

# AHA Coding Clinic®

## ICD-10-CM ICD-10-PCS

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### **In This Issue**

Changes to the ICD-10-CM  
Official Guidelines for Coding  
and Reporting 52

Changes to the ICD-10-PCS  
Official Guidelines for Coding  
and Reporting 59

### **New/Revised ICD-10-CM Codes**

Adenosine Deaminase Deficiency 5

Atrial Fibrillation 7

Breast Lump in Overlapping  
Quadrants 12

Congenital Deformities of Feet 13

Cyclical Vomiting Syndrome 15

Deep Vein Thrombosis 8

Ehlers-Danlos Syndrome 13

External Cause of Injury Codes  
for Legal Intervention 18

Exertional Heat Stroke 17

Fracture of Orbit 16

Glucose-6-Phosphate  
Dehydrogenase Deficiency

Without Anemia 4

Multiple Drug Ingestion 17

Phlebitis and Thrombophlebitis 8

Post Endometrial Ablation  
Syndrome 12

Prader-Willi Syndrome 14

Pressure-Induced Deep  
Tissue Damage 10

Pyuria 16

Subsegmental Pulmonary  
Embolism 6

### **Z Code Update**

Examination of Vision Following

Failed Vision Screening  
with and without  
Abnormal Findings 20

Health Counseling Related  
to Travel 20

History of In-Situ Neoplasms 20

Latent Tuberculosis Screening 20

Latent Tuberculosis Status 19

Neurostimulator Status 19

### **New/Revised ICD-10-PCS Codes**

Aneurysm Treatment Using  
Flow Diverter Stent 27

Bifurcation Qualifier 27

Breast Procedures 30

Bypass Thoracic Aorta  
to Innominate Artery 23

Cell Suspension Epithelial  
Autograft 32

Cerebral Ventricle Bypass  
Qualifier 21

Coronary Artery Body Part  
to Root Operation Insertion 23

Coronary Artery to Root  
Operation Supplement 25

Extirpation of Jaw 35

Hyperthermic Antineoplastic  
Chemotherapy 36

Intestinal Bypass 29

Intramedullary Limb Lengthening  
Internal Fixation Device 34

**New codes contained in this issue effective with discharges October 1, 2019. Other  
coding advice or code assignments contained in this issue effective October 1, 2019.**

Intraoperative Extracorporeal Membrane Oxygenation	39	<b>Section X - New Technology</b>	
Intraoperative Fluorescence Guidance	41	Cerebral Embolic Filtration	46
Intraoperative Fluorescence Lymphatic Mapping in Gynecological Cancers		New Therapeutic Substances	47
Using Indocyanine Green Dye	38	Apalutamide Antineoplastic	47
Irrigation of Joint Using Irrigating Substance	38	Caplacizumab	50
Percutaneous Approach Upper Artery Bypass	26	Erdaftinib Antineoplastic	48
Sinus Supplement	28	Fosfomycin Anti-infective	48
Subcutaneous Implantable Cardioverter Defibrillator Lead	33	Gilteritinib Antineoplastic	50
T-Cell Depleted Hematopoietic Stem Cells for Transplantation	36	Imipenem-Cilastatin-Relebactam Anti-Infective	50
Transfer Large Intestine to Vagina	29	Iobenguane I-131 Antineoplastic	49
Transfusion of Blood Products	35	Meropenem-Aborbactam Anti-Infective	48
Transorifice Occlusion of Gastric Varices	28	Ruxolitinib	48
Unidirectional Source Brachytherapy	42	Tagraxofusp-Erzs Antineoplastic	49
Upper Artery Bypass Qualifier	26	Venetoclax Antineoplastic	49
		Renal Function Monitoring Sustained Released Drug-Eluting Stent	46
		Whole Blood Nucleic Acid-Base Microbial Detection	45
			50
		<b>Ask the Editor</b>	
		Coding Social Determinants of Health Based on Documentation from Other Clinicians	67
		Hierarchy of Conventions in the Classification, the <i>Official Guidelines for Coding and Reporting</i> and <i>Coding Clinic</i>	65
		Mesenteric Vein Thrombosis	68
		Patient Self-Reported Information and Social Determinants of Health Codes	66

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## **ICD-10-CM NEW/REVISED CODES**

Summary explanations of the Fiscal Year 2020 (FY 2020) ICD-10-CM changes effective October 1, 2019 are provided below. Addenda changes demonstrating the specific revisions to the code titles or instructional notes are not included in the explanations. The official ICD-10-CM addenda has been posted on the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics website at <https://www.cdc.gov/nchs/icd/icd10cm.htm>.

There are 273 new ICD-10-CM codes effective October 1, 2019. In addition, there are 30 revised codes and 21 deleted codes. While it is unusual for codes to be deleted, many of the deleted codes have been further expanded, and thus became subcategories. However, there were four exceptions. Codes describing vertigo of central origin of right, left, bilateral and unspecified ear were deleted, because they were not clinically appropriate. Central vertigo is a condition in which a person experiences hallucinations of motion of their surroundings, or a sensation of spinning, secondary to a dysfunction of the vestibular structures in the central nervous system. New code H81.4, Vertigo of central origin, describes this condition.

### **Glucose-6-Phosphate Dehydrogenase (G6PD) Deficiency Without Anemia**

Code **D75.A, Glucose-6 phosphate dehydrogenase (G6PD) deficiency without anemia**, was created for the deficiency in the glucose-6 phosphate dehydrogenase enzyme, without hemolytic anemia. G6PD protects red blood cells against levels of reactive oxygen species molecules that accumulate and damage red blood cells. When there is a deficiency in G6PD, red blood cells are destroyed, by hemolysis. When there is a lack of healthy red blood cells because they are being destroyed faster than they can be replaced by the bone marrow, the result is hemolytic anemia.

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Common signs and symptoms of hemolytic anemia are jaundice, shortness of breath, fatigue, dark urine, splenomegaly and a rapid heart rate. However, a deficiency in the G6PD enzyme alone does not cause hemolytic anemia. There are additional factors that trigger hemolytic anemia, such as infectious diseases, exposure to certain antibiotics or pain medications or the ingestion of fava beans causing the onset of favism. Without such triggers, an individual with G6PD deficiency may not ever experience any signs and symptoms of the condition. Code D75.A was created for asymptomatic individuals who do not have anemia but are at risk for anemia because of a G6PD deficiency.

## **Adenosine Deaminase Deficiency**

Code **D81.31, Severe combined immunodeficiency due to adenosine deaminase deficiency**, was created for adenosine deaminase (ADA) deficiency that damages the immune system and causes severe combined immunodeficiency (SCID), which is commonly referred to as SCID due to ADA deficiency. ADA is an inherited disorder of purine metabolism that is characterized by the accumulation of deoxyadenosine, a molecule that is toxic to lymphocytes, the cells that make up the immune system. The loss of infection-fighting lymphocytes results in the signs and symptoms of SCID.

SCID due to ADA deficiency may present before 6 months of age. The individual experiences infections caused by organisms that do not usually cause illness in a person with a normal immune system. There may be recurrent pneumonia, chronic diarrhea, widespread skin rashes, and growth and developmental delays. Diagnosis is confirmed by blood and genetic tests. The condition is treated with stem cell transplantation to build a functional immune system.

Code **D81.32** was created for adenosine deaminase 2 deficiency. Adenosine deaminase 2 (ADA2) deficiency or deficiency of adenosine deaminase 2 (DADA2) is characterized by abnormal, unprovoked inflammation of various tissues that can cause damage to the body's organs. The severity and location of inflammation varies among individuals, but the condition usually affects the skin, blood vessels, gastrointestinal and nervous systems, liver and kidneys. There may be intermittent fever, a mottled skin discoloration (livedo racemosa), recurrent strokes and hepatosplenomegaly. Signs and symptoms

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of ADA2 deficiency can begin early in childhood or manifest in adulthood. ADA2 deficiency is caused by mutations in the ADA2 gene that is responsible for instructions for making the adenosine deaminase 2 enzyme. The mutations in the ADA2 gene cause a reduction or elimination in the activity of the ADA2 enzyme. The ADA2 enzyme plays an important role in the growth and development of macrophages and other cells of the immune system. ADA2 enzyme deficiency causes a disruption in the balance between pro-inflammatory cells and anti-inflammatory cells leading to a build-up of pro-inflammatory macrophages and abnormal inflammation. Treatment presently consists of anti-TNF (tumor necrosis factor)-agents that reduce inflammation.

Codes **D81.39, Other adenosine deaminase deficiency**, and **D81.30, Adenosine deaminase deficiency, unspecified**, were created for other specified ADA deficiency and unspecified ADA deficiency, respectively.

## **Subsegmental Pulmonary Embolism**

New ICD-10-CM codes have been created to identify single subsegmental pulmonary embolism without acute cor pulmonale (**I26.93**) and multiple subsegmental pulmonary emboli without acute cor pulmonale (**I26.94**).

An embolus is a blood clot that most commonly originates in the veins of the legs (deep vein thrombosis). The blood clot can dislodge and travel as an embolus to other organs in the body, generally the lungs. A pulmonary embolism is a clot that lodges in the lungs, potentially blocking one or more of the pulmonary arteries and reducing blood flow to a region of the lungs.

The use of advanced imaging techniques has increased the detection of small subsegmental pulmonary emboli (SSPE) in asymptomatic patients that may not be clinically significant. These SSPEs are often isolated to distal (subsegmental) branches of the pulmonary artery, without coexisting deep venous thrombosis, and are usually too small to cause any major problems. Previously, subsegmental pulmonary emboli were treated with anticoagulation for months or years. However, it is unknown whether these emboli are in fact an indication for future thromboembolic events, and there is no consistent evidence that patients with SSPE benefit from short- and long-term anticoagulation therapy. The most recent guidelines from

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the American College of Chest Physicians (ACCP) recommend that patients with isolated SSPE and no proximal DVT undergo surveillance rather than anticoagulation.

These new codes will enable important clinical differentiation, and will be beneficial for quality measures for hospitals, as well as for research and evaluation of treatment efficacy.

## **Atrial Fibrillation**

Codes in category I48, Atrial fibrillation and flutter, were expanded and the following new codes created to provide unique codes to describe the different types of atrial fibrillation (AF).

- I48.11 Longstanding persistent atrial fibrillation
- I48.19 Other persistent atrial fibrillation
- I48.20 Chronic atrial fibrillation, unspecified
- I48.21 Permanent atrial fibrillation

Atrial fibrillation (AF) is a common cause of an abnormal, irregular heartbeat. The heart wall does not move normally in atrial fibrillation, so there is a risk of blood clots forming in the heart, and risk of thromboembolism, including thromboembolic stroke. AF is typically treated by electrical or pharmacological cardioversion.

Persistent atrial fibrillation describes AF that does not terminate within seven days, or that requires repeat pharmacological or electrical cardioversion. Longstanding persistent atrial fibrillation (**I48.11**) is persistent and continuous AF lasting longer than one year.

Permanent atrial fibrillation (**I48.21**) is persistent or longstanding persistent atrial fibrillation where cardioversion cannot or will not be performed, or is not indicated.

Chronic atrial fibrillation, unspecified (**I48.20**) may refer to any persistent, longstanding persistent, or permanent atrial fibrillation. However, in clinical practice, use of one of the more specific descriptive terms is preferred over the use of the nonspecific term chronic AF.

Chronic persistent AF has no widely accepted clinical definition or meaning. Assign code I48.19, Other persistent atrial fibrillation, for chronic persistent AF.

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## Phlebitis and Thrombophlebitis

New codes have been created to describe phlebitis and thrombophlebitis of the peroneal vein and the calf muscular vein of the distal lower extremities. Phlebitis is inflammation of a vein. Thrombophlebitis is caused by blood clots in a vein that can lead to inflammation. Typically, thrombophlebitis will develop in veins of the legs, but can also occur in the upper extremities, in either superficial or deep veins.

Previously, ICD-10-CM did not provide specific codes to capture phlebitis/thrombophlebitis involving the peroneal vein or muscular branch veins. Coding professionals were referred to nonspecific codes for “phlebitis and thrombophlebitis of other deep vessels of lower extremities.” However, these codes did not differentiate whether the “other specified deep vein” was proximal or distal, which is an important clinical distinction. The new codes for phlebitis and thrombophlebitis are as follows:

- **I80.241**      **Phlebitis and thrombophlebitis of right peroneal vein**
- **I80.242**      **Phlebitis and thrombophlebitis of left peroneal vein**
- **I80.243**      **Phlebitis and thrombophlebitis of peroneal vein, bilateral**
- **I80.249**      **Phlebitis and thrombophlebitis of unspecified peroneal vein**
- **I80.251**      **Phlebitis and thrombophlebitis of right calf muscular vein**
- **I80.252**      **Phlebitis and thrombophlebitis of left calf muscular vein**
- **I80.253**      **Phlebitis and thrombophlebitis of calf muscular vein, bilateral**
- **I80.259**      **Phlebitis and thrombophlebitis of unspecified calf muscular vein**

## Deep Vein Thrombosis

New codes have been created to identify acute and chronic venous embolism and thrombosis of deep vessels of the distal lower extremities, such as the peroneal vein and calf muscular vein. Deep vein thrombosis (DVT), also referred to as venous thromboembolism, is a blood clot in a major vein, generally occurring in the legs or pelvis.



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Calf vein thrombosis refers to any clot affecting the deep veins of the calf, also known as the distal portion of the lower extremity, without extending into the popliteal vein. The calf veins include three paired veins (posterior tibial, peroneal, and anterior tibial) and two sets of muscular veins (soleal and gastrocnemius).

Thromboembolic disease involving proximal deep veins is a more serious condition. It can be associated with a higher risk of pulmonary embolism and thus represents the primary target for surveillance. On the other hand, acute thrombosis involving distal deep veins are considered lower risk and are more likely to be detected on routine surveillance testing, without symptoms.

The new codes will differentiate acute and chronic thrombosis involving deep veins of the proximal lower extremity, from acute and chronic thrombosis involving deep veins of the distal lower extremity. Previously, ICD-10-CM did not provide specific codes to capture DVT of the peroneal vein or muscular branch veins. Coding professionals were referred to very nonspecific codes. The new codes are as follows:

- **I82.451**      **Acute embolism and thrombosis of right peroneal vein**
- **I82.452**      **Acute embolism and thrombosis of left peroneal vein**
- **I82.453**      **Acute embolism and thrombosis of peroneal vein, bilateral**
- **I82.459**      **Acute embolism and thrombosis of unspecified peroneal vein**
- **I82.461**      **Acute embolism and thrombosis of right calf muscular vein**
- **I82.462**      **Acute embolism and thrombosis of left calf muscular vein**
- **I82.463**      **Acute embolism and thrombosis of calf muscular vein, bilateral**
- **I82.469**      **Acute embolism and thrombosis of unspecified calf muscular vein**
- **I82.551**      **Chronic embolism and thrombosis of right peroneal vein**
- **I82.552**      **Chronic embolism and thrombosis of left peroneal vein**
- **I82.553**      **Chronic embolism and thrombosis of peroneal vein, bilateral**

- **I82.559**      **Chronic embolism and thrombosis of unspecified peroneal vein**
- **I82.561**      **Chronic embolism and thrombosis of right calf muscular vein**
- **I82.562**      **Chronic embolism and thrombosis of left calf muscular vein**
- **I82.563**      **Chronic embolism and thrombosis of calf muscular vein, bilateral**
- **I82.569**      **Chronic embolism and thrombosis of unspecified calf muscular vein**

## **Pressure-Induced Deep Tissue Damage**

Codes at category L89, Pressure ulcer, have been expanded to capture pressure-induced deep tissue damage of various sites, such as:

- Elbow (**L89.006**, **L89.016**, and **L89.026**)
- Upper and lower back (**L89.106**, **L89.116**, **L89.126**, **L89.136**, and **L89.146**)
- Sacral region (**L89.156**)
- Hip (**L89.206**, **L89.216**, and **L89.226**)
- Buttock (**L89.306**, **L89.316**, and **L89.326**)
- Contiguous site of back, buttock and hip (**L89.46**)
- Ankle (**L89.506**, **L89.516**, and **L89.526**)
- Heel (**L89.606**, **L89.616**, and **L89.626**)
- Head (**L89.816**)
- Other site (**L89.896**) and
- Unspecified site (**L89.96**)

The new codes were created to align with updates to the National Pressure Ulcer Advisory Panel (NPUAP) pressure ulcer staging. Prior to this change, deep tissue pressure ulcers were coded to unstageable. Changes to the NPUAP pressure ulcer staging were made based on recent clinical literature and expert consensus; however, they resulted in minor inconsistencies with ICD-10-CM. The new codes will help resolve the discrepancy.

Pressure-induced deep tissue damage is also referred to as deep tissue pressure injury and deep tissue pressure ulcer and the new codes should be assigned for these conditions. According to the NPUAP, deep tissue injury refers to persistent non-blanchable deep

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red, maroon or purple discoloration. It may involve intact or non-intact skin with a localized area of persistent non-blanchable deep red, maroon, or purple discoloration, or epidermal separation revealing a dark wound bed or blood filled blister. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss.

**Question:**

Please clarify the appropriate coding for deep tissue pressure injuries. There seems to be a discrepancy between the Alphabetical Index and the newly revised guidelines that seem to indicate that they should be coded to the new codes in category L89 with sixth digit of 6 rather than to unstageable ulcers. The Alphabetical Index currently says:

**Injury**

- deep tissue -see Contusion, by site  
- - meaning pressure ulcer -see Ulcer, pressure, unstageable, by site

**Answer:**

Assign only the appropriate code for pressure-induced deep tissue damage (L89.--6) for pressure-induced deep tissue damage or deep tissue pressure injury. Since new codes have been created for pressure-induced deep tissue damage, the new codes should be used instead of the unstageable codes. A corresponding change is reflected in the changes to the *Official Guidelines for Coding and Reporting* that used to point to unstageable ulcer (L89.-0). Please refer to page 54 of this issue for a summary of FY 2020 guideline changes.

The discrepancy in the Alphabetic Index has been referred to the Centers for Disease Control and Prevention's National Center for Health Statistics for consideration for a future revision.

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## Breast Lump in Overlapping Quadrants

Category N63, Unspecified lump in breast, has been expanded and two new codes were created to allow for proper code assignment when an unspecified lump in the breast overlaps anatomic sites classifiable to different codes. The new codes will align with the current structure of codes for malignant neoplasm of breast (i.e., subcategory C50.8). The new codes identifying unspecified lump in the breast of overlapping sites are as follows:

- **N63.15, Unspecified lump in the right breast, overlapping quadrants**
- **N63.25, Unspecified lump in the left breast, overlapping quadrants**

## Post Endometrial Ablation Syndrome

Code **N99.85, Post endometrial ablation syndrome**, was created to allow for improved coding specificity and tracking of this syndrome. Prior to the creation of this code, there was no way to uniquely capture the syndrome, and only signs and symptoms related to the condition were coded.

Post endometrial ablation syndrome is a condition that may occur in women who have undergone endometrial ablation, but most commonly occurs in women who have previously had fallopian tube occlusion performed for sterilization. This syndrome can occur in up to 10% of women who have undergone endometrial ablation. Symptoms include cyclic pelvic pain and hematometra, which is a medical condition involving collection or retention of blood in the uterus.

### Question:

A patient with a history of endometrial ablation presents due to severe pelvic pain. The patient is admitted, and the final diagnosis is post endometrial ablation syndrome. What is the appropriate code assignment for post endometrial ablation syndrome?

### Answer:

Assign code N99.85, Post endometrial ablation syndrome. Do not code separately the pelvic pain, since it is a symptom of the syndrome.

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## **Congenital Deformities of Feet**

Some of the most familiar congenital deformities in newborns are problems with the feet. Some of the most common congenital foot abnormalities include metatarsus adductus, talipes equinovarus (clubfoot), calcaneovalgus (flexible flatfoot) and vertical talus (rigid flatfoot). There are also multiple digital deformities, such as polydactyly, syndactyly and overlapping toes. Most of these foot deformities are treated nonsurgically, and in many cases, the condition can simply be observed.

Category Q66, Congenital deformities of feet, was expanded to allow specificity to capture the actual part of the foot involved as well as laterality.

Several new codes were created to describe the following congenital deformities of the right, left, and unspecified foot:

- Congenital talipes equinovarus (**Q66.00-Q66.02**);
- Congenital talipes calcaneovarus (**Q66.10-Q66.12**);
- Congenital metatarsus (primus) varus (**Q66.211-Q66.219**);
- Congenital metatarsus adductus (**Q66.221-Q66.229**);
- Other congenital varus deformities of feet (**Q66.30-Q66.32**);
- Congenital talipes calcaneovalgus (**Q66.40-Q66.42**);
- Congenital pes cavus (**Q66.70-Q66.72**); and
- Congenital deformity of feet, unspecified (**Q66.90-Q66.92**).

## **Ehlers-Danlos Syndrome (EDS)**

New codes were created for Ehlers-Danlos Syndrome (EDS) to distinguish between the most common and severe types of EDS recognized by the International Consortium on EDS. EDS is a clinically and genetically heterogeneous group of heritable connective tissue disorders. These disorders are characterized by articular hypermobility, skin hyperextensibility or laxity, and tissue fragility affecting virtually every organ system: skin, ligaments, joints, bone, muscle, blood vessels and various organs. EDS is a life-long progressive condition that has a major impact on the lives and daily function of most living with this condition.

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The most prevalent and common types of EDS are:

**Classical (Q79.61)**—People with classical EDS (cEDS) have wounds that split open (with little bleeding) and leave scars that widen over time to create “cigarette paper” scars. These patients typically have loose skin that sags and wrinkles, and extra folds of skin may be present.

**Hypermobile (Q79.62)**—The diagnosis of hypermobile EDS (hEDS) is a clinical one as no molecular, genetic cause that is yet identified. A certain set of criteria must be met for a patient to be diagnosed with hEDS. Some common symptoms include joint hypermobility, somewhat elastic (stretchy) skin, easy bruising, and chronic musculoskeletal pain.

**Vascular (Q79.63)**—This type of EDS is the most severe in presentation and the only one associated with early mortality. Vascular EDS (vEDS) can cause unpredictable tearing (rupture) of blood vessels, leading to internal bleeding and other potential life-threatening complications. It is also associated with an increased risk of organ rupture, including tearing of the intestine and rupture of the uterus during pregnancy. The long-term outlook for vEDS is generally poor. The median life expectancy for people affected by vEDS is 48 years.

In addition, there are codes to identify Ehlers-Danlos Syndrome, unspecified (**Q79.60**) and Other Ehlers-Danlos Syndromes (**Q79.69**).

## **Prader-Willi Syndrome**

Prader-Willi syndrome (PWS) is a complex neurodevelopmental disorder that affects many parts of the body. It is caused by lack of expression of genes in the paternally inherited chromosome 15q11.2-q13. During infancy, PWS is characterized by hypotonia, feeding difficulties, poor growth, and delayed development. Beginning in childhood, affected individuals develop an insatiable appetite, which leads to chronic overeating (hyperphagia) and obesity. PWS is the most common genetic syndrome causing obesity. Some people with PWS, particularly those with obesity, also develop type 2 diabetes.

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There is typically mild to moderate intellectual impairment and learning disabilities in people with PWS. Behavioral problems are common, including temper outbursts, stubbornness, and compulsive behavior such as picking at the skin. Sleep abnormalities can also occur. Additional features include distinctive facial features such as a narrow forehead, almond-shaped eyes, and a triangular mouth; short stature (generally treated with growth hormones), and small hands and feet. Both males and females have underdeveloped genitals. Puberty is delayed or incomplete, and most affected individuals are infertile.

Code Q87.1, Congenital malformation syndromes predominately associated with short stature, was expanded and a unique code, **Q87.11, Prader-Willi Syndrome**, was created for PWS. This will help facilitate communication and research related to PWS. Code **Q87.19** will capture other congenital malformation syndromes predominantly associated with short stature.

## **Cyclical Vomiting Syndrome**

Code **R11.15, Cyclical vomiting syndrome unrelated to migraine**, has been created to specifically identify those cases in which a patient has cyclical vomiting that is totally unrelated to a migraine.

Cyclical vomiting syndrome is described as episodes of severe vomiting that have no noticeable cause. Episodes can last for days or hours and alternate with symptom-free periods. Each episode tends to start at the same time of day, last the same length of time and occur with the same symptoms and level of intensity. Treatment usually involves medications, including anti-nausea and migraine therapies that may lessen symptoms.

Previously, the only way to capture cyclical vomiting was with a code from category G43, Migraine. However, cyclical vomiting syndrome may or may not be related to migraines. Cyclical vomiting syndrome NOS and persistent vomiting are inclusion terms at code R11.15.

In addition, the code titles for codes in subcategory G43.A, Cyclical vomiting, have been revised, and “in migraine” added to codes G43.A0 and G43.A1.

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## Pyuria

Subcategory R82.8, Abnormal findings on cytological and histological examination of urine, was expanded, and two codes were created to uniquely capture pyuria and other abnormal findings on cytological and histological examination of urine as follows:

- **R82.81 Pyuria**
- **R82.89 Other abnormal findings on cytological and histological examination of urine**

Pyuria is a laboratory finding of white blood cells in the urine and most commonly occurs in urinary tract infections. Other diseases and conditions that can cause pyuria include inflammation, kidney stones, tumors in the urinary tract, certain autoimmune disease, and pneumonia. Sterile pyuria is the finding of pyuria when no underlying cause can be found. Previously, pyuria was indexed to code N39.0, Urinary tract infection, and there was no way to uniquely capture pyuria without UTI.

### Question:

A patient was diagnosed with pyuria and started on antibiotics; however when the urine cultures returned negative, antibiotics were discontinued. The physician's final diagnostic statement listed "mild pyuria, no urinary tract infection (UTI)." How is pyuria without a UTI coded in ICD-10-CM?

### Answer:

Assign code R82.81, Pyuria, for a diagnosis of pyuria without urinary tract infection.

## Fracture of Orbit

Changes have been made to subcategory S02.1, Fracture of base of skull, and new codes were created to provide additional detail on fractures of the orbital roof, right side, left side, and unspecified side.

In addition, new codes have been created at subcategory S02.8, Fractures of other specified skull and facial bones, to provide additional anatomical detail on the specific orbital wall fractured,



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namely medial orbital wall, lateral orbital wall, and unspecified. These codes also specify right side, left side and unspecified side.

The changes to subcategory S02.1 and S02.8 resulted in 60 new codes, including the seventh character extensions.

## **Multiple Drug Ingestion**

A new subcategory (T50.91-) has been created for poisoning by, adverse effect of, and underdosing of multiple unspecified drugs, medicaments and biological substances. The change resulted in 18 new codes, including the seventh character extensions to better identify and track these episodes of care. Individuals may ingest multiple drugs, by accident or intentionally as a suicidal attempt. In many cases, the only information available within the medical record on the initial encounter is that more than one drug was ingested. There are also cases where the identity of one or more of the ingested agents is not identified.

## **Exertional Heat Stroke**

Unique codes were created to identify heatstroke and sunstroke (**T67.01-**), exertional heat stroke (**T67.02-**), and other heatstroke and sunstroke (**T67.09-**). The change will improve tracking of incidences and outcomes of exertional heat stroke (EHS). In keeping with the current tabular format, the addition of these codes is identified in an initial, subsequent, or sequela phase of diagnosis.

EHS is the most severe form of exertional heat illness. It is identified by an elevated core body temperature associated with signs of organ system failure from hyperthermia, and neurocognitive dysfunction. EHS is life threatening and can be fatal unless promptly treated. Unlike classical/passive heat stroke, which typically involves prolonged heat exposure, EHS can develop within hours, often in healthy people exerting strenuous activity in hot, humid environments. Signs and symptoms include sweating, altered mental status, hyperventilation, seizures and tachycardia. Associated complications and risks include brain damage, acute kidney injury, liver damage, and death. Treatment consists of methods to cool the body, (e.g., water immersion, ice packs), and other supportive measures (e.g., I.V. fluids and respiratory support).

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**Question:**

A 19-year-old male was brought to the emergency department (ED), after experiencing mental status changes while playing basketball in extremely hot temperatures. He arrived with hyperventilation, profuse sweating, and rapid heartbeat, and experienced a seizure in the ED. The provider admitted the patient for seizures associated with exertional heat stroke. How is this case coded?

**Answer:**

Assign code T67.02XA, Exertional heatstroke, initial encounter, for the heat stroke, and code R56.9, Unspecified convulsions, for the seizures. The instructional note at subcategory T67.0, Heatstroke and sunstroke, directs the coding professional to, "Use additional code(s) to identify any associated complications of heatstroke." Code Y93.67 Activity, basketball, should also be assigned, to provide additional information about the event.

## **External Cause of Injury Codes for Legal Intervention**

Several changes were made to category Y35, Legal intervention, to improve the tracking of injuries related to legal interventions. The codes will provide the necessary specificity to track for public information, law enforcement, morbidity and mortality data collection and reporting purposes. Improving public health monitoring of law-enforcement-related morbidity and mortality is a critical part of efforts to ensure public accountability for these incidents.

***Unspecified person injured.*** New codes have been created at the subcategories below to identify "unspecified person injured." Current codes in these subcategories already provided options including law enforcement officer injured, bystander injured, or suspect injured.

- Y35.0-, Legal intervention involving firearm discharge
- Y35.1-, Legal intervention involving explosives
- Y35.2-, Legal intervention involving gas

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- Y35.3-, Legal intervention involving blunt objects
  - Y35.4-, Legal intervention involving sharp objects
  - Y35.8-, Legal intervention involving other specified means
  - Y35.9-, Legal intervention, means unspecified

**Energy device.** Subcategory Y35.8, Legal intervention involving other specified means, was expanded to identify injuries from legal interventions involving conducted energy devices (CED). These devices include electroshock devices (tasers) and stun guns. Similar to subcategories Y35.0 to Y35.9, the new codes identify law enforcement officer injured, bystander injured, or suspect injured.

## Z Code Update

New Z codes were created as noted below.

### Status

There are two new status codes as noted below.

- **Z22.7, Latent tuberculosis**—This code will allow differentiating patients that have been infected with the *Mycobacterium tuberculosis* bacterium but do not have active tuberculosis (TB) disease.
- **Z96.82, Presence of neurostimulator**—This code includes the presence of neurostimulators for different sites (e.g., brain, gastric, peripheral nerve, sacral nerve, spinal cord, or vagus nerve).

In addition, the note at category Z68, Body mass index [BMI], has revised the age ranges for adult and pediatric BMI codes to resolve an overlap in the age ranges. The changes are as follows:

- BMI adult codes are for use for persons 20 years of age or older. The previous note identified the age range as 21 years of age or older.
- BMI pediatric codes are for use for persons 2-19 years of age. The previous note identified the age range as 2-20 years of age.

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## History (of)

There are seven new personal history codes. Six of them are for personal history of in-situ neoplasms (Z86.002 - Z86.007) and one for personal history of latent tuberculosis infection (Z86.15).

There are currently specific codes in ICD-10-CM for personal history of carcinoma in-situ of the breast (Z86.000), cervix uteri (Z86.001), and other site (Z86.008). The new codes will allow the reporting of personal history of carcinoma in-situ of other additional specific sites as noted below:

- Other and unspecified genital organs (**Z86.002**)
- Oral cavity, esophagus and stomach (**Z86.003**)
- Other and unspecified digestive organs (**Z86.004**)
- Middle ear and respiratory system (**Z86.005**)
- Melanoma (**Z86.006**), and
- Skin (**Z86.007**).

## Screening

Code **Z11.7, Encounter for testing for latent tuberculosis infection**, allows identification of encounters for testing for TB in populations at increased risk.

## Counseling

Code **Z71.84, Encounter for health counseling related to travel**, has been created to identify encounters where the patient presents without any signs or symptoms for health risk and safety counseling for future travel purposes. The encounter may be unrelated to other preventive medical care.

## Routine and Administrative Examinations

The following two new codes have been created:

- **Z01.020, Encounter for examination of eyes and vision following failed vision screening without abnormal findings**
- **Z01.021, Encounter for examination of eyes and vision following failed vision screening with abnormal findings**

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## ICD-10-PCS NEW/REVISED CODES

A summary of the Fiscal Year 2020 (FY 2020) ICD-10-PCS changes effective October 1, 2019 is provided below. The addenda changes demonstrating the specific revisions to the code titles are not included in the explanations. The FY 2020 ICD-10-PCS updates, including the complete list of ICD-10-PCS code titles, addenda, and a conversion table showing changes from the previous year are available on the Centers for Medicare & Medicaid Services (CMS) website at <https://www.cms.gov/Medicare/Coding/ICD10/2020-ICD-10-PCS.html>.

There are 734 new ICD-10-PCS codes effective October 1, 2019. In addition, there are 2 revised code titles and 2,056 deleted codes.

The majority of new codes are in Section 0-Medical and Surgical. There are also a small number of changes in Sections 3-Administration, 4-Measurement and Monitoring, 5-Extracorporeal or Systemic Assistance and Performance, 8-Other Procedures, D-Radiation Therapy, and X-New Technology.

The specific changes are described below by section. Additions are shown as underlined, and deletions are shown as ~~strikeouts~~ in the excerpts from the ICD-10-PCS Tables below. The changes originate from public comments, CMS internal review, as well as questions submitted to *Coding Clinic* and discussed by the Editorial Advisory Board with recommendations for more specific values.

### Section 0-Medical and Surgical

#### Cerebral Ventricle Bypass Qualifier

In code table 001, Central Nervous System and Cranial Nerves, Bypass, the qualifier value A Subgaleal Space has been added for the body part value Cerebral Ventricle. This change enables capture of detail for procedures from the cerebral ventricle to the subgaleal space, such as subgaleal shunt placement.

Body Part	Qualifier
6 Cerebral Ventricle	<u>A Subgaleal Space</u>

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**Question:**

A newborn patient with posthemorrhagic neonatal hydrocephalus underwent insertion of a subgaleal shunt. An incision was made in the scalp and an extensive subgaleal cerebral spinal fluid pocket was developed anteriorly and posteriorly. The overlying dura was opened. A small brain needle was passed into the ventricular space and slow aspiration of fluid with blood was undertaken. A catheter was passed down the tract into the frontal horn. Some of the distal catheter was cut off and the remainder was tucked into the subgaleal pocket. What is the appropriate body part value and code assignment for insertion of a subgaleal shunt?

**Answer:**

Assign the following procedure code:

**00163JA**      Bypass cerebral ventricle to subgaleal space with synthetic substitute, percutaneous approach

The catheter was placed in the frontal horn by passing it along the tract of the needle and inserted to drain the ventricle. Blood from hemorrhaging commonly blocks the absorption of the fluid that flows in and around the brain causing pressure on the brain. The procedure is done by placing a small tube into the enlarged chambers in the brain and connecting it to another tube under the skin, allowing drainage of the fluid and the blood clot to the subgaleal space.

## Bypass Thoracic Aorta to Innominate Artery

In code table 021, Heart and Great Vessels, Bypass, the qualifier value A Innominate Artery has been added for the Thoracic Aorta body part values. This change enables capture of detail for bypass procedures from the thoracic aorta to the innominate artery.

Body Part	Qualifier
W Thoracic Aorta, Descending X Thoracic Aorta, Ascending/Arch	<u>A Innominate Artery</u>

### Question:

A 70-year-old male patient has a history of cerebrovascular and peripheral arterial occlusive disease. He has had bilateral carotid endarterectomies and bilateral femoral popliteal artery bypass graft in the past. The patient underwent an open rerouting of the passage of blood from the ascending aorta to the innominate artery using a 10 mm woven Dacron graft for a subtotal occlusion of the proximal innominate artery. How should the procedure be coded?

### Answer:

Assign code **021X0JA**, Bypass thoracic aorta, ascending/arch to innominate artery with synthetic substitute, open approach.

## Coronary Artery Body Part to Root Operation Insertion

In code table 02H, Heart and Great Vessels, Insertion, coronary artery body part values have been added to allow the capture of detail for procedures on the coronary arteries such as insertion of a stent into the coronary artery to prevent the risk of coronary obstruction following a prosthetic valve deployment.

Body Part	Approach	Device	Qualifier
<u>0 Coronary Artery, One Artery</u> <u>1 Coronary Artery, Two Arteries</u> <u>2 Coronary Artery, Three Arteries</u> <u>3 Coronary Artery, Four or More</u>	0 Open 3 Percutaneous 4 Percutaneous Endoscopic	D Intraluminal Device Y Other Device	Z No Qualifier

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**Question:**

A patient with severe symptomatic prosthetic aortic stenosis and regurgitation underwent transfemoral valve-in-valve transcatheter aortic valve replacement (TAVR). The provider applied electrocautery, creating an intentional laceration to the prosthetic aortic valve leaflet to prevent risk of coronary obstruction (BASILICA technique) following prosthetic valve deployment. A bioprosthetic valve was deployed across the previously placed prosthetic aortic valve. A valvuloplasty balloon was then advanced across the new prosthetic valve, and inflated, resulting in further expansion of the valve. The provider then performed prophylactic stenting of the left main coronary artery (LMCA) and the right coronary artery (RCA). What is the correct code assignment for the BASILICA technique and stent insertion during TAVR?

**Answer:**

Do not assign a unique code for the BASILICA technique that is utilized during a TAVR procedure. The provider documented that the intent of the stent placement is to prevent the risk of coronary obstruction following the prosthetic valve deployment. The Insertion table 02H has been revised and now has an option for the coronary artery body part and intraluminal device. Assign the following procedure codes:

<b>02RF3JZ</b>	Replacement of aortic valve with synthetic substitute, percutaneous approach, to capture the TAVR procedure
<b>02H13DZ</b>	Insertion of intraluminal device into coronary artery, two arteries, percutaneous approach, to capture the prophylactic stenting of coronary arteries to maintain patency



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## Coronary Artery to Root Operation Supplement

In code table 02U, Heart and Great Vessels, Supplement, coronary artery body part values have been added to enable capture of specific detail for a procedure to reinforce or augment coronary arteries, such as a stent graft placed to seal and reinforce a perforated coronary artery status post atherectomy.

Body Part	Approach	Device	Qualifier
<u>0 Coronary Artery, One Artery</u>	0 Open	7 Autologous Tissue Substitute	Z No Qualifier
<u>1 Coronary Artery, Two Arteries</u>	3 Percutaneous	8 Zooplasic Tissue	
<u>2 Coronary Artery, Three Arteries</u>	4 Percutaneous Endoscopic	J Synthetic Substitute	
<u>3 Coronary Artery, Four or More</u>		K Nonautologous Tissue Substitute	

### Question:

A patient underwent rotational atherectomy and stenting of her coronary artery. Following the rotational atherectomy, angiography revealed a perforation in the proximal circumflex coronary artery and pericardial effusion. A balloon was advanced and inflated, followed by deployment of a JoMed Graftmaster® stent graft to seal the perforation. The provider documented that the perforation was successfully repaired/treated with the JoMed GraftMaster®. What is the appropriate root operation for the deployment of the JoMed Graftmaster® stent graft to repair/treat the coronary perforation?

### Answer:

Supplement is the appropriate root operation for the deployment of the synthetic stent graft to repair/treat the coronary perforation. In this case, the JoMed Graftmaster® stent graft was deployed to seal the perforation of the proximal circumflex artery. Although stents are often used for dilation of a vessel, they can also

be used to reinforce or augment a vessel, so “Supplement” is the appropriate root operation

Assign the following ICD-10-PCS code:

**02U03JZ** Supplement coronary artery, one artery with synthetic substitute, percutaneous approach, for the placement of the JoMed Graftmaster® stent graft

### Upper Artery Bypass Qualifier

In code table 031, Upper Arteries, Bypass, the qualifier W Lower Extremity Vein, has been added. This change enables the capture of detail for an arteriovenous bypass (fistula) from an upper extremity artery to a lower extremity vein such as the femoral vein.

Body Part	Qualifier
2 Innominate Artery 3 Subclavian Artery, Right 4 Subclavian Artery, Left 5 Axillary Artery, Right 6 Axillary Artery, Left 7 Brachial Artery, Right 8 Brachial Artery, Left	<u>W Lower Extremity Vein</u>

### Percutaneous Approach Upper Artery Bypass

In code table 031, Upper Arteries, Bypass, the approach value 3 Percutaneous, has been added for the ulnar and radial artery body part values, to identify percutaneous endovascular AV fistula creation.

Body Part	Approach	Device	Qualifier
9 Ulnar Artery, Right A Ulnar Artery, Left B Radial Artery, Right C Radial Artery, Left	<u>3 Percutaneous</u>	Z No Device	F Lower Arm Vein

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## **Bifurcation Qualifier**

Over 1,800 ICD-10-PCS codes are deleted as a result of deleting the qualifier Bifurcation from the following tables in the peripheral artery body systems Upper Arteries and Lower Arteries:

- 037 Dilation of Upper Arteries,
- 03C Extirpation of Upper Arteries,
- 047 Dilation of Lower Arteries,
- 04C Extirpation of Lower Arteries, and
- 04V Restriction of Lower Arteries

The original proposal for the qualifier Bifurcation was intended to capture data regarding procedures on the coronary arteries. The use of the Bifurcation qualifier in the peripheral artery body systems created confusion among coding professionals as to the correct application of these codes.

Please note that this change does not affect the codes in the ICD-10-PCS Heart and Great Vessels body system as the qualifier Bifurcation has been retained for those tables.

## **Aneurysm Treatment Using Flow Diverter Stent**

A new device value H Intraluminal Device, Flow Diverter, has been created at table 03V, Restriction, Upper Arteries, applied to upper artery body part values noted below, to describe a stent used to treat wide-necked, giant, and fusiform intracranial aneurysms. The Flow Diverter device is implanted in the parent blood vessel (instead of placing a device inside the aneurysm sac as is done with coiling) to divert blood flow away from the aneurysm itself. Flow Diverters have a significantly higher mesh density and many more uniformly placed struts/edges than traditional vascular stents, which prevents flow in the parent artery from entering the aneurysm, thus eliminating the need for a coil.

When vascular stents are used for aneurysm therapy, they are used as adjunctive devices to the primary therapy, coil embolization. However, Flow Diverter devices may be used as a standalone therapy for aneurysm treatment without the need for other adjunctive devices.

Body Part	Device
G Intracranial Artery H Common Carotid Artery, Right J Common Carotid Artery, Left K Internal Carotid Artery, Right L Internal Carotid Artery, Left M External Carotid Artery, Right N External Carotid Artery, Left P Vertebral Artery, Right Q Vertebral Artery, Left	<u>H Intraluminal Device, Flow Diverter</u>

### Transorifice Occlusion of Gastric Varices

In code table 06L, Lower Veins, Occlusion, for the body part value 2 Gastric Vein, the following transorifice approach values were added: 7 Via Natural or Artificial Opening and 8 Via Natural or Artificial Opening Endoscopic.

This change enables accurate coding for transorifice and transorifice endoscopic procedures where occlusion of the gastric vein is performed. This change is consistent with previous changes made to the table for the body part value Esophageal Vein.

Body Part	Approach
2 Gastric Vein	<u>7 Via Natural or Artificial Opening</u> <u>8 Via Natural or Artificial Opening Endoscopic</u>

For example, assign code 06L28ZZ, Occlusion of gastric vein, via natural or artificial opening endoscopic, for an EGD with ligation of gastric varices

### Sinus Supplement

In code table 09U, Ear, Nose, Sinus, Supplement, new sinus body part values noted below have been added to allow the capture of further detail for procedures where biological or synthetic material is used to reinforce or augment the sinus.

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**Body Part**

B Mastoid Sinus, Right  
C Mastoid Sinus, Left  
L Nasal Turbinate  
P Accessory Sinus  
Q Maxillary Sinus, Right  
R Maxillary Sinus, Left  
S Frontal Sinus, Right  
T Frontal Sinus, Left  
U Ethmoid Sinus, Right  
V Ethmoid Sinus, Left  
W Sphenoid Sinus, Right  
X Sphenoid Sinus, Left

**Intestinal Bypass**

In code table 0D1, Gastrointestinal System, Bypass, general body part values 8 Small Intestine and E Large Intestine, were added with applicable qualifier values including new general qualifier Small Intestine and new general qualifier Large Intestine. The change will enable accurate coding for bypass procedures where the physician cannot determine the specific anatomical site on the intestine, such as colostomy formation in patients with previous colon resection.

Body Part	Qualifier
8 Small Intestine	8 Small Intestine
E Large Intestine	E Large Intestine

**Transfer Large Intestine to Vagina**

In code table 0DX, Gastrointestinal System, Transfer, the qualifier value 7 Vagina has been added for the large intestine body part value. This change enables the capture of vaginal construction procedures using the large intestine.

Body Part	Qualifier
E Large Intestine	7 Vagina

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**Question:**

A patient with congenital absence of the vagina (vaginal agenesis) is admitted for vaginal construction. The physician performed a laparoscopic-assisted colovaginoplasty with development of sigmoid advancement flap as the conduit for the vaginoplasty. How is this surgery coded?

**Answer:**

A sigmoid advancement pedicle was utilized to create the vagina. Although the root operation Creation was expanded in FY 2017 to be utilized also for the correction of congenital anomalies, the root operation "Transfer," best describes this procedure. Assign the following ICD-10-PCS code:

**0DXE0Z7**      Transfer large intestine to vagina, open approach, for the vaginal construction

In this case, the root operation "Creation" is not appropriate because the definition of Transfer "moving, without taking out, all or a portion of a body part to another location to take over the function of all or a portion of a body part," more closely aligns with the intent of the procedure performed.

**Breast Procedures**

In the Skin and Breast body system of the Medical and Surgical section, 83 codes with the External approach value, X, were deleted for the Breast body part for the following tables:

Table	Root Operation/Body System
0H0	Alteration, Skin and Breast
0H5	Destruction, Skin and Breast
0H9	Drainage, Skin and Breast
0HB	Excision, Skin and Breast

0HC	Extirpation, Skin and Breast
0HD	Extraction, Skin and Breast
0HH	Insertion, Skin and Breast
0HJ	Inspection, Skin and Breast
0HN	Release, Skin and Breast
0HP	Removal, Skin and Breast
0HQ	Repair, Skin and Breast
0HR	Replacement, Skin and Breast
0HU	Supplement, Skin and Breast
0HW	Revision, Skin and Breast

Body Part	Approach
T Breast, Right U Breast, Left V Breast, Bilateral Y Supernumerary Breast	<del>X External</del>

This change will not affect the root operations Change and Reattachment. The External approach for the Breast body part will remain for those two tables.

This change allows a clear distinction between procedures that are performed on the skin of the chest and those performed on breast tissue. Procedures performed on the skin of the chest will be classified to the body part value 5, Skin, Chest with the approach value, X, External. Procedures that are performed on breast tissue will be captured with the approach value, 0, Open.

In addition, new body part values were added to table 0HD, Skin and Breast, Extraction, for the Breast body part value and the approach value Open. This change will allow reporting of nonexcisional debridement of breast tissue beneath the level of the skin of the chest.

Body Part	Approach	Device	Qualifier
T <u>Breast, Right</u> U <u>Breast, Left</u> V <u>Breast, Bilateral</u> Y <u>Supernumerary Breast</u>	0 <u>Open</u>	Z No Device	Z No Qualifier

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## Cell Suspension Epithelial Autograft

Cell Suspension is a method by which autologous cells are harvested, prepared and applied to the wound bed of acute thermal burns to promote wound healing and reconstruction.

In the RECELL® technique, a thin split-thickness skin sample is obtained from a donor site. The skin sample is incubated in an enzyme solution that allows a mixed population of cells that include keratinocytes, fibroblasts and melanocytes to be disaggregated and scraped away from the epidermis and dermis of the skin sample. The cells are collected and drawn into a syringe of buffer solution for cell suspension. The cell suspension produces a Regenerative Epidermal Suspension (RES™) that can be sprayed or dripped directly onto the partial-thickness wound.

In table 0HR, Replacement, Skin and Breast, the qualifier, 2 Cell Suspension Technique, has been created for this autologous skin replacement.

Body Part	Approach	Device	Qualifier
0 Skin, Scalp 1 Skin, Face 2 Skin, Right Ear 3 Skin, Left Ear 4 Skin, Neck 5 Skin, Chest 6 Skin, Back 7 Skin, Abdomen 8 Skin, Buttock 9 Skin, Perineum A Skin, Inguinal B Skin, Right Upper Arm C Skin, Left Upper Arm D Skin, Right Lower Arm E Skin, Left Lower Arm F Skin, Right Hand G Skin, Left Hand H Skin, Right Upper Leg J Skin, Left Upper Leg K Skin, Right Lower Leg L Skin, Left Lower Leg M Skin, Right Foot N Skin, Left Foot	X External	7 Autologous Tissue Substitute	2 <u>Cell Suspension Technique</u>



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## Subcutaneous Implantable Cardioverter Defibrillator Lead

A new device value F Subcutaneous Defibrillator Lead has been added to the following tables:

- 0JH Subcutaneous Tissue and Fascia, Insertion

Body Part	Approach	Device	Qualifier
6 Subcutaneous Tissue and Fascia, Chest	0 Open 3 Percutaneous	<u>F</u> <u>Subcutaneous</u> <u>Defibrillator</u> <u>Lead</u>	Z No Qualifier

- 0JP Subcutaneous Tissue and Fascia, Removal
- 0JW Subcutaneous Tissue and Fascia, Revision

Body Part	Approach	Device	Qualifier
T Subcutaneous Tissue and Fascia, Trunk	0 Open 3 Percutaneous	<u>F</u> <u>Subcutaneous</u> <u>Defibrillator</u> <u>Lead</u>	Z No Qualifier

The Subcutaneous Implantable Cardioverter Defibrillator (S-ICD) System is used to treat life-threatening ventricular tachyarrhythmia. Similar to conventional implantable cardioverter defibrillators (ICDs), the subcutaneous implantable cardioverter defibrillator senses and converts cardiac arrhythmia via an electrical shock. Unlike traditional ICDs, in which transvenous electrodes/leads are placed directly into the heart via a large vein, the S-ICD utilizes a subcutaneous electrode that rests near (but not in) the heart for sensing and defibrillation. The electric pulse generator is implanted just below the axilla.

Previously, there were not any ICD-10-PCS device values in tables 0JH, 0JP and 0JW to describe the insertion, removal and revision of a subcutaneous implantable cardioverter defibrillator (S-ICD™) lead.

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## Intramedullary Limb Lengthening Internal Fixation Device

The device value 7 Internal Fixation Device, Intramedullary Limb Lengthening was added to the following tables:

- 0PH Upper Bones, Insertion

Body Part	Device
F Humeral Shaft, Right	<u>7 Internal Fixation Device,</u>
G Humeral Shaft, Left	<u>Intramedullary Limb Lengthening</u>

- 0QH Lower Bones, Insertion

Body Part	Device
8 Femoral Shaft, Right	<u>7 Internal Fixation Device,</u>
9 Femoral Shaft, Left	<u>Intramedullary Limb Lengthening</u>
G Tibia, Right	<u>7 Internal Fixation Device,</u>
H Tibia, Left	<u>Intramedullary Limb Lengthening</u>

An example of this type of system is the PRECICE® Intramedullary Limb Lengthening (IMLL) System which is composed of the PRECICE® nail, locking screws, end cap, surgical instruments, and an external remote controller (ERC or ERC 2P).

This system is designed to lengthen the limb gradually without the use of external fixation. The procedure is similar to implanting an intramedullary nail in the femur, tibia or humerus. However, the PRECICE® implant differs from traditional intramedullary surgical techniques in that it has a small magnet that allows the implant to get shorter or longer when the magnet is turned by the ERC. The ERC is a hand held device with two large magnets. The magnet in the implant turns when the ERC is placed on the arm or leg and turned on.

The removal of the device is coded to the root operation Removal and device value, Internal Fixation Device.

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## Extirpation of Jaw

In code table 0WC, Anatomical Regions, General Body System, Extirpation, the body part values, 4 Upper Jaw and 5 Lower Jaw, have been added to allow the capture of an extirpation procedure of the upper or lower jaw such as evacuation of a semi-solid hematoma from mandibular and maxillary spaces.

Body Part	Approach	Device	Qualifier
<u>4 Upper Jaw</u> <u>5 Lower Jaw</u>	0 Open 3 Percutaneous 4 Percutaneous Endoscopic	Z No Device	Z No Qualifier

## Section 3-Administration

### Transfusion of Blood Products

In the Administration section, in the Circulatory body system, the body part values, 5 Peripheral Artery and 6 Central Artery, are deleted from Transfusion table, 302. This deletion removes 128 clinically invalid codes involving transfusion of substances in the peripheral and central arteries.

Body System/Region	Substance
<del>5 Peripheral Artery</del> <del>6 Central Artery</del>	G Bone Marrow H Whole Blood J Serum Albumin K Frozen Plasma L Fresh Plasma M Plasma Cryoprecipitate N Red Blood Cells P Frozen Red Cells Q White Cells R Platelets S Globulin T Fibrinogen V Antihemophilic Factors W Factor IX X Stem Cells, Cord Blood Y Stem Cells, Hematopoietic

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## T-Cell Depleted Hematopoietic Stem Cells for Transplantation

In table 302, Administration, a new substance value was added, U Stem Cells, T-cell Depleted Hematopoietic, where the qualifier value specifies an allogeneic donor source.

Body Part	Substance	Qualifier
3 Peripheral Vein 4 Central Vein	<u>U Stem Cells,</u> <u>T-cell Depleted</u> <u>Hematopoietic</u>	2 Allogeneic, Related 3 Allogeneic, Unrelated 4 Allogeneic, Unspecified

Allogeneic hematopoietic stem cell (HSC) transplants are used in the treatment of certain blood cancers, such as leukemia, multiple myeloma, and some types of lymphoma. Several sources are used for HSC transplantation, including HLA-identical sibling donors, other related and unrelated donors. The risk of graft versus host disease (GVHD) is increased when cells from unrelated donors or other related donors are used compared to HLA-identical sibling donors. One method to reduce the risk of GVHD is to use a T-cell depleted stem cell transplant. The procedure to produce T-cell depleted stem cells for transplant occurs following apheresis and prior to the infusion of the cells.

## Hyperthermic Antineoplastic Chemotherapy

In the Administration section, code table 3E0, Introduction, Circulatory body system, a new qualifier value, Y Hyperthermic, has been created for the body part value, M Peritoneal Cavity for the antineoplastic substance. This change enables the capture of administration of hyperthermic intraperitoneal chemotherapy (HIPEC).

Body System/ Region	Approach	Substance	Qualifier
M Peritoneal Cavity	3 Percutaneous	0 Antineoplastic	Y Hyperthermic

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Hyperthermic intraperitoneal chemotherapy (HIPEC) combines surgery with chemotherapy for the treatment of cancers in the abdomen. It is administered at the end of cytoreductive surgery, delivering chemotherapy directly into the abdominal cavity after the visible tumors are removed. The hyperthermia enhances absorption of chemotherapy into tumor cells and continues for approximately 90 to 120 minutes. The solution is then removed, and the incision closed. The purpose of the procedure is to increase the temperature inside the abdominal cavity, which helps to destroy cancer cells. The source of the heat is the infusion.

**Question:**

A patient with adenocarcinoma of the appendix with peritoneal metastasis presented for scheduled hyperthermic intraperitoneal chemotherapy (HIPEC). The patient underwent cytoreductive surgery, along with removal of additional pelvic and abdominal organs. Inflow and outflow cannulas were placed, and the patient was given mitomycin in the perfusion circuit for a total of two hours of hyperthermic intraperitoneal chemotherapy. What is the correct code assignment for hyperthermic intraperitoneal chemotherapy?

**Answer:**

Assign the following procedure code:

**3E0M30Y** Introduction of hyperthermic antineoplastic into peritoneal cavity, percutaneous approach, for hyperthermic intraperitoneal chemotherapy

Code DWY38ZZ, Hyperthermia of abdomen, is not appropriate as Section D codes are only for radiation therapy.

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## Irrigation of Joint using Irrigating Substance

In table 3E1, Irrigation, Physiological Systems and Anatomical Regions, approach value, 4 Percutaneous Endoscopic, was added for the body part value Joints.

Body Part	Approach
U Joints	3 Percutaneous 4 Percutaneous Endoscopic

This change will enable accurate coding for procedures where arthroscopic irrigation of a joint is the definitive procedure.

## Section 4-Measurement and Monitoring

### Intraoperative Fluorescence Lymphatic Mapping Using Indocyanine Green Dye

In table 4A1, Monitoring of Physiological Systems, a new qualifier value, H Indocyanine Green Dye, has been created for the body system value 6 Lymphatic and the function value 5 Flow, to enable the capture of additional detail for lymphatic mapping procedures using Indocyanine Green dye.

Body System	Approach	Function/ Device	Qualifier
6 Lymphatic	0 Open 3 Percutaneous 7 Via Natural or Artificial Opening 8 Via Natural or Artificial Opening Endoscopic	5 Flow	H Indocyanine Green Dye Z No Qualifier

During gynecological surgery, sentinel lymph node imaging using Indocyanine green (ICG) is accomplished by injecting ICG into the uterine cervix, or endometrium. The fluorescence of ICG is visualized using near infrared light. Color-coded quantified imaging of ICG makes it possible to differentiate between lymphatic pathways/lymph nodes and ICG fluorescence outside the lymphatic system.

Surgical staging and its pathological assessment provides useful information regarding the primary tumor and lymph node status, which

can be critical in predicting disease progression, possible outcomes and adjuvant treatment. Lymphadenectomy is the standard surgical technique for uterine and endometrial tumors. However, the use of intraoperative fluorescence lymphatic mapping using ICG dye can decrease the number of lymph nodes resected, reduce surgical time, as well as morbidity, and the risks associated with full staging lymphadenectomy.

## Section 5-Extracorporeal or Systemic Assistance and Performance

### Intraoperative ECMO

In code table 5A1, Physiological Systems, Performance, new duration value A Intraoperative was added to enable differentiating Extracorporeal Membrane Oxygenation (ECMO) that is utilized for intraoperative support from ECMO that is utilized as life support.

Intraoperative ECMO may be used as temporary circulatory support for the duration of a procedure such as a lung transplant or a high-risk percutaneous coronary intervention (PCI).

Body System	Duration	Function	Qualifier
5 Circulatory	2 Continuous <u>A Intraoperative</u>	2 Oxygenation	F Membrane, Central G Membrane, Peripheral Veno-Arterial H Membrane, Peripheral Veno-venous

**Question:**

The patient is a 75-year-old male with coronary artery disease, who is admitted for a non-ST elevation myocardial infarction. Coronary angiography reveals a heavily calcified 80% left main stenosis. Veno-Arterial (VA) ECMO was used for hemodynamic support during the percutaneous coronary intervention.

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Under fluoroscopic guidance, VA ECMO is instituted and the PCI of the left main lesion using a drug-eluting stent is undertaken. At the end of the procedure, VA ECMO is weaned, percutaneous femoral sheaths are removed, and the access sites are closed. Is it appropriate to assign intraoperative ECMO codes for procedures performed in the cardiac catheterization lab rather than the operating suite? How should the procedures be coded?

**Answer:**

Yes, it is appropriate to assign codes for intraoperative ECMO performed in the cardiac catheterization lab. The term “intraoperative” is applicable to ECMO that is used during an operative episode only and is no longer used at the conclusion of the procedure, regardless of the setting. The intraoperative ECMO procedure codes are not limited to procedures performed in the operating room. Assign the following ICD-10-PCS codes:

- |                |  |
|----------------|--|
| <b>027034Z</b> | Dilation of coronary artery, one artery with drug-eluting intraluminal device, percutaneous approach, for the percutaneous coronary intervention with a drug-eluting stent |
| <b>5A15A2G</b> | Extracorporeal oxygenation, membrane, peripheral veno-arterial, intraoperative, for the intraoperative ECMO performed in the cardiac catheterization laboratory            |



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**Question:**

What is the meaning of “central” in the context of the ICD-10-PCS ECMO codes? Is the list of vessels considered “central” for the ECMO codes the same as the list published in *Coding Clinic*, Third Quarter 2014, p. 27, which established a coding convention for sections of the ICD-10-PCS containing values that distinguish central vessels from peripheral vessels?

**Answer:**

No, the list published in *Coding Clinic*, Third Quarter 2014, p. 27, referred to a coding convention for the central artery/vein body part values. For ECMO procedures, central cannulation is performed via an open sternotomy using the great vessels that attach to the heart or directly in the heart chambers, while peripheral cannulation refers to a percutaneous approach and typically involves the femoral, cervical, or axillary vessels.

## Section 8-Other Procedures

### Intraoperative Fluorescence Guidance

In section 8, Other Procedures, a new method value E Fluorescence Guided Procedure, was added for the body regions, Head and Neck, Trunk, Upper Extremity, and Lower Extremity, to capture additional detail for fluorescence-guided procedures.

For example, the new codes can be used to report fluorescence guided surgery performed following administration of Aminolevulinic Acid (ALA, also known by its trade name Gleolan™). The fluorescent agent allows the surgeon to more accurately identify tumor margins during brain tumor resection.

Body Region	Method
9 Head and Neck Region W Trunk Region X Upper Extremity Y Lower Extremity	<u>E Fluorescence Guided Procedure</u>

In addition, the qualifier value, M Aminolevulinic Acid, has been created for Fluorescence Guided Procedure, Open Approach in the Head and Neck Region, to specify the fluorescing agent used in the example above.

Body Region	Approach	Method	Qualifier
9 Head and Neck Region	0 Open	<u>E Fluorescence Guided Procedure</u>	M Aminolevulinic Acid Z No Qualifier

## Section D-Radiation Therapy

### Unidirectional Source Brachytherapy

In the Radiation Therapy section, a new qualifier value, 1 Unidirectional Source, has been added to all Brachytherapy tables for the fifth character modality value B Low Dose Rate and the sixth character Isotope value B Palladium 103, to identify CivaSheet® brachytherapy.

Modality Qualifier	Isotope	Qualifier
B Low Dose Rate (LDR)	Palladium 103 (Pd-103)	1 Unidirectional Source

The qualifier, 1 Unidirectional Source, has been added to the following tables in the Radiation Therapy System, Brachytherapy modality:

Table	Body System
D01	Central and Peripheral Nervous System
D71	Lymphatic and Hematologic System
D81	Eye
D91	Ear, Nose, Mouth and Throat
DB1	Respiratory System
DD1	Gastrointestinal System
DF1	Hepatobiliary System and Pancreas
DG1	Endocrine
DM1	Breast
DT1	Urinary System
DU1	Female Reproductive System
DV1	Male Reproductive System
DW1	Anatomical Regions

In addition, new fourth character treatment sites have been added to table DW1, Brachytherapy of Anatomical Regions as noted below to capture additional treatment sites:

<b>Treatment Site</b>
<u><b>0</b> Cranial Cavity</u>
<u><b>K</b> Upper Back</u>
<u><b>L</b> Lower Back</u>
<u><b>P</b> Gastrointestinal Tract</u>
<u><b>Q</b> Respiratory Tract</u>
<u><b>R</b> Genitourinary Tract</u>
<u><b>X</b> Upper Extremity</u>
<u><b>Y</b> Lower Extremity</u>

A new section has been added to the ICD-10-PCS *Official Guidelines for Coding and Reporting* to explain the usage of the brachytherapy codes.

The CivaSheet® Brachytherapy Device (“CivaSheet®”) is a unidirectional implantable low dose rate (LDR) brachytherapy source applied intraoperatively during the same operative episode. CivaSheet® is configured as an array of directional radioactive palladium-103 sources encapsulated in an organic polymer and embedded within a flexible, membrane-like bioabsorbable substrate. The device uses a gold shielding incorporated into each source, giving the sheet an active and an inactive side. The active side delivers a full dose of radiation to surgical margins, while radiosensitive and healthy tissues on the inactive side are shielded from unnecessary and potentially harmful radiation.

Some of the localized tumors for which CivaSheet® may be used include colorectal, gynecological, head and neck, pancreatic cancers, soft tissue sarcomas, non-small-cell lung cancer, ocular melanoma, and atypical meningioma.

**Question:**

The patient is a 48-year-old woman with a diagnosis of retroperitoneal sarcoma, who had previously undergone resection of a well-differentiated sarcoma followed by re-excision of local recurrence, with extension to the left retroperitoneum. She now returns because of

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recurrence along the anterior margin of the left psoas muscle within the pelvis. The left psoas muscle tumor was resected. Intraoperative radiation therapy (IORT) was accomplished by implanting a 5 cm × 15 cm CivaSheet® in the left psoas muscle with the hot side facing the tumor bed within the pelvis, and the gold shielded side facing the inside of the abdominal cavity to protect the left kidney and bowel from radiation. The wound was sutured with the brachytherapy source left in place. How should this case be coded?

**Answer:**

Assign code C49.4, Malignant neoplasm of connective and soft tissue of abdomen, for the sarcoma of the psoas muscle where it passes through the pelvic region. Assign the following procedure codes:

- |                |  |
|----------------|--|
| <b>0KBP0ZZ</b> | Excision of left hip muscle, open approach, for the excision of the left psoas muscle tumor  |
| <b>0WHJ01Z</b> | Insertion of radioactive element into pelvic cavity, open approach, for the insertion of the radioactive element in the left psoas muscle, within the pelvis                                       |
| <b>DW16BB1</b> | Low dose rate (LDR) brachytherapy of pelvic region using palladium 103 (pd-103), unidirectional source, for the insertion of the brachytherapy source in the left psoas muscle, within the pelvis. |

According to the ICD-10-PCS Guideline D1a., “When a radioactive brachytherapy source is left in the body at the end of the procedure, it is coded separately using the root operation Insertion with the device value Radioactive

Element.” In addition, the guideline indicates, “the implantation of the brachytherapy source is coded separately to the device value Radioactive Element in the appropriate Insertion table of the Medical and Surgical section. The Radiation Therapy section code identifies the specific modality and isotope of the brachytherapy, and the root operation Insertion code identifies the implantation of the brachytherapy source that remains in the body at the end of the procedure.”

If the device value Radioactive Element does not exist in the applicable Insertion table, assign the device value Other Device.

## Section X-New Technology

Three new code tables were created in Section X and values were added to existing code tables. All the new codes below have the qualifier value, 5 New Technology Group 5.

### Sustained Released Drug-Eluting Stent

New code table X27, Cardiovascular System, Dilation, captures the insertion of sustained release drug-eluting stents for peripheral arteries of the leg. The new device values also identify the number of stents similar to other drug-eluting stents in the Medical Surgical Section, Dilation, of the Lower Arteries.

Body Part	Device/Substance/Technology
H Femoral Artery, Right	<u>8 Intraluminal Device, Sustained Release Drug-eluting</u>
J Femoral Artery, Left	<u>9 Intraluminal Device, Sustained Release Drug-eluting, Two</u>
K Popliteal Artery, Proximal Right	<u>B Intraluminal Device, Sustained Release Drug-eluting, Three</u>
L Popliteal Artery, Proximal Left	<u>C Intraluminal Device, Sustained Release Drug-eluting, Four or</u>
M Popliteal Artery, Distal Right	<u>More</u>
N Popliteal Artery, Distal Left	
P Anterior Tibial Artery, Right	
Q Anterior Tibial Artery, Left	
R Posterior Tibial Artery, Right	
S Posterior Tibial Artery, Left	
T Peroneal Artery, Right	
U Peroneal Artery, Left	

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The new stents, used to treat peripheral artery disease differ from traditional drug-eluting stents, as the sustained release of the anti-restenotic drug paclitaxel lasts significantly longer than the two-month duration of drug deposited from drug-coated balloons and drug-coated stents.

### **Cerebral Embolic Filtration**

A new code has been created at table X2A, Cardiovascular System, Assistance, to describe cerebral embolic protection for the aortic arch and to differentiate the filter device. Prior to this change, ICD-10-PCS described only the innominate artery and left common carotid artery in the Body Part value and a dual filter device.

<b>Body Part</b>	<b>Device/Substance/Technology</b>
6 Aortic Arch	2 Cerebral Embolic Filtration, Single Deflection Filter

The cerebral embolic filtration device is used in conjunction with transcatheter aortic valve replacement (TAVR) procedures to treat high-risk and moderate-risk patients with aortic stenosis.

An example of the single deflection cerebral embolic filtration device is the Keystone Heart TriGuard 3™ Cerebral Embolic Protection Device (CEPD). The CEPD consists of a temporary, retrievable, sterile, single use, biocompatible filter. The CEPD is introduced transfemorally, delivered percutaneously under fluoroscopic guidance, and positioned in the aortic arch to cover the innominate, left carotid, and left subclavian arteries.

A separate code is assigned for the TAVR procedure with the appropriate values from table 02R, Replacement of Heart and Great Vessels.

### **Renal Function Monitoring**

New code table XT2, Urinary System, Monitoring, provides a new code to capture the point-of-care transdermal real-time monitoring of the glomerular filtration rate (GFR) by noninvasively measuring fluorescent light emission from an exogenous tracer agent that is cleared by glomerular filtration.

Device/Substance/Technology
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E Fluorescence Pyrazine
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Current clinical practice for renal function monitoring is to calculate estimated glomerular filtration rate (eGFR), using one of several empirically derived equations. The calculation of eGFR includes inputs of serum creatinine concentration (requiring a blood draw) and several other parameters including height, weight, gender, and ethnicity.

The Transdermal GFR Measurement System is a three-component system consisting of (1) an optical skin sensor, (2) a monitor and (3) MB-102, which is a proprietary pyrazine based small molecule fluorescent tracer agent that glows in the presence of light. The noninvasive monitoring technology works in a similar fashion to pulse oximetry by using a light sensor placed on the skin. The proprietary biocompatible tracer is administered after the sensor has been placed. The system can then monitor the patient's real-time point of care kidney function.

### New Therapeutic Substances

Eleven new substance values were added to code table XW0, Anatomical Regions, Introduction, as noted below.

Device/Substance/Technology
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<u>J Apalutamide Antineoplastic</u>
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<u>K Fosfomycin Anti-infective</u>
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<u>L Erdafitinib Antineoplastic</u>
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<u>N Meropenem-vaborbactam Anti-infective</u>
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<u>Q Tagraxofusp-erzs Antineoplastic</u>
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<u>R Venetoclax Antineoplastic</u>
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<u>S Iobenguane I-131Antineoplastic</u>
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<u>T Ruxolitinib</u>
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<u>U Imipenem-cilastatin-relebactam Anti-infective</u>
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<u>V Gilteritinib Antineoplastic</u>
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<u>W Caplacizumab</u>
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### Apalutamide Antineoplastic

Apalutamide, also known by its trade name ERLEADA™, is an oral androgen receptor inhibitor indicated for the treatment of patients with non-metastatic castration-resistant prostate cancer (NM-CRPC).

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Prostate cancer that has not spread to other parts of the body and no longer responds to medical or surgical treatment that lowers testosterone is called non-metastatic castration-resistant prostate cancer or NM-CRPC.

### **Fosfomycin Anti-infective**

Fosfomycin, also known by its brand name CONTEPO™, is a new anti-infective drug administered intravenously to treat complicated urinary tract infections caused by multi-drug resistant pathogens.

### **Erdafitinib Antineoplastic**

Erdafitinib is an orally administered antineoplastic used as a targeted treatment for patients with metastatic or surgically unresectable urothelial cancer or transitional cell cancer. These cancers start in the urothelial cells lining the inside of the bladder.

Erdafitinib may be indicated for use in a subset of patients with urothelial cancer who have a fibroblast growth factor receptor (FGFR) genetic alteration in the tumor, and who have had disease progression during or following at least one line of prior chemotherapy including within 12 months of chemotherapy.

### **Meropenem-vaborbactam Anti-infective**

Meropenem-vaborbactam is a medication administered intravenously and developed to treat complicated urinary tract infections including acute pyelonephritis caused by susceptible enterobacteriaceae such as *Escherichia coli*, *Klebsiella pneumoniae* and *Enterobacter cloacae* species complex and other drug-resistant infections. Meropenem is an antibacterial. Vaborbactam inhibits certain types of resistance mechanisms used by bacteria. The combination of meropenem and vaborbactam addresses the need for medications that treat CRE (Carbapenem-resistant Enterobacteriaceae) bacteria that are associated with high mortality rates and severe infections.

Complicated urinary tract infections are a common cause of hospitalizations with Enterobacteriaceae being the predominant pathogen. Carbapenems are a class of antibiotics that are generally the first-line of treatment against both Gram-negative and Gram-positive organisms; however, the emergence of carbapenem



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resistance in Enterobacteriaceae poses a worldwide threat to public health. Meropenem-vaborbactam is the first carbapenem beta-lactamase inhibitor combination approved in the USA for patients with complicated urinary tract infections (cUTIs).

### **Tagraxofusp-erzs Antineoplastic**

Tagraxofusp-erzs, also known by its brand name ELZONRIS™, is administered as an intravenous infusion for the treatment of blastic plasmacytoid dendritic cell neoplasm (BPDCN). BPDCN, previously known as blastic natural killer (NK) cell leukemia/lymphoma, is a rare, highly aggressive hematologic malignancy that occurs predominantly in males between the ages of 60 and 70. Primary sites include the skin and bone marrow.

### **Venetoclax Antineoplastic**

Venetoclax, also known by its brand name VENCLEXTA®, is an oral drug for the treatment of chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL). In combination with azacitidine, or decitabine, or low-dose cytarabine, venetoclax is also used to treat adults with newly-diagnosed acute myeloid leukemia (AML) who are 75 years of age or older, or have other medical conditions that prevent the use of standard chemotherapy.

### **Iobenguane I-131 Antineoplastic**

Iobenguane Iodine-131, also known by its brand name AZEDRA®, is a drug formulated for intravenous (IV) use in the treatment of patients with unresectable, locally advanced or metastatic pheochromocytoma or paraganglioma (collectively referred to as PPGL) who require systemic anticancer therapy. PPGL are ultra-rare neuroendocrine tumors, affecting only 2 to 8 people per million in the United States.

### **Ruxolitinib**

Ruxolitinib, also known by its brand name JAKAFI™, is an oral medication for the treatment of patients with intermediate or high-risk myelofibrosis (MF), polycythemia vera (PV), or acute graft versus host disease (GVHD) in patients who have had an inadequate response to corticosteroids.

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## **Imipenem-cilastatin-relebactam Anti-infective**

Imipenem, Cilastatin, and Relebactam (IMI/REL) injection is a fixed dose combination of imipenem/cilastatin (IMI), a  $\beta$ -lactam (BL) antibacterial (specifically, a carbapenem), and relebactam (REL), a novel  $\beta$ -lactamase inhibitor (BLI). IMI/REL did not have a trade name at the time of publication. It is anticipated that when approved, IMI/REL will be indicated for the treatment of adult patients with (a) complicated intra-abdominal infections caused by susceptible gram-negative microorganisms where limited or no alternative therapies are available and (b) complicated urinary tract infections, including pyelonephritis, caused by susceptible gram-negative microorganisms where limited or no alternative therapies are available.

## **Gilteritinib Antineoplastic**

Gilteritinib, also known by its brand name XOSPATA® is an oral medication for the treatment of adult patients who have relapsed or refractory (R/R) Acute Myeloid Leukemia (AML) with a FLT3 mutation. FLT3 is one of the most commonly identified mutations in AML<sup>30</sup>. AML is a type of cancer in which the bone marrow makes abnormal myeloblasts, red blood cells, or platelets.

## **Caplacizumab**

Caplacizumab, also known by its brand name CABLIVI®, is administered intravenously to treat adults with acquired thrombotic thrombocytopenic purpura. The condition is a life-threatening, immune-mediated thrombotic microangiopathy characterized by severe thrombocytopenia, hemolytic anemia, and organ ischemia with an estimated 3 to 11 cases per million per year in the U.K. and U.S.

### **Whole Blood Nucleic Acid-Base Microbial Detection**

New code table XXE, Physiological System, Measurement, provides a new code for the T2Bacteria® Panel (Whole Blood Nucleic Acid-base Microbial Detection).

<b>Device/Substance/Technology</b>
M Infection, Whole Blood Nucleic Acid-base Microbial Detection

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The T2Bacteria® Panel is a new diagnostic technology that can detect five major bacterial pathogens directly from whole blood and provide a result within three to five hours. The detected species are five of the most common and virulent sepsis-causing organisms, including *E. coli*, *E. faecium*, *K. pneumoniae*, *P. aeruginosa*, and *S. aureus*.

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## CHANGES TO THE ICD-10-CM OFFICIAL GUIDELINES FOR CODING AND REPORTING

A summary of the modifications to the *ICD-10-CM Official Guidelines for Coding and Reporting* are included below. The complete guidelines may be downloaded by visiting <http://www.cdc.gov/nchs/icd/icd10cm.htm>

The modifications are published below using the following format:

Narrative changes appear in bold text (e.g., **severe sepsis**).  
Items underlined were moved within the guidelines since October 1, 2019 (e.g., severe sepsis).  
Deletions are shown as strikeouts (e.g., ~~severe sepsis~~).

Please note the term “physician” has been revised to “provider” in the following sections of the *Official Guidelines for Coding and Reporting*:

- Section I. Conventions, General Coding Guidelines and Chapter Specific Guidelines
  - o Chapter 1: Certain Infectious and Parasitic Diseases
  - o Chapter 17: Congenital malformations, deformations, and chromosomal abnormalities (Q00-Q99)
- Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services.

### Section I. Conventions, general coding guidelines and chapter specific guidelines . . .

#### A. Conventions for the ICD-10-CM . . .

##### 15. “With” . . .

The word “with” in the Alphabetic Index is sequenced immediately following the main term **or subterm**, not in alphabetical order. . . .

#### C. Chapter Specific Coding Guidelines . . .

##### 1. Chapter 1: Certain Infectious and Parasitic Diseases. . .

##### d. Sepsis, Severe Sepsis, and Septic Shock

##### 4) Sepsis and or severe sepsis with a localized infection.

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~~f. Zika virus infections . . .~~

~~1) Code only confirmed cases . . .~~

~~In this context, “confirmation” does not require documentation of the type of test performed; the physician’s provider’s diagnostic statement that the condition is confirmed is sufficient.~~

2. Chapter 2: Neoplasms (C00-D49) . . .

d. Primary malignancy previously excised . . .

The secondary site may be the principal or first listed **diagnosis** with the Z85 code used as a secondary code.

I. Sequencing of neoplasm codes . . .

5) Complication from surgical procedure for treatment of a neoplasm

See the guideline regarding the coding of a current malignancy versus personal history to determine if the code for the neoplasm should also be assigned.

9. Chapter 9: Diseases of the Circulatory System (I00-I99)

e. Acute myocardial infarction (AMI) . . .

5) Other Types of Myocardial Infarction

The ICD-10-CM provides codes for different types of myocardial infarction. Type 1 myocardial infarctions are assigned to codes I21.0-I21.4 and I24.9.

Type 2 myocardial infarction, (myocardial infarction due to demand ischemia or secondary to ischemic imbalance) is assigned to code I21.A1, Myocardial infarction type 2 with a code for the underlying cause **coded first**. Do not assign code I24.8, Other forms of acute ischemic heart disease, for the demand ischemia. ~~Sequencing of type 2 AMI or the underlying cause is dependent on the circumstances of admission.~~

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## 12. Chapter 12: Diseases of the Skin and Subcutaneous Tissue (L00-L99)

### a. Pressure ulcer stage codes

#### 1) Pressure ulcer stages . . .

Codes from category L89, Pressure ulcer, identify the site **and stage** of the pressure ulcer as well as the stage of the ulcer.

The ICD-10-CM classifies pressure ulcer stages based on severity, which is designated by stages 1-4, **deep tissue pressure injury**, unspecified stage, and unstageable. . . .

#### 2) Unstageable ulcer stages . . .

Assignment of the code for unstageable pressure ulcer (L89.--0) should be based on the clinical documentation. These codes are used for pressure ulcers whose stage cannot be clinically determined (e.g., the ulcer is covered by eschar or has been treated with a skin or muscle graft ~~and pressure ulcers that are documented as deep tissue injury but not documented as due to trauma.~~) . . .

#### 4) Patients admitted with pressure ulcers documented as healed

No code is assigned if the documentation states that the pressure ulcer is completely healed **at the time of admission.** . . .

#### 7) Pressure-induced deep tissue damage

**For pressure-induced deep tissue damage or deep tissue pressure injury, assign only the appropriate code for pressure-induced deep tissue damage (L89.--6).** . . .

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**15. Chapter 15: Pregnancy, Childbirth, and the Puerperium (O00-O9A) . . .**

**n. Normal Delivery, Code O80**

**1) Encounter for full term uncomplicated delivery . . .**

Code O80 is always a principal diagnosis. It is not to be used if any other code from chapter 15 is needed to describe a current complication of the antenatal, delivery, or ~~perinatal~~ **postnatal** period. . . .

**q. Termination of Pregnancy and Spontaneous abortions**

**2) Retained Products of Conception following an abortion . . .**

If the patient has a specific complication associated with the spontaneous abortion or elective termination of pregnancy in addition to retained products of conception, assign the appropriate complication ~~in category~~ **code (e.g., O03.-, or O04.-, O07.-)** instead of code O03.4 or O07.4.

**17. Chapter 17: Congenital malformations, deformations, and chromosomal abnormalities (Q00-Q99) . . .**

Although present at birth, a malformation/deformation/ or chromosomal abnormality may not be identified until later in life. Whenever the condition is diagnosed by the ~~physician~~ **provider**, it is appropriate to assign a code from codes Q00-Q99.

**19. Chapter 19: Injury, poisoning, and certain other consequences of external causes (S00-T88) . . .**

**b. Coding of Injuries . . .**

**3) Iatrogenic injuries**

**Injury codes from Chapter 19 should not be assigned for injuries that occur during, or as a result of, a medical intervention. Assign the appropriate complication code(s).**

- 
- c. **Coding of Traumatic Fractures . . .**
- 3) **Physeal fractures**  
For physeal fractures, assign only the code identifying the type of physeal fracture. Do not assign a separate code to identify the specific bone that is fractured.
- e. **Adverse Effects, Poisoning, Underdosing and Toxic Effects . . .**
- 4) If two or more drugs, medicinal or biological substances  
If two or more drugs, medicinal or biological substances are ~~reported~~ **taken**, code each individually unless a combination code is listed in the Table of Drugs and Chemicals.
- If multiple unspecified drugs, medicinal or biological substances were taken, assign the appropriate code from subcategory T50.91, Poisoning by, adverse effect of and underdosing of multiple unspecified drugs, medicaments and biological substances.**
- g. **Complications of care**
- 5) **Complications of care codes within the body system chapters . . .**  
Complication codes from the body system chapters should be assigned for intraoperative and postprocedural complications (e.g., the appropriate complication code from chapter 9 would be assigned for a vascular intraoperative or postprocedural complication) unless the complication is specifically indexed to a T code in chapter 19.



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## 21. Chapter 21: Factors influencing health status and contact with health services (Z00-Z99) . . .

### c. Categories of Z Codes . . .

#### 3) Status . . .

Z68     Body mass index (BMI)  
BMI codes should only be assigned when ~~the~~ **there is an** associated, **reportable** diagnosis (such as ~~overweight or obesity~~). ~~meets the definition of a reportable diagnosis (see Section III, Reporting Additional Diagnoses).~~

#### 7) Aftercare . . .

Aftercare codes should be used in conjunction with other aftercare codes or diagnosis codes to provide better detail on the specifics of an aftercare encounter visit, unless otherwise directed by the classification. ~~Should a patient receive multiple types of antineoplastic therapy during the same encounter, code Z51.0, Encounter for antineoplastic radiation therapy, and codes from subcategory Z51.1, Encounter for antineoplastic chemotherapy and immunotherapy, may be used together on a record. The sequencing of multiple aftercare codes depends on the circumstances of the encounter. . . .~~

#### 10) Counseling . . .

Z71     Persons encountering health services for other counseling and medical advice, not elsewhere classified

**Note: Code Z71.84, Encounter for health counseling related to travel, is to be used for health risk and safety counseling for future travel purposes.**

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## Section II. Selection of Principal Diagnosis . . .

### H. Uncertain Diagnosis

If the diagnosis documented at the time of discharge is qualified as “probable,” “suspected,” “likely,” “questionable,” “possible,” or “still to be ruled out,” **“compatible with,” “consistent with,”** or other similar terms indicating uncertainty, code the condition as if it existed or was established.

## Section III. Reporting Additional Diagnoses . . .

### C. Uncertain Diagnosis

If the diagnosis documented at the time of discharge is qualified as “probable,” “suspected,” “likely,” “questionable,” “possible,” or “still to be ruled out,” **“compatible with,” “consistent with,”** or other similar terms indicating uncertainty, code the condition as if it existed or was established. . . .

## Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services . . .

### G. ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit . . .

In some cases, the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the ~~physician~~ **provider**.

### H. Uncertain diagnosis

Do not code diagnoses documented as “probable,” “suspected,” “questionable,” “rule out,” **“compatible with,” “consistent with,”** or “working diagnosis” or other similar terms indicating uncertainty.

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## CHANGES TO THE ICD-10-PCS OFFICIAL GUIDELINES FOR CODING AND REPORTING

A summary of the modifications to the *ICD-10-PCS Official Guidelines for Coding and Reporting* is included below. The complete guidelines may be downloaded by visiting <https://www.cms.gov/Medicare/Coding/ICD10/2020-ICD-10-PCS.html>.

The modifications are published below using the following format:

Narrative changes appear in bold text (e.g., **a more definitive root operation**).

Items underlined were moved within the guidelines since October 1, 2019 (e.g., control of acute bleeding).

Deletions are shown as strikeouts (e.g., ~~any of the definitive root operations~~).

[Foreword] . . .

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-PCS itself. **They are intended to provide direction that is applicable in most circumstances. However, there may be unique circumstances where exceptions are applied.**

**Conventions . . .**

[Note: In the *Official Guidelines for Coding and Reporting*, the table below has been updated and the device value “Y Other Device” has been added to the example to reflect current options in this table.]

A9 . . .

**Section:** 0 Medical and Surgical

**Body System:** J Subcutaneous Tissue and Fascia

**Operation:** H Insertion: Putting in a nonbiological appliance that monitors, assists, performs, or prevents a physiological function but does not physically take the place of a body part

Body Part	Approach	Device	Qualifier
S Subcutaneous Tissue and Fascia, Head and Neck V Subcutaneous Tissue and Fascia, Upper Extremity W Subcutaneous Tissue and Fascia, Lower Extremity	0 Open 3 Percutaneous	1 Radioactive Element 3 Infusion Device <b>Y Other Device</b>	Z No Qualifier
T Subcutaneous Tissue and Fascia, Trunk	0 Open 3 Percutaneous	1 Radioactive Element 3 Infusion Device V Infusion Pump <b>Y Other Device</b>	Z No Qualifier

## **Medical and Surgical Section Guidelines (section 0)**

### **B2. Body System**

#### *General guidelines*

#### **B2.1a**

The procedure codes in the ~~general anatomical regions body systems~~ **Anatomical Regions, General, Anatomical Regions, Upper Extremities and Anatomical Regions, Lower Extremities** can be used when the procedure is performed on an anatomical region rather than a specific body part (e.g., ~~root operations Control and Detachment, Drainage of a body cavity~~), or on the rare occasion when no information is available to support assignment of a code to a specific body part.

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*Examples:* Control of postoperative hemorrhage is coded to the root operation Control found in the general anatomical regions body systems. Chest tube drainage of the pleural cavity is coded to the root operation Drainage found in the general anatomical regions body systems **body system Anatomical Regions, General**. Suture repair of the abdominal wall is coded to the root operation Repair in the general anatomical regions **body system Anatomical Regions, General**.

**Amputation of the foot is coded to the root operation Detachment in the body system Anatomical Regions, Lower Extremities.**

### **B3. Root Operation . . .**

#### **B3.1b**

Components of a procedure specified in the root operation definition ~~and/or~~ **as integral to that root operation** are not coded separately. . . . **Exceptions: Mastectomy followed by breast reconstruction, both resection and replacement of the breast are coded separately.**

#### *Overlapping body layers*

##### **B3.5**

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

#### *Excision for graft*

##### **B3.9**

If an autograft is obtained from a different procedure site in order to complete the objective of the procedure, a separate procedure is coded, **except when the seventh character qualifier value in the ICD-10-PCS table fully specifies the site from which the autograft was obtained.**

*Examples:* Coronary bypass with excision of saphenous vein graft, excision of saphenous vein is coded separately.

**Replacement of breast with autologous deep inferior epigastric artery perforator (DIEP) flap, excision of the DIEP flap is not coded separately. The seventh character qualifier value Deep Inferior Epigastric Artery Perforator Flap in the Replacement table fully specifies the site of the autograft harvest.**

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B4.1b . . .

Examples: . . .

**A procedure site documented as involving the periosteum is coded to the corresponding bone body part.**

### ***Radiation Therapy Section Guidelines (section D)***

#### ***D. Radiation Therapy Section***

##### ***Brachytherapy***

###### **D1.a**

**Brachytherapy is coded to the modality Brachytherapy in the Radiation Therapy section. When a radioactive brachytherapy source is left in the body at the end of the procedure, it is coded separately to the root operation Insertion with the device value Radioactive Element.**

**Example: Brachytherapy with implantation of a low dose rate brachytherapy source left in the body at the end of the procedure is coded to the applicable treatment site in section D, Radiation Therapy, with the modality Brachytherapy, the modality qualifier value Low Dose Rate, and the applicable isotope value and qualifier value. The implantation of the brachytherapy source is coded separately to the device value Radioactive Element in the appropriate Insertion table of the Medical and Surgical section. The Radiation Therapy section code identifies the specific modality and isotope of the brachytherapy, and the root operation Insertion code identifies the implantation of the brachytherapy source that remains in the body at the end of the procedure.**

**Exception: Implantation of Cesium-131 brachytherapy seeds embedded in a collagen matrix to the treatment site after resection of brain tumor is coded to the root operation Insertion with the device value Radioactive Element, Cesium-131 Collagen Implant. The procedure is coded to the root operation Insertion only, because the device value identifies both the implantation of the radioactive element and a specific brachytherapy isotope that is not included in the Radiation Therapy section tables.**

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## D1.b

A separate procedure to place a temporary applicator for delivering the brachytherapy is coded to the root operation Insertion and the device value Other Device.

**Examples:** Intrauterine brachytherapy applicator placed as a separate procedure from the brachytherapy procedure is coded to Insertion of Other Device, and the brachytherapy is coded separately using the modality Brachytherapy in the Radiation Therapy section.

Intrauterine brachytherapy applicator placed concomitantly with delivery of the brachytherapy dose is coded with a single code using the modality Brachytherapy in the Radiation Therapy section.

## *New Technology Section Guidelines (section X)*

### E. New Technology Section

#### *General guidelines*

#### ~~D1~~ E1.a

~~Section X codes are standalone codes. They are not supplemental codes.~~ Section X codes fully represent the specific procedure described in the code title, and do not require any additional codes from other sections of ICD-10-PCS. When section X contains a code title which **fully** describes a specific new technology procedure, and it is the only **procedure performed**, **only the that** section X code is reported for the procedure. There is no need to report **an additional broader, non-specific** code in another section of ICD-10-PCS.

#### E1.b

**When multiple procedures are performed, New Technology section X codes are coded following the multiple procedures guideline.**

**Examples:** Dual filter cerebral embolic filtration used during transcatheter aortic valve replacement (TAVR), X2A5312 Cerebral Embolic Filtration, Dual Filter in Innominate Artery and Left Common Carotid Artery, Percutaneous Approach, New Technology Group 2, is coded for the cerebral embolic filtration, along with an ICD-10-PCS code for the TAVR procedure.

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**Magnetically controlled growth rod (MCGR) placed during a spinal fusion procedure, a code from table XNS, Reposition of the Bones is coded for the MCGR, along with an ICD-10-PCS code for the spinal fusion procedure.**



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## Ask the Editor

### Question:

The coding hierarchy is clearly defined by the *Official Guidelines for Coding and Reporting* and within *Coding Clinic* (Fourth Quarter 2018, pages 90-91). However, it becomes confusing when *Coding Clinic* advice deviates from the Alphabetic Index and Tabular List. For example, the ICD-10-CM Index presumes a link between sepsis and organ dysfunction by the “with” sub-entry but this appears to conflict with *Coding Clinic* advice from Fourth Quarter 2017, pages 99-100, which instructs the link must be noted. Could you please provide additional clarification?

### Answer:

*Coding Clinic* strives to provide advice that is aligned with the classification instructions and the guidelines. However, sometimes there are inconsistencies and errors in the classification that may take time to resolve and *Coding Clinic* has tried to provide guidance/interpretation in those situations until the classification can be revised. It is important to note that earlier *Coding Clinic* advice may be superseded by any changes in the classification.

The exception to the “with” guideline which said “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

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the sepsis’)' was added for FY 2018. In that instance, we waited to publish the advice on linking sepsis and organ dysfunction at the same time as the guideline change, and the guideline change was referenced in the answer. There are many instances where *Coding Clinic* has been asked to interpret potentially conflicting instructions in the classification and the Editorial Advisory Board (EAB) with the assistance of the Cooperating Parties (including the code set maintainers Centers for Disease Control and Prevention’s National Center for Health Statistics and the Centers for Medicare & Medicaid Services) has had to provide an interpretation.

Conflicting Excludes1 notes is one example. No matter what is published in *Coding Clinic* in response to the conflict, some readers may have concern that the coding advice will essentially be disregarding one of the classification instructions, as it is not possible to fully adhere to all the classification instructions if there are conflicting instructions. Another example is Index entries that default to one etiology or part of the body, but the documentation clearly specifies a different etiology or organ. In such instances, *Coding Clinic* has provided assistance on the correct code assignment, since the default code would clearly be incorrect.

Publishing advice on such guidance ensures that an official answer is established for national consistency of the coded data.

**Question:**

Is it appropriate to utilize patient self-reported documentation to assign codes for social determinants of health, such as information found in categories Z55-Z65, Persons with potential health hazards

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related to socioeconomic and psychosocial circumstances? Currently, the *ICD-10-CM Official Guidelines for Coding and Reporting* allows code assignment based on medical record documentation from clinicians involved in the care of the patient who are not the patient's provider since this information represents social information, rather than medical diagnoses.

**Answer:**

Yes. If the patient self-reported information is signed-off and incorporated into the health record by either a clinician or provider, it would be appropriate to assign codes from categories Z55-Z65, describing social determinants of health.

**Question:**

Please define "clinicians" in the context of the *ICD-10-CM Official Guidelines for Coding and Reporting*, which allow code assignment for social determinants of health codes based on medical record documentation from clinicians involved in the care of the patient who are not the patient's provider since this information represents social information, rather than medical diagnoses. For example, may coding professionals utilize documentation of social information from social workers or community health workers in order to assign codes for social determinants of health?

**Answer:**

The *ICD-10-CM Official Guidelines for Coding and Reporting* do not have a unique definition of the term "clinicians." In the context of code assignment for social determinants of health Z codes, documentation deemed meeting the requirements for inclusion in the patient's official medical record based on regulatory or accreditation requirements or internal hospital

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policies, could be utilized since the information pertains to social rather than medical information.

**Question:**

The patient was diagnosed with acute ischemia of the ascending colon due to mesenteric vein thrombosis, which was attributed to Antithrombin III deficiency. The Index to Diseases references code I81, Portal vein, under Thrombosis, mesenteric, vein. However, mesenteric thrombosis are inclusion terms under subcategory K55.0-, Acute vascular disorders of intestine. What is the appropriate code assignment for mesenteric vein thrombosis?

**Answer:**

In this case, assign code K55.039, Acute (reversible) ischemia of large intestine, extent unspecified, for mesenteric vein thrombosis, as the provider did not document focal or diffuse. As of October 1, 2019, the Index to Diseases has been revised and the coding professional is directed to subcategory K55.0 for a diagnosis of mesenteric thrombosis. The specific code assignment would be based on the provider's documentation.

Mesenteric vein thrombosis occurs when a blood clot develops in the major veins of the intestines. The thrombus obstructs blood flow to the intestines, and can lead to ischemia and necrosis.