:

When sepsis and aspiration pneumonia are related and present on admission, the sepsis should be sequenced as the principal diagnosis.

Assign code **A41.50**, Gram-negative sepsis, unspecified, as the **principal diagnosis**.

Codes **J15.6**, Pneumonia due to other Gram-negative bacteria, and **J69.0**, Pneumonitis due to inhalation of food and vomit, should be assigned as **additional diagnoses**.

The pneumonia is a gram-negative bacterial aspiration pneumonia and is the localized infection that has led to sepsis. Code J69.0 is assigned to capture aspiration pneumonia.

The coding professional should follow **guideline 1.C.1.d.4**, Sepsis and severe sepsis with a localized infection, which states, "**if the reason for admission is both sepsis or severe sepsis and a localized infection, such as pneumonia or cellulitis, a code(s) for the underlying systemic infection should be assigned first and the code for the localized infection should be assigned as a secondary diagnosis**."

GAIT INSTABILITY DUE TO CHRONIC CVA

Question:

An 84-year-old male with chronic gait instability is admitted after a fall. The provider's documentation states that the patient's gait instability is related to chronic cerebrovascular accident (CVA). How is gait instability due to chronic CVA coded?

Answer:

Although the index leads to code I63.9, Cerebral infarction, unspecified, based on the documentation, the patient does not have a current cerebrovascular infarction.

Assign code **R26.89**, Other abnormalities of gait and mobility and code **I69.398**, Other sequelae of cerebral infarction.

The gait instability is coded as a late effect or sequela (neurological deficit), associated with the patient's previous CVA.

DUHRSSEN CERVICAL INCISION

Question:

A patient with twin pregnancy presented with Twin A in a frank breech position too low in the vagina for a cesarean section. The decision was made for a vaginal breech delivery. The head of Twin A was noted to be entrapped in the cervix so a Duhrssen incision was performed to facilitate delivery. After Twin A was delivered, Twin B experienced recurrent prolonged heart decelerations prompting cesarean delivery of Twin B. After surgical closure of the cesarean section, the cervix was examined and bleeding was noted from the Duhrssen incision, which was closed with suture. What ICD-10-PCS code is assigned for a Duhrssen cervical incision and is an additional code assigned for the repair?

Answer:

The purpose of the Duhrssen incision is to widen the opening of the incompletely dilated cervix to facilitate delivery of the trapped fetal head. Although Division is the appropriate root operation, ICD-10-PCS table 0W8 does not provide a body part value for Cervix. Therefore, the root operation Dilation is the closest available option. Coding a Duhrssen incision is similar to coding an episiotomy. **The repair of the incision is integral to the procedure and not coded separately**.

Assign the following ICD-10- PCS code:

0U7C7ZZ Dilation of cervix, via natural or artificial opening, for the Duhrssen incision.

HERNIATION OF THE BRAIN DUE TO TBI

Question:

A patient, who had suffered a traumatic brain injury (TBI) without loss of consciousness secondary to a high-speed motor vehicle accident, developed brain herniation. There is an Excludes1 note that prohibits assigning code G93.5, Compression of brain, with codes from subcategories S06.2, Diffuse traumatic brain injury, and S06.3, Focal traumatic brain injury. How should herniation of the brain due to TBI not further specified be coded?

Answer:

If the physician does not provide further specificity about the type of brain injury, assign codes S06.9X0A, Unspecified intracranial injury without loss of consciousness, initial encounter, and G93.5, Compression of brain. The Excludes1 note prohibits assigning code G93.5 together with codes from subcategories S06.2, Diffuse traumatic brain injury, and S06.3, Focal traumatic brain injury, not subcategory S06.9.

CORRECTION NOTICE
PUERPERAL SEPSIS DUE TO OBSTETRICAL WOUND INFECTION

Question:

In the Fourth Quarter 2018 issue of *Coding Clinic*, page 23, and Second Quarter 2019 issue, page 39, it was advised to report code O85, Puerperal sepsis, in addition to codes O86.02, Infection of obstetrical surgical wound, deep incisional site, and O86.04, Sepsis following an obstetrical procedure, to capture sepsis due to deep incisional infection of cesarean wound. Is code O85 appropriate for sepsis that occurs in the postpartum period regardless of cause, including surgical wound infections? Are all three codes needed to capture sepsis that occurred due to the obstetrical surgical wound infection?

Answer:

Coding Clinic, Fourth Quarter 2018, page 23, and Second Quarter 2019, page 39, advised to assign code O85, Puerperal sepsis, as an additional diagnosis to capture sepsis due to deep incisional infection of cesarean wound. Although the use additional code note at O86.04 instructs to assign an additional code to identify sepsis, puerperal sepsis is a postpartum infection involving the genital tract. Therefore, code O85 is not appropriate. When sepsis is due to an obstetric procedure, assign code O86.04, instead of code O85. Code O86.04 is more specific to the type of infection.

Therefore, assign codes **O86.02**, Infection of obstetrical surgical wound, deep incisional site, and **O86.04**, Sepsis following an obstetrical procedure, for sepsis due to deep incisional infection of cesarean wound.

The *Official Guidelines for Coding and Reporting* for sepsis due to a postprocedural infection state, "For infections following a procedure, a code from T81.40, to T81.43 Infection following a procedure, or a code from O86.00 to O86.03, Infection of obstetric surgical wound, that identifies the site of the infection should be coded first, if known. Assign an additional code for sepsis following a procedure (**T81.44**) or sepsis following an obstetrical procedure (**O86.04**). Use an additional code to identify the infectious agent.

QUESTIONS