Coding Clinic for ICD-10-CM/PCS Update
Wolters Kluwer Law & Business
April 20, 2017

Barry Libman, MS, RHIA, CDIP, CCS, CCS-P, CIC
President, Libman Education
President, Barry Libman Inc.
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  
- Q2 2014  
- Q3 2014  
- Q4 2014  
- Q1 2015  
- Q2 2015  
- Q3 2015  
- Q4 2015  
- Q1 2016  
- Q2 2016  
- Q3 2016  
- Q4 2016  
- Q1 2017
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:

......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
Today’s topics

Sepsis
COPD
Stoma Reversal
Clinical Criteria and Code assignment
DM w Osteomyelitis
Readmission Post MI
HTN and CHF
Toxic Encephalopathy
BMI 19 or less
Manual Reduction of Hernia
TKR
Uncontrolled DM
Postoperative Ileus
The AHA Central Office on ICD-10-CM/PCS has received a number of inquiries about the appropriate coding of “viral sepsis.”

The following guidance has been developed to assist coders in classifying viral sepsis.

Viral sepsis is a systemic infection caused by the presence of a virus in the blood. Although sepsis is most commonly caused by bacterial infection, it may also be caused by virus, fungi, and/or parasites.
Sepsis Coding Issues - Viral Sepsis

Assign code **A41.89**, Other specified sepsis, for a diagnosis of viral sepsis.

Although codes in categories A30-A49 classify bacterial illnesses, ICD-10-CM does not provide a specific viral sepsis code, and **A41.89 is the best available option**. Code **B97.89**, Other viral agents as the cause of diseases classified elsewhere, should also be assigned as an additional code to provide further specificity and convey that the sepsis is due to a viral infection, when the specific type of viral infection is not documented.

A code from subcategory R65.2, Severe sepsis, would not be assigned unless severe viral sepsis or an associated acute organ dysfunction is documented.
Sepsis Coding Issues - Viral Sepsis

**A41.89**, Other specified sepsis (best option)

**B97.89**  Other viral agents as the cause of diseases classified elsewhere, *should also be assigned as an additional code*

Add

R65.20, Severe sepsis without septic shock

or

R65.21 Severe sepsis with septic shock

if documented.
Question:
How would the diagnosis “viral sepsis” be coded in ICD-10-CM?

Answer:
Assign codes
**A41.89**, Other specified sepsis, and
**B97.89**, Other viral agents as the cause of diseases classified elsewhere.
Sepsis secondary to Viral Syndrome

Question:
How would a diagnosis of “sepsis secondary to viral syndrome” be coded?

Answer:
Assign codes:
A41.89, Other specified sepsis, for the viral sepsis along with code
B34.9, Viral infection, unspecified, for the viral syndrome.

In this case, code B34.9 is assigned rather than code B97.89, because “Syndrome, virus,” is specifically indexed to B34.9.
Question:
What are the correct ICD-10-CM codes for a provider’s diagnostic statement of “viral sepsis due to acute viral bronchitis due to influenza A?” The sepsis was present on admission.

Answer:
Assign code A41.89, Other specified sepsis, for a diagnosis of sepsis due to influenza A.
Assign also code J10.1, Influenza due to other identified influenza virus with other respiratory manifestations, and code J20.8, Acute bronchitis due to other specified organisms.

Codes from subcategory J09.X-, Influenza due to identified novel influenza A virus, are intended for a specific strain of influenza A, such as “novel” influenza A, and not the ordinary seasonal influenza A.
Now that flu season is approaching I would like to offer a friendly reminder as to how to code flu. Remember: Influenza A is not the same as Novel Influenza A.

Influenza A is just plain old influenza and coded to J10-, Influenza due to identified influenza virus or J11-, Influenza due to unidentified influenza virus. Influenza A is often documented as being diagnosed on the basis of a nasal swab.

Novel Influenza A is either H1N1 or H5N1 which are both animal-born influenzas (either swine or bird in origin) and are coded to the J09- category.
Question:
How should we report codes for a patient who is admitted with sepsis from influenza with pneumonia?

Answer:
Assign code:
A41.89, Other specified sepsis, for a diagnosis of sepsis due to influenza.

In addition, assign code:
J11.00, Influenza due to unidentified influenza virus with unspecified type of pneumonia, for the influenza with pneumonia.
Sepsis and severe sepsis with a localized infection

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.
Question:
How should sepsis due to Lyme disease be coded?

Answer:
Assign code:
**A41.89**, Other specified sepsis, for a diagnosis of sepsis due to Lyme disease. Although codes A30-A49 classify bacterial illnesses, there is no specific code for sepsis due to Lyme disease.

Assign also code:
**A69.29**, Other conditions associated with Lyme disease.
Question:
How should acute respiratory failure due to severe viral sepsis be coded?

Answer:
Assign code **A41.89**, Other specified sepsis, for a diagnosis of viral sepsis.
Assign also codes
**B97.89**, Other viral agents as the cause of diseases classified elsewhere,
**R65.20**, Severe sepsis without septic shock, and
**J96.00**, Acute respiratory failure, unspecified whether with hypoxia or hypercapnia.
(b) Severe sepsis
The coding of severe sepsis requires a minimum of 2 codes:
first a code for the underlying systemic infection, followed by a code from subcategory R65.2, Severe sepsis.
If the causal organism is not documented, assign code A41.9, Sepsis, unspecified organism, for the infection.
Additional code(s) for the associated acute organ dysfunction are also required.
2016 Sepsis Diagnostic Guidelines

New clinical consensus definitions for sepsis and septic shock were included in the 2016 sepsis diagnostic guidelines developed by a joint task force of the Society of Critical Care Medicine and European Society of Intensive Care Medicine and published in the *Journal of the American Medical Association* (JAMA).

Coders are questioning whether ICD-10-CM codes for sepsis may be assigned based on the new clinical criteria. Coders should never assign a code for sepsis based on clinical definition or criteria or clinical signs alone.

Code assignment should be based strictly on physician documentation (regardless of the clinical criteria the physician used to arrive at that diagnosis).

Refer to the Official Guidelines for Coding and Reporting when assigning codes for sepsis, severe sepsis, and septic shock.
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.
Question:
We have seen the recently issued consensus definitions for sepsis and septic shock.
How and when will this affect the coding of sepsis and septic shock for ICD-10-CM?
Will the Cooperating Parties be modifying the coding guidelines because of the new clinical definitions for sepsis?

Answer:
The coding guidelines are based on the ICD-10-CM classification as it exists today.
Continue to code sepsis, severe sepsis and septic shock using the most current version of the ICD-10-CM classification and the ICD-10-CM Official Guidelines for Coding and Reporting.
Code assignment is based on provider documentation (regardless of the clinical criteria the provider used to arrive at that diagnosis).
Question:
The patient has chronic obstructive pulmonary disease (COPD), and is admitted to the hospital for treatment of lobar pneumonia. Under code J44.10, Chronic obstructive pulmonary disease with acute lower respiratory infection, there is a note instructing: “Use additional code to identify the infection.” Based on this note is the COPD required to be sequenced first?

Answer:
Yes, based on the instructional note, the COPD must be sequenced first. Assign code J44.0, Chronic obstructive pulmonary disease with acute lower respiratory infection, as the principal diagnosis. Code J18.1, Lobar pneumonia, unspecified organism, should be assigned as an additional diagnosis.
Acute Exacerbation of COPD with Pneumonia

Question:
What are the diagnosis code assignments for an acute exacerbation of COPD with pneumonia?
Is it appropriate to assign code J44.0, COPD with acute lower respiratory infection, and code J44.1, COPD with (acute) exacerbation and the code for pneumonia?

Answer:
Yes, it is appropriate to assign both codes (J44.0 and J44.1).

Either code may be sequenced first, based on the reason for the admission.

Assign codes:
J44.0, COPD with acute lower respiratory infection, code
J18.9, Pneumonia, unspecified organism, and code
J44.1, COPD with (acute) exacerbation.

As stated in the ICD-10-CM Official Guidelines for Coding and Reporting in relation to category J44, “An acute exacerbation is a worsening or a decompensation of a chronic condition. An acute exacerbation is not equivalent to an infection superimposed on a chronic condition, though an exacerbation may be triggered by an infection.”
Question:
The patient has an acute exacerbation of chronic obstructive pulmonary disease, and acute bronchitis. What are the diagnosis code assignments?

Answer:
Assign codes
**J44.0**, Chronic obstructive pulmonary disease with acute lower respiratory infection,
**J44.1**, Chronic obstructive pulmonary disease with (acute) exacerbation, and
**J20.9**, Acute bronchitis, unspecified, to fully capture the provider’s diagnostic statement.
Question:
The title of code J44.0 states, “Chronic obstructive pulmonary disease with acute lower respiratory infection.”
What infections are included in “lower respiratory infections?”

Answer:
Acute bronchitis and pneumonia are included, but influenza is not.
Influenza involves both upper and lower respiratory infection. When present with COPD, additional codes should be assigned to specify the infection, such as bronchitis or pneumonia.
Question:

Does the advice published in *Coding Clinic*, Third Quarter 2016, pages 15-16, regarding chronic obstructive pulmonary disease (COPD) and pneumonia apply to all pneumonias, including aspiration pneumonia?

Is the correct sequencing J44.0 and J69.0, in that order, or would the instructional note not apply to aspiration pneumonia and COPD?
Answer:

No, the instructional note at code J44.0, Chronic obstructive pulmonary disease, with acute lower respiratory infection, stating “Use additional code to identify the infection,” does not apply to aspiration pneumonia.

The ICD-10-CM code for aspiration pneumonia does not fall in the “respiratory infection” codes. Code J69.0, Pneumonitis due to inhalation of food and vomit, is under the section titled “Lung diseases due to external agents.” Aspiration pneumonia is an inflammation of the lungs caused by the inhalation of solid and/or liquid matter.
Assign codes J44.9, Chronic obstructive pulmonary disease, unspecified, and J69.0, Pneumonitis due to inhalation of food and vomit, for a patient with chronic obstructive pulmonary disease and aspiration pneumonia.

Sequencing of the two conditions will depend on the circumstances of admission.
Question:
Does the instructional note providing sequencing guidance at code J44.0, Chronic obstructive pulmonary disease with acute lower respiratory infection, apply also to ventilator associated pneumonia?
Answer:

No, the instructional note “Use additional code to identify the infection,” at code J44.0 does not apply to ventilator associated pneumonia. The ICD-10- CM code for ventilator associated pneumonia does not fall in the “respiratory infection” codes. Code J95.851, Ventilator associated pneumonia, is under the section titled “Intraoperative and postprocedural complications and disorders of respiratory system, not elsewhere classified.”
Assign codes J44.9, Chronic obstructive pulmonary disease, unspecified, and J95.851, Ventilator associated pneumonia, for a patient with chronic obstructive pulmonary disease and ventilator associated pneumonia. Sequencing will depend on the circumstances of admission. For example, if the reason for admission is the ventilator associated pneumonia, code J95.851 would be sequenced as principal diagnosis.
Question:
The patient has chronic obstructive pulmonary disease (COPD) with asthma. Is code J44.9, Chronic obstructive pulmonary disease, unspecified, sufficient, or is an additional code needed for the asthma when the asthma is not further specified?
Answer:

If the specific type of asthma is documented, assign an additional code for the asthma. If, however, the type of asthma is not further specified, do not assign code J45.909, Unspecified asthma, uncomplicated, separately. The instructional note under category J44, Other chronic obstructive pulmonary disease, states “code also type of asthma, if applicable (J45-). “Unspecified” isn’t a type of asthma.
Question:
When a patient with asthma and chronic obstructive pulmonary disease has an acute exacerbation of COPD, is the asthma reported as exacerbated or unspecified?

Answer:
If the health record documentation is not clear whether the asthma is acutely exacerbated, query the provider for clarification.

An exacerbation of COPD does not automatically make the asthma exacerbated.
Question:
A patient who is status post liver transplant was admitted for exploratory laparotomy due to intraperitoneal bleeding. A redo of the bile duct anastomosis was performed due to questionable leaking.
The anastomosis was cut out with evidence of excellent bile from the transplanted liver and the anastomosis was re-sutured. What is the correct root operation for revision of the bile duct anastomosis?

Answer:
Assign the following ICD-10-PCS code:
0FQ90ZZ Repair common bile duct, open approach, for re-suture of the common bile duct anastomosis with the common bile duct of the transplanted liver The excision of the anastomosis was done in order to re-suture the anastomosis.
The root operation “Repair” is most consistent with what was done. The bile duct anastomosis was restored to its normal anatomic structure and function.
Provides an in-depth discussion of bowel diversion and reversal procedures

Ileostomy closure (or takedown) is coded using the root operation “Excision.”

During takedown surgery, an incision is made around the stoma, the intestine is pulled out of the abdominal cavity, and both ends of the intestine are excised.
Similarly, during reversal surgery of a transverse or other loop colostomy, an incision is made around the stoma to access the abdomen and the distal colon is identified.

After mobilization, both ends of the intestine are excised and end-to-end anastomosis is done.

Therefore, “Excision” is the appropriate root operation for a transverse loop colostomy takedown.

Occasionally, the divided portions of the colon are just sutured together without any removal, in which case “Repair” would be the appropriate root operation, although this is less commonly done currently.
Closure of a Hartmann (end stoma) is more complex, "Reposition" is the appropriate root operation for a Hartmann closure or other takedown of an end stoma, because it captures the specific objective of the procedure.

The root operation “Reposition” is defined as moving some or all of a body part to a normal or other suitable location.
Coders should note that although the Index entry under “Takedown, Stoma” leads to “Repair,” there are various types of procedures with different root operations for stoma takedown.

Coders should not assign ICD-10-PCS procedure codes based on where the Index directs without further review of the documentation to determine what was actually done.
Question:
A patient with a loop ileostomy is admitted for takedown of an ileostomy.
At surgery, the two open ends of the intestine were excised, and the remaining ends of intestine were reanastomosed in a hand sewn end-to-end fashion.
Is a separate code needed for repair of the abdominal wall? Our surgeons have indicated that repair of the abdominal wall is intrinsic to the stoma closure.
Ileostomy takedown page 5

Answer:
The root operation for ileostomy takedown is "Excision," because part of the ileum is removed. The anastomosis is considered inherent to the surgery and not coded separately. Further, the root operation "Repair" would only be coded when a parastomal hernia is repaired.

Assign the following ICD-10-PCS code:

**0DBB0ZZ**  Excision of ileum, open approach, for the ileostomy takedown
Question:
The patient had creation of a Hartmann end colostomy due to perforated diverticulitis and fecal peritonitis. The patient now presents for laparoscopic Hartmann reversal.

The splenic flexure was mobilized to reach the descending colon, the two ends of the bowel were reconnected (anastomosed) using suture, and the bowel was returned to its proper position in the abdominal cavity.

How is the reversal of the Hartmann end colostomy coded?
Answer:
Assign the following ICD-10-PCS code:

0DSM4ZZ Reposition descending colon, percutaneous endoscopic approach, for the Hartmann reversal

The stoma end and the distal end of the bowel must first be mobilized, and then reanastomosed. After anastomosing (reconnecting) the two ends of the intestine, the bowel is returned to its proper anatomical location within the abdominal cavity.

“Reposition” is the appropriate root operation for a Hartmann closure or other takedown of an end stoma, because it captures the specific objective of the procedure.

The root operation “Reposition” is defined as moving some or all of a body part to a normal or other suitable location.
Question:
The patient had previously undergone colectomy and ileostomy formation due to refractory acute diverticulitis. The patient now presents for reversal of the ileostomy.

The surgeon excised part of the ileostomy site along with adjacent bowel to ensure removal of the diseased portion as well as ensuring that only non-damaged bowel remained. Diseased small bowel was excised including the site of ileostomy. Next, side-to-side anastomosis was carried out. Attention was then turned towards repair of a parastomal hernia.

How should this surgery be coded?
Answer:
Assign the following ICD-10-PCS codes for the ileostomy closure and parastomal hernia repair:

**0DBB0ZZ** Excision of ileum, open approach, for takedown of the ileostomy

**0WQF0ZZ** Repair abdominal wall, open approach, for the repair of the parastomal hernia
Question:

......... the patient is admitted for reversal of Hartmann colostomy. The surgeon listed, “Partial colon resection, coloproctostomy (side to side anastomosis) and reversal of Hartmann colostomy,” in the operative summary. In accordance with Coding Clinic Third Quarter 1997, pages 9-10, our hospital has been routinely coding “bowel resection” with colostomy closure. However, it seems that the bowel resection is inherent to the procedure. How should this case be coded?

Answer:

..... Assign codes 46.52, Closure of stoma of large intestine, for the reversal of the colostomy, 45.79, Other and unspecified partial excision of large intestine, for the partial colon resection .......... When further resection of the colon is performed, an additional code is assigned for the partial colectomy.
If, however, only minor trimming is done in order to freshen-up the edges of the colon for the anastomosis, it would be considered inherent to the total procedure and an additional procedure code is not assigned.
 Repair

• Definition: Restoring, to the extent possible, a body part to its normal anatomic structure and function
• Explanation: Used only when the method to accomplish the repair is not one of the other root operations
• Examples: Colostomy takedown, suture of laceration
.... procedures are coded to the root operation that accurately identifies the objective of the procedure.

The procedures described in the preceding paragraph by ICD-9-CM codes are coded in ICD-10-PCS according to the root operation that matches the objective of the procedure.

By relying on the universal objectives defined in root operations rather than eponyms or specific procedure titles that change or become obsolete, ICD-10-PCS preserves the capacity to define past, present, and future procedures accurately using stable terminology in the form of characters and values.

A root operation value is not dependent on any character but the section for its meaning, and identifies a single consistent objective wherever the third character is defined as root operation.
Stoma Creation & Takedown Procedures

Summary:

In the course of a bowel diversion reversal, if an excision of intestine is performed, the procedure should be coded as an excision.

If no excision of intestine is performed, the reversal procedure alone is reported (e.g., repair, reposition).

If a stomal hernia repair is performed in addition to excision of intestine, both procedures are reported.
Question:
Please explain the intent of the new ICD-10-CM guideline regarding code assignment and clinical criteria that reads as follows:

“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.”

Some are interpreting this to mean that clinical documentation improvement (CDI) specialists should no longer question diagnostic statements that don’t meet clinical criteria. Is this true?
Answer:
Coding must be based on provider documentation.

This guideline is not a new concept, although it had not been explicitly included in the official coding guidelines until now. Coding Clinic and the official coding guidelines have always stated that code assignment should be based on provider documentation. ......

www.LibmanEducation.com
The guideline noted addresses coding, not clinical validation. It is appropriate for facilities to ensure that documentation is complete, accurate, and appropriately reflects the patient’s clinical conditions. Although ultimately related to the accuracy of the coding, clinical validation is a separate function from the coding process and clinical skill.

The distinction is described in the Centers for Medicare & Medicaid (CMS) definition of clinical validation from the Recovery Audit Contractors Scope of Work document and cited in the AHIMA Practice Brief (“Clinical Validation: The Next Level of CDI”) published in the August issue of JAHIMA: “Clinical validation is an additional process that may be performed along with DRG validation.”
Clinical validation involves a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented in the medical record.

Clinical validation may be performed by a clinician (RN, CMD, or therapist).

Clinical validation is beyond the scope of DRG (coding) validation, and the skills of a certified coder.

This type of review can only be performed by a clinician or may be performed by a clinician with approved coding credentials.”
While physicians may use a particular clinical definition or set of clinical criteria to establish a diagnosis, **the code is based on his/her documentation, not on a particular clinical definition or criteria.**

In other words, regardless of whether a physician uses the new clinical criteria for sepsis, the old criteria, his personal clinical judgment, or something else to decide a patient has sepsis (and document it as such), the code for sepsis is the same—as long as sepsis is documented, regardless of how the diagnosis was arrived at, the code for sepsis can be assigned.

Coders should not be disregarding physician documentation and deciding on their own, based on clinical criteria, abnormal test results, etc., whether or not a condition should be coded.
For example, if the physician documents sepsis and the coder assigns the code for sepsis, and a clinical validation reviewer later disagrees with the physician’s diagnosis, that is a clinical issue, but it is not a coding error.

By the same token, coders shouldn’t be coding sepsis in the absence of physician documentation because they believe the patient meets sepsis clinical criteria.

A facility or a payer may require that a physician use a particular clinical definition or set of criteria when establishing a diagnosis, but that is a clinical issue outside the coding system.
Question:

*Coding Clinic*, Fourth Quarter 2013, page 114, indicated that ICD-10-CM does not presume a linkage between diabetes and osteomyelitis and that the provider would need to document a linkage or relationship between the two conditions before it can be coded as such.

Is this still true?
Answer:

No, effective October 1, 2016, the Index has been revised as follows:

Diabetes, diabetic (mellitus) (sugar) E11.9
with
osteomyelitis E11.69
The subterm “with” in the Index should be interpreted as a link between diabetes and any of those conditions indented under the word “with.”

The physician documentation does not need to provide a link between the diagnoses of diabetes and osteomyelitis to accurately assign code E11.69, Type 2 diabetes mellitus with other specified complication.

This link can be assumed since osteomyelitis is now listed under the subterm “with.”

These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the osteomyelitis is unrelated and due to some other underlying cause besides diabetes.
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.
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
Question:

A patient, who is three weeks post-acute myocardial infarction, is readmitted for treatment of exacerbated chronic obstructive pulmonary disease and acute bronchitis. During the hospital stay, the patient is continued on cardiac medications.

Based on chapter 9 of the *ICD-10-CM Official Guidelines for Coding and Reporting* would the myocardial infarction still be coded as acute with a code from category I21, or would this be considered history of myocardial infarction?
Answer:

Continue to assign a code from category I21, ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction, **as the patient is within four weeks of the initial acute myocardial infarction.**

The updated *ICD-10-CM Official Guidelines for Coding and Reporting* for acute myocardial infarction state “For encounters occurring while the myocardial infarction is equal to, or less than, four weeks old, including transfers to another acute setting or a postacute setting, and the myocardial infarction meets the definition for “other diagnoses” (see Section III, Reporting Additional Diagnoses), codes from category I21 may continue to be reported.”
For encounters occurring while the myocardial infarction is equal to, or less than, four weeks old, including transfers to another acute setting or a postacute setting, and the myocardial infarction meets the definition for “other diagnoses” (see Section III, Reporting Additional Diagnoses), codes from category I21 may continue to be reported.

For encounters after the 4 week time frame and the patient is still receiving care related to the myocardial infarction, the appropriate aftercare code should be assigned, rather than a code from category I21. For old or healed myocardial infarctions not requiring further care, code I25.2, Old myocardial infarction, may be assigned.
Question:
In the guideline for hypertension with heart disease, category I50, Heart failure, is included in the list of heart conditions that are classified as hypertensive heart disease, but it is not included in the Alphabetic Index nor Tabular List.

Is congestive heart failure (CHF) in a patient with hypertension coded as hypertensive heart disease with failure, when the provider’s documentation has not explicitly linked the two conditions?
Answer:
Assign code I11.0, Hypertensive heart disease, with failure, along with the appropriate code from category I50, Heart failure, for CHF in a patient with hypertension.

The classification presumes a causal relationship between hypertension and heart involvement unless the provider documents that the conditions are unrelated.
Although heart failure is not in the list of heart conditions in the inclusion note, in ICD-10-CM, there is a note instructing “Use additional code to identify type of heart failure” in the Tabular List. The code range under category I11, Hypertensive heart failure, is not intended to be an all-inclusive list.

The range of heart conditions in the Alphabetic Index and Tabular List will be considered for future modification through the Coordination and Maintenance Committee.
The classification presumes a causal relationship between hypertension and heart involvement and between hypertension and kidney involvement, as the two conditions are linked by the term “with” in the Alphabetic Index.

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 hypertension and conditions not specifically linked by relational terms such as “with,” “associated with” or “due to” in the classification, provider documentation must link the conditions in order to code them as related.
1) Hypertension with Heart Disease

Hypertension with heart conditions classified to I50.- or I51.4-I51.9, are assigned to a code from category I11, Hypertensive heart disease.

Use an additional code from category I50, Heart failure, to identify the type of heart failure in those patients with heart failure.
Hypertension with Heart Disease

ICD-10-CM Index

Hypertension  I10

-with

--heart involvement (conditions in I51.4 - I51.9) - see Hypertension, heart

-heart (disease) (conditions in I51.4 - I51.9 due to hypertension)  I11.9

-with

----heart failure (congestive) I11.0
Hypertension with Heart Disease

ICD-10-CM Tabular

I11 Hypertensive heart disease

Includes: any condition in I51.4-I51.9 due to hypertension

I11.0 Hypertensive heart disease with heart failure
Hypertensive heart failure

Use additional code to identify type of heart failure (I50.-)

I11.9 Hypertensive heart disease without heart failure
Hypertensive heart disease NOS
Hypertension with Heart Disease

ICD-10-CM Tabular

I50 Heart failure

**Code first** heart failure complicating abortion or ectopic or molar pregnancy (O00-O07, O08.8)
heart failure due to hypertension (I11.0)
heart failure due to hypertension with chronic kidney disease (I13.-)
heart failure following surgery (I97.13-)
obstetric surgery and procedures (O75.4)
rheumatic heart failure (I09.81)
With

Guidelines Section I.A.15

“With”

The word “with” should be interpreted to mean “associated with” or “due to” when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List.
3) Hypertensive Heart and Chronic Kidney Disease

Assign codes from combination category I13, Hypertensive heart and chronic kidney disease, when there is hypertension with both heart and kidney involvement.

If heart failure is present, assign an additional code from category I50 to identify the type of heart failure.
Question:
A patient with dementia, who is confined to a nursing home, was admitted to the hospital after falling from his wheelchair. The provider’s final diagnostic statement listed, “Toxic encephalopathy due to ciprofloxacin.” When queried, the provider confirmed that the antibiotic had been properly administered.
We are confused by the note at G92, Toxic encephalopathy instructing to “Code first (T51-T65) to identify toxic agent.” Can code G92 be assigned along with the adverse effect T-code?
Toxic effects of substances chiefly nonmedicinal as to source (T51-T65)

**Note:** When no intent is indicated code to accidental. Undetermined intent is only for use when there is specific documentation in the record that the intent of the toxic effect cannot be determined.

**Use additional code(s):**

for all associated manifestations of toxic effect, such as: respiratory conditions due to external agents (J60-J70)
<table>
<thead>
<tr>
<th>Substance</th>
<th>Poisoning, Accidental (unintentional)</th>
<th>Poisoning, Intentional self-harm</th>
<th>Poisoning, Assault</th>
<th>Poisoning, Undetermined</th>
<th>Adverse effect</th>
<th>Underdosing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetyl - bromide</td>
<td>T53.6X1</td>
<td>T53.6X2</td>
<td>T53.6X3</td>
<td>T53.6X4</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Acetyl chloride</td>
<td>T53.6X1</td>
<td>T53.6X2</td>
<td>T53.6X3</td>
<td>T53.6X4</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Acetylcarbromal</td>
<td>T42.6X1</td>
<td>T42.6X2</td>
<td>T42.6X3</td>
<td>T42.6X4</td>
<td>T42.6X5</td>
<td>T42.6X6</td>
</tr>
</tbody>
</table>
If the intent of the poisoning is unknown or unspecified, code the intent as accidental intent.

The undetermined intent is only for use if the documentation in the record specifies that the intent cannot be determined.

Use additional code(s) for all manifestations of poisonings.
Answer:
Yes. Since this is an adverse reaction to medication, assign code G92, Toxic encephalopathy, as the principal diagnosis.
Assign code T36.8X5A, Adverse effect of other systemic antibiotics, initial encounter, as an additional diagnosis.
The code first note is intended to provide sequencing guidance when coding toxic effects.
However, the instructional note does not prohibit assigning code G92 along with adverse effect codes.
Adverse Effect

When coding an adverse effect of a drug that has been correctly prescribed and properly administered, assign the appropriate code for the nature of the adverse effect followed by the appropriate code for the adverse effect of the drug (T36-T50).

The code for the drug should have a 5th or 6th character “5” (for example T36.0X5-)

Examples of the nature of an adverse effect are tachycardia, delirium, gastrointestinal hemorrhaging, vomiting, hypokalemia, hepatitis, renal failure, or respiratory failure.
## Tables of Drugs and Chemicals

<table>
<thead>
<tr>
<th>Substance</th>
<th>Poisoning, Accidental (unintentional)</th>
<th>Poisoning, Intentional self-harm</th>
<th>Poisoning, Assault</th>
<th>Poisoning, Undetermined</th>
<th>Adverse effect</th>
<th>Underdosing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tablets -see also specified substance</td>
<td>T50.901</td>
<td>T50.902</td>
<td>T50.903</td>
<td>T50.904</td>
<td>T50.905</td>
<td>T50.906</td>
</tr>
<tr>
<td>Tace</td>
<td>T38.5X1</td>
<td>T38.5X2</td>
<td>T38.5X3</td>
<td>T38.5X4</td>
<td>T38.5X5</td>
<td>T38.5X6</td>
</tr>
<tr>
<td>Tacrine</td>
<td>T44.0X1</td>
<td>T44.0X2</td>
<td>T44.0X3</td>
<td>T44.0X4</td>
<td>T44.0X5</td>
<td>T44.0X6</td>
</tr>
<tr>
<td>Tadalafil</td>
<td>T46.7X1</td>
<td>T46.7X2</td>
<td>T46.7X3</td>
<td>T46.7X4</td>
<td>T46.7X5</td>
<td>T46.7X6</td>
</tr>
<tr>
<td>Talampicillin</td>
<td>T36.0X1</td>
<td>T36.0X2</td>
<td>T36.0X3</td>
<td>T36.0X4</td>
<td>T36.0X5</td>
<td>T36.0X6</td>
</tr>
</tbody>
</table>
Question:
A patient with bipolar disorder presents to the Emergency Department (ED) with mental status change, diarrhea, nausea and vomiting after ingesting ten lithium carbonate tablets with suicidal intent.

She is admitted to the hospital, treated for acute lithium toxicity and discharged to a skilled nursing facility.

The provider’s diagnostic statement listed toxic encephalopathy due to lithium toxicity.

Coding professionals are confused about the instructional note under code G92, which states “code first (T51-T65) to identify toxic agent,” because the code for lithium poisoning/toxicity is outside of the range.

How is toxic encephalopathy due to lithium poisoning/toxicity coded?
Answer:

Assign code T43.592A, Poisoning by other antipsychotics and neuroleptics, intentional self-harm, initial encounter, as the principal diagnosis.

Code G92, Toxic encephalopathy, should be assigned as an additional diagnosis.

The code first note is intended to provide sequencing guidance when coding toxic effects, and does not preclude assigning code G92 along with poisoning codes.

In this case, since the toxic encephalopathy was due to a poisoning rather than an adverse effect, the poisoning code would be sequenced first.
Poisoning

When coding a poisoning or reaction to the improper use of a medication (e.g., overdose, wrong substance given or taken in error, wrong route of administration), first assign the appropriate code from categories T36-T50.

The poisoning codes have an associated intent as their 5th or 6th character (accidental, intentional self-harm, assault and undetermined).

If the intent of the poisoning is unknown or unspecified, code the intent as accidental intent. The undetermined intent is only for use if the documentation in the record specifies that the intent cannot be determined.

Use additional code(s) for all manifestations of poisonings.
Question:
What is the correct ICD-10-CM diagnosis code assignment for an adult patient with a documented body mass index (BMI) of 19.5?

Answer:
Assign code Z68.1, Body mass index (BMI) 19 or less, adult, for an adult BMI documented as 19.5.
Q1 2017 BMI 19 or less

Question:
What is the correct ICD-10-CM diagnosis code assignment for an adult patient with a documented body mass index (BMI) of 19.5?

Answer:
Assign code Z68.1, Body mass index (BMI) 19 or less, adult, for an adult BMI documented as 19.5.
Question:
A patient presented due to a large umbilical hernia that was easily reduced manually.
What is the appropriate root operation for manual reduction of a hernia?
What body part value should we report for this procedure?

Answer:
Manual reduction of a hernia is not a separately reportable procedure.
Question:

The Central Office has received several requests for clarification pertaining to the replacement of the patella when performed with a total knee replacement.

Is the patella considered part of the knee joint or, since it has its own body part value, is a separate code assigned to capture the replacement of the patella?
Answer:
The patella is part of a total knee joint replacement. The patella has its own bone body part values in the lower bones body system. However, the patella does not have its own joint surface body part value in the lower joints body system.

When reporting total knee replacements in ICD-10-PCS, assign either value “C,” Knee joint, right, or “D,” Knee joint, left, for the body part character under table 0SR, Replacement, lower joints.

These body part values include the femoral, tibial and patellar portions of the total knee replacement, and therefore, no additional code is necessary to capture replacement of the patella.
Question:
How is uncontrolled diabetes mellitus (DM) coded in ICD-10-CM?
Is uncontrolled the same as “poorly controlled” or “out of control?”
Currently, only “out of control” and “poorly controlled” diabetes mellitus are coded as diabetes with hyperglycemia.
Answer:
There is no default code for “uncontrolled diabetes.” Effective October 1, 2016, uncontrolled diabetes is classified by type and whether it is hyperglycemia or hypoglycemia.

If the documentation is not clear, query the provider for clarification whether the patient has hyperglycemia or hypoglycemia so that the appropriate code may be reported; uncontrolled diabetes indicates that the patient’s blood sugar is not at an acceptable level, because it is either too high or too low.
Answer:

In the ICD-10-CM Index to Diseases, uncontrolled diabetes can be referenced as follows:

Diabetes, diabetic (mellitus) (sugar) uncontrolled

meaning

hyperglycemia – see Diabetes, by type, with hyperglycemia

hypoglycemia – see Diabetes, by type, with hypoglycemia
Question:

Since an ileus does not always involve obstruction, should a diagnosis of postoperative ileus be assigned code K91.3, Postprocedural intestinal obstruction?

Previously, postoperative ileus defaulted to a complication code.

However, in ICD-10-CM, there is no default code assignment for postoperative ileus.
Answer:
Query the physician to determine if the ileus is a postoperative complication.

If the physician confirms that the ileus is a postoperative complication, assign code K91.89, Other postprocedural complications and disorders of digestive system.

Code K56.7, Ileus, unspecified, should be assigned as an additional diagnosis to describe the specific complication.

If, however, after query, the physician confirms that the ileus is not a surgical complication, assign only code K56.7.

Only assign code K91.3, Postprocedural intestinal obstruction, for an obstructive ileus that the physician has documented as a post-op complication.
Questions?

Barry Libman, MS, RHIA, CDIP, CCS, CCS-P, CIC
President, Libman Education
President, Barry Libman Inc.
978-369-7180
barry@barrylibmaninc.com

www.LibmanEducation.com
www.BarryLibmanInc.com