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*Coding advice or code assignments contained in this issue effective with discharges September 15, 2012.*
Ask the Editor

Question:
Do two conditions have to be listed together in the diagnostic statement in order to assume an association?

Answer:
It is not required that two conditions be listed together in the health record. However, the provider needs to document the linkage, except for situations where the classification assumes an association (e.g., hypertension with chronic kidney involvement). When the provider establishes a linkage or relationship between the two conditions, they should be coded as such. However, the entire record should be reviewed to determine whether a relationship between the two conditions exists. The fact that a patient has two conditions that commonly occur together does not necessarily mean they are related. A different cause may be documented by the provider. If it is not clear whether or not two conditions are related, query the provider.

Question:
The patient is a 60-year-old man who is status post right mastectomy for invasive ductal carcinoma of the right breast. The patient developed cellulitis and chronic seroma on the right chest wall at the mastectomy site. The procedure is listed as debridement of wound, evacuation of chronic seroma with pulsed irrigation of seroma site, placement of wound VAC system to constant suction. Provider documentation indicates that the eschar in the lateral third of the wound was excised down to subcutaneous tissue. The seroma cavity was entered and opened. A thorough lavage was carried out with Sims pulse irrigation utilizing 3000 ml of saline with bacitracin. Would it be appropriate to assign
procedure code 86.22, Excisional debridement of wound, infection, or burn, or 86.04, Other incision with drainage of skin and subcutaneous tissue, for this admission?

Answer:
Assign code 85.21, Local excision of lesion of breast, for the excision of the eschar (escharactomy)/debridement. Assign code 96.59, Other irrigation of wound, for pulsed irrigation of the seroma site. Do not assign a separate code for the VAC, since it was part of the operative closure. Although escharactomy is indexed to code 86.22, procedures on the breast (mastectomy site) are excluded from code category 86, Operations on skin and subcutaneous tissue. The classification directs the coder to category 85, Operations on breast.

Question:
There is some confusion among coders regarding the appropriate code assignment for Charcot’s arthropathy without documentation of syphilis. Code 094.0, Tabes dorsalis, appears to be the default since the Index leads to this code under the term Arthropathy, Charcot’s. What are the appropriate code assignments for Charcot’s arthropathy with no mention of syphilis?

Answer:
While the default is code 094.0, it is not appropriate in this case. Assign codes 349.9, Unspecified disorders of nervous system, and 713.5, Arthropathy associated with neurological disorders, for a diagnosis of Charcot’s arthropathy, when syphilis is not documented by the provider. Code 349.9 can be found by referencing the Index to Diseases as follows:

Arthropathy
neurogenic, neuropathic (Charcot’s)(tabetic)
nonsyphilitic NEC 349.9 [713.5]
**Question:**
We have a newborn with a diagnosis of V30.00, Single liveborn, born in hospital, and 282.5, Sickle-cell trait. Would code 779.89, Other specified conditions originating in the perinatal period, be assigned in addition to code 282.5 for these patients?

**Answer:**
Assign code V30.00, Single liveborn, born in hospital, as the principal diagnosis. Assign code 282.5, Sickle-cell trait, as an additional diagnosis. The infant was born with sickle cell trait, which is an inherited (genetic) condition, not a perinatal condition. Perinatal conditions are not the same as congenital conditions. Code 779.89, Other specified conditions originating in the perinatal period, is not used to describe congenital, genetic, or chromosomal disorders.

**Question:**
A patient diagnosed with inferolateral wall ischemia was sent to the cardiac catheterization laboratory. An angioplasty was performed and the proximal left anterior descending (LAD) branch was stented with a drug-eluting stent. The guidewire was removed. Then, another drug eluting stent was deployed in the distal LAD into the posterior descending branch. The wires were removed and provider documentation indicates “upon removal, it was noted that the previously placed stent was bound to one of the guidewires, or in other words, it was actually pulled out of the artery.” A second drug-eluting stent was then deployed in the distal right coronary artery into the proximal posterior descending branch exactly as the first one had been deployed. What codes are assigned for the number of stents and number of vessels treated?

**Answer:**
Assign codes 00.66, Percutaneous transluminal coronary angioplasty [PTCA], and 36.07, Insertion of drug-eluting coronary artery stent(s), for the
angioplasty and deployment of coronary artery stents into the proximal LAD and the distal LAD into the posterior descending branch. Assign code 00.46, Insertion of two vascular stents, since only two stents remained in the patient at the end of the procedure, and code 00.41, Procedure on two vessels, since stents were deployed into two vessels.

**Question:**
What is the appropriate procedure code for an endoscopic Nissen fundoplication?

**Answer:**
Assign code 44.66, Other procedures for creation of esophagogastric sphincteric competence, for the endoscopic Nissen fundoplication and EGD. Do not assign an additional code for the endoscopic approach, since the surgical approach is not coded separately. However, if an endoscopy is done post procedure, it would be appropriate to code it.

Until specific codes for the endoscopic approach are created, the current code for the procedure, as indexed in ICD-9-CM, must be applied; this traditionally may be an open procedure code.

**Question:**
What is the correct code assignment for ultrasound guided insertion of a dialysis catheter?

**Answer:**
Assign code 38.95, Venous catheterization for renal dialysis, and a code from category 88.7x, Diagnostic ultrasound, for ultrasound guided insertion of a dialysis catheter.

**Question:**
A patient who is status post Apligraf application is admitted for treatment after failure of the graft. Which is the correct complication code, 996.55, Complication due to artificial skin graft, or 996.52, Complication due to graft of other tissue, NEC?
Since Apligraf® is a “living cell” based product, it seems to fit the category of “other tissue” rather than “artificial skin.”

**Answer:**
Assign code 996.52, Mechanical complication of other specified prosthetic device, implant, and graft, due to graft of other tissue, NEC, for the failure of the Apligraft®. Apligraft® is a biological substance that is created from living cells found in healthy human skin. It is used to treat nonhealing wounds, (e.g., diabetic foot ulcers and venous ulcers), which do not respond to conventional therapies. Other examples of biological wound care products that include graft of other human tissue are Celtx and Dermagraft.

**Question:**
We were wondering if we could use code V24.1, Lactating mother, for an outpatient encounter for a woman receiving lactation counseling because of feeding problems of the infant, or would the diagnosis of the infant’s feeding problem be assigned?

**Answer:**
Assign code V24.1, Postpartum care and examination, Lactating mother, for an encounter to provide care, examination, supervision, counseling or other care related to lactation. An additional counseling code is not necessary. Assign code 676.8x, Other disorders of lactation, if there is a problem with the breast or lactation. It is not appropriate to assign code 779.31, Feeding problems in newborn, for the mother’s encounter.

**Question:**
An 18-year-old male with newly diagnosed soft tissue Ewing’s sarcoma of the left lower distal extremity was admitted for his first cycle of chemotherapy. The provider documented that the MRI of the left lower extremity revealed a soft
tissue mass adjacent to, but not invading the posterior medial aspect of the left distal tibia. The mass is adjacent to, but not involving the tibialis anterior and posterior artery and the flexor tendons. Bone marrow aspiration and biopsy revealed no metastatic involvement. The bone scan is also negative for distal bony metastasis. What is the correct code assignment for soft tissue Ewing’s sarcoma of the left lower extremity with no bone involvement? Ewing’s sarcoma is specifically indexed to malignant neoplasm of the bone and articular cartilage.

**Answer:**
Assign code, 171.3, Malignant neoplasm of connective and other soft tissue, Lower limb, including hip, for the soft tissue Ewing’s sarcoma of the left lower distal extremity. Although Ewing’s sarcoma most commonly occurs in bone, it can also develop in soft tissue (called extra-osseous). The condition is cross-referenced in ICD-9-CM’s Index to Diseases as follows:

**Sarcoma**—See also Neoplasm, connective tissue, malignant

**Question:**
What is the appropriate diagnosis code for pediatric autoimmune neuropsychiatric disorders associated with post streptococcal infections (PANDAS)?

**Answer:**
Assign code 279.49, Autoimmune disease, NEC, for PANDAS. Additional codes should be assigned for any manifestations (e.g., motor tic, obsessive compulsive disorder, etc.) that may be present.

Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) is a condition discovered in a subset of children, who developed a sudden onset or exacerbation of psychiatric symptoms or movement disorders (e.g.,
obsessive compulsive disorder (OCD), Tourette’s syndrome and/or motor tics) following an untreated group A beta hemolytic streptococci (GABHS) infection. An autoimmune process is responsible for the onset of symptoms. The condition is considered to be a neurological variant of rheumatic fever and involves the region of the brain referred to as the basal ganglia. Similar to rheumatic fever, PANDAS may follow a streptococcal infection, but it is not an infection. Rather, it is an inflammatory reaction caused by antineuronal antibodies. These antibodies mistake brain tissue for invading streptococci bacteria.

Question:
The patient is an 18-year-old female admitted secondary to bradycardia. Provider documentation indicates bradycardia secondary to malnutrition due to bulimia. The consultant’s diagnostic impression indicates bulimia nervosa, binge-purge type, and bradycardia secondary to malnutrition. How should the diagnoses be sequenced for this admission?

Answer:
Code 307.51, Bulimia nervosa, should be sequenced as the principal diagnosis for binge-purge type bulimia. Assign code 263.9, Unspecified protein-calorie malnutrition, for malnutrition, and code 427.89, Other specified cardiac dysrhythmias, Other, for bradycardia, as secondary diagnoses.

Question:
A 28-year-old female was admitted through the emergency department with chest pain due to peripartum cardiomyopathy with ejection fraction of 21% and congestive heart failure. The patient is approximately 2 to 3 months postpartum. She suffered dyspnea, edema of the lower extremity, and episodes of near syncope while pregnant. The symptoms worsened following delivery. Although the patient was on ACE inhibitors and beta blockers for cardiac protection, she was taken to surgery for
implantation of a dual-chamber defibrillator. What are the diagnosis code assignments and sequencing for this admission?

**Answer:**
Assign code 674.54, Peripartum cardiomyopathy, postpartum condition or complication, as the principal diagnosis. The peripartum period is defined as the last month of pregnancy to five months postpartum. Peripartum cardiomyopathy is specifically indexed to subcategory 674.5. Assign also codes 648.64, Other cardiovascular diseases, postpartum condition or complication, and 428.0, Congestive heart failure, unspecified, as additional diagnoses.

The *Official Guidelines for Coding and Reporting* state, “Chapter 11 codes have sequencing priority over codes from other chapters. Additional codes from other chapters may be used in conjunction with chapter 11 codes to further specify conditions.”

**Question:**
When coding moderate - severe malnutrition, is it appropriate to assign a code for the highest level of severity or the lower level of severity?

**Answer:**
Query the provider for clarification of whether moderate - severe malnutrition is referring to malnutrition that has progressed from moderate to severe or malnutrition that is at least moderate but has not yet reached severe. If provider documentation indicates that the malnutrition has progressed from moderate to severe, assign code 261, Nutritional marasmus, for severe malnutrition. In this case, it would be appropriate to assign the code for the highest level of severity. If provider documentation indicates that the malnutrition is moderate, assign code 263.0, Malnutrition of moderate degree.
Question:
A patient with failed right quadriceps mechanism of total knee is admitted for surgery. The surgeon identified his operation as “right knee quadriceps reconstruction with new tibial polyethylene.” Based on the title of the operative report, it appears that a revision of knee replacement was performed. However, based on the description of the surgery within the operative report, it appears that the surgeon replaced the tendon and kneecap with a donor tendon and kneecap. Therefore, would this be coded as a revision of a total knee replacement or as a tendon transplant? What is the appropriate procedure code assignment for this case?

Answer:
Assign codes 78.06, Bone graft, patella, and 83.81, Tendon graft, for the tendon and bone grafts used to reconstruct the quadriceps. “Quadriceps mechanism” is the orthopedic name for the natural quadriceps tendon with the patella embedded in it. Failed quadriceps mechanism is an uncommon complication of knee replacement surgery in which the quadriceps tendon is ripped off the tibial tubercle.

Although the surgeon described the surgery as quadriceps reconstruction with replacement of tibial polyethylene, the operative report does not support this. There is no description of replacement or revision of knee joint, or device name or model number. According to the operative report, the surgeon replaced the tendon and kneecap with a donor tendon and kneecap.

Question:
This 73-year-old patient presented with fever. Blood cultures were positive for Candida albicans and the patient received antifungal therapy. In the final diagnostic statement the provider listed sepsis due to urinary tract yeast (Candida) infection. She also had
an obstructing kidney stone and hydronephrosis and a nephrostomy tube was placed prior to the current admission. Which would be the principal diagnosis, unspecified sepsis (038.9), disseminated candidiasis (112.5) or candidiasis of urogenital site (112.2)? Is code 995.91, Sepsis, appropriate as a secondary code assignment?

**Answer:**
Assign code 112.5, Candidiasis, disseminated, as principal diagnosis. Disseminated candidiasis is a systemic (sepsis) infection. Codes 995.91, Sepsis; 112.2, Candidiasis, of other urogenital sites; 592.0, Calculus of kidney; 591, Hydronephrosis; and V44.6, Other artificial opening of urinary tract, should also be assigned as secondary diagnoses. Code 112.2 is assigned as an additional code to convey information about the nature of the urinary tract infection. There are no instructional notes in the classification that prohibit assigning codes 112.5 and 112.2 together. Category 038 is meant to classify bacterial infections; whereas candidiasis is a mycotic infection. Code 112.5 is the equivalent of code 038.9. The following reference can be found in the Official Guidelines for Coding and Reporting, “Sepsis and severe sepsis require a code for the systemic infection (038.xx, 112.5, etc.) and either code 995.91, Sepsis, or 995.92, Severe sepsis. This advice is similar to that previously published in Coding Clinic, Second Quarter 1989, page 10.

**Question:**
How should endoscopic ablation of jejunum lesions be coded?

**Answer:**
Assign code 45.34, Other destruction of lesion of small intestine, except duodenum, for endoscopic ablation of jejunum lesions.
**Question:**
I am familiar with the *Coding Clinic*, Fourth Quarter, 1996, page 63, advice that stated that “an angioplasty, by any technique, is performed in the placement of a stent(s), code 39.50, Angioplasty or atherectomy of non-coronary vessel should be assigned in addition to code 39.90, Insertion of non-coronary artery stent or stents.” I have reviewed the FY 2012 index and tabular changes for code 17.5 (atherectomy), 39.50 (angioplasty), 39.90/00.55 (stents) and my question boils down to: 1) When an arterial stent is inserted and there is no mention of separate angioplasty or atherectomy, then is angioplasty code 39.50 still assumed and coded as per the *Coding Clinic* guideline above? 2) When an arterial stent is inserted (00.55/39.90) and also there is atherectomy (17.5x), then are those two codes sufficient, ‘or’ does an angioplasty code (39.50) also get reported because of the stent insertion method?

**Answer:**
When a stent is inserted an angioplasty by definition is performed. Therefore, when an arterial stent is inserted, angioplasty should be coded, even if there is no mention of a separate angioplasty or atherectomy.

When an arterial stent is inserted (00.55/39.90) and an atherectomy (17.5x) is also performed, the angioplasty code (39.50) should also be reported.

**Question:**
A 55-year-old male was admitted with sepsis and cellulitis of the lower leg. Blood cultures grew Pasteurella multocida and the final diagnosis was documented as sepsis due to Pasteurella multocida. What are the code assignments for sepsis due to Pasteurella multocida?
**Answer:**
Assign code 038.49, Septicemia due to other gram-negative organisms, other, as principal diagnosis. Assign codes 995.91, Sepsis, 027.2, Pasteurellosis, and 682.6, Other cellulitis and abscess, leg, except foot, as additional diagnoses. Pasteurella is a type of gram-negative bacteria and code 027.2 may be used for both systemic and localized infection, the additional assignment of code 038.9 is necessary to reflect the presence of a systemic infection.

**Question:**
The patient is diagnosed with severe deep infection of the right total hip prosthesis. The surgeon documented that he performed debridement, removal of arthroplasty with placement of Prostalac® acetabular component augmented with vancomycin and gentamicin. What is the correct code assignment for the insertion of the Prostalac® device?

**Answer:**
Assign code 80.05, Arthrotomy for removal of prosthesis without replacement, hip, and code 84.56, Insertion or replacement of (cement) spacer, for insertion of the Prostalac® device. This is a two stage procedure where, in the first stage, the infected prosthesis is removed followed by placement of a spacer. The Prostalac® device is an articulating spacer that temporarily functions similar to a total hip arthroplasty. However, it is not a permanent hip joint replacement. The design of the device allows the spacer to release antibiotics within the periprosthetic space after an infected total hip prosthesis is removed and allows the patient some motion. The device normally remains in the patient for about three months. The patient then undergoes a second surgery for placement of the permanent total hip prosthesis.
**Question:**
A patient is diagnosed with chronic infection of her left total knee arthroplasty. The provider documented removal of left total knee arthroplasty and left total knee arthroplasty revision with articulating antibiotic cement spacers. What is the correct code assignment for this procedure?

**Answer:**
Assign code 80.06, Arthrotomy for removal of prosthesis without replacement, knee, and code 84.56, Insertion or replacement of (cement) spacer, for insertion of the antibiotic cement spacers.

**Question:**
How is the application of Matrix powder coded?

**Answer:**
Assign code 93.57, Application of other wound dressing, for the application of Matrix wound powder. Currently, ICD-9-CM does not have a unique code to capture this new technology. Matrix wound powder is used to help regenerate the tips of fingers of patients who have suffered a traumatic amputation as effectively as skin grafts alone. The wound powder consists of extracellular matrix, which is a network of biomolecules (mostly proteins) that supports the cells and holds them together. A common extracellular matrix protein is collagen.

MatriStem™ works by covering the wound in extracellular matrix. The matrix then provides a base to begin wound healing (the body doesn’t have to regenerate so much extracellular matrix on its own) and rapidly attracting and then stimulating the cells involved in healing. This wound powder is already approved for animals, and is being tested extensively in people. Recently, scaffolding and tissue engineering had been used as a framework for stem cells to grow around and form a tracheal implant.
Question:
An 84-year-old female with multiple myeloma and numerous severe complications has been hospitalized several times with gradual expected deterioration in her general condition. She was recently discharged to subacute rehabilitation but was readmitted when she developed nausea, vomiting and lethargy with a change in cognitive state. She was noted to be markedly hypercalcemic from the multiple myeloma. The patient was given intravenous hydration and supportive care. Aggressive treatment for the multiple myeloma was not pursued and the patient was transferred to hospice. How should this case be coded?

Answer:
The thrust of treatment was directed at the hypercalcemia. Hypercalcemia is a complication of the multiple myeloma. Assign code 275.42, Hypercalcemia, as principal diagnosis. Assign codes 203.00, Multiple myeloma, without mention of having achieved remission, and V66.7, Encounter for palliative care, as additional diagnoses.

As stated in Coding Clinic Second Quarter 2010, The basic rule for designating principal diagnosis is the same for neoplasm as for any other condition; that is, the principal diagnosis is the condition found after study to have occasioned the current admission or encounter. There is no guideline that indicates that a code for the malignancy takes precedence. Because the principal diagnosis may be difficult to determine, the focus of treatment can often be used as a guide.

Question:
A patient with end-stage renal disease received a unilateral transplant of two kidneys. The surgeon described it as a two-pack kidney transplant from a donor after cardiac death (DCD). Both donor kidneys were prepared and transplanted to the right
iliac fossa of the recipient. Although this is not a bilateral procedure, should code 55.69, Other kidney transplantation, be reported twice to reflect the transplant of two kidneys?

**Answer:**
Assign code 55.69, Other kidney transplantation, once. ICD-9-CM does not have the ability to identify these types of procedures. Even though two kidneys were transplanted, this is not a bilateral procedure, and therefore the procedure code is assigned only once.

**Question:**
A 77 year-old female was seen for cardiac clearance prior to surgery. A previous cardiac catheter showed 50% stenosis of the left anterior descending coronary artery, 20% stenosis of the right coronary artery and small vessel disease of the branch of the first obtuse marginal branch. Medical management was advised. In his final diagnostic statement, the provider listed “Nonobstructive coronary artery disease and small vessel disease of the heart.” What is the code assignment for small vessel disease?

**Answer:**
Assign code 414.01, Coronary atherosclerosis, of native coronary artery, for the nonobstructive coronary artery disease and small vessel disease of the heart. In this case, small vessel disease is not coded separately since it is part of a more specific diagnosis (i.e., coronary artery disease). If small vessel disease is present without a more specific heart diagnosis, assign code 429.2, Cardiovascular disease, unspecified.

Small vessel disease is an unusual but well-known phenomenon that is more common in postmenopausal women than in men. The accompanying chest pain is atypical, and often resembles angina pectoris. These patients have risk
factors, such as diabetes mellitus, obesity, blood lipid abnormalities, and hypertension. If surgery is not indicated, treatment is directed at reversing risk factors with the usual measures, and the use of medications such as the arteriole dilators calcium channel blockers and ACE inhibitors, plus beta blockers, and statins as indicated.

The etiology of this entity is not clear, but there is research evidence that malfunction of the smaller arteries serving the heart, the coronary microvasculature, is involved.

**Question:**
Provider documentation indicates normal spontaneous vaginal delivery of a baby girl over midline episiotomy. The placenta was delivered spontaneously with intact 3-vessels cord. The episiotomy was repaired; and the patient tolerated the procedure well. Cord blood was collected for a cryopreservation – cell kit. Is it appropriate to assign a code for the collection of cord blood? If a code is assigned for the collection of cord blood, what is the appropriate code?

**Answer:**
Do not assign a procedure code for the collection of umbilical cord blood.

**Question:**
How is a diagnosis of “secondary thrombocytosis” coded?

**Answer:**
Assign code 790.99, Other nonspecific findings on examination of blood, when the condition is clinically significant. Per the *Official Guidelines for Coding and Reporting*, “Abnormal findings are not coded and reported unless the provider indicates their clinical significance.” However, if the underlying cause of the thrombocytosis is documented, code that condition instead.
Secondary thrombocytosis is strictly reactive and not a platelet disorder. Platelets are acute-phase reactants; therefore, they increase in response to various stimuli, including systemic infections, inflammatory conditions, bleeding, and tumors. It can arise in a wide variety of other circumstances including rebound from myelosuppression, iron deficiency, or as part of an acute phase response.

**Question:**
An eight-year-old boy with autism, attention deficit hyperactivity disorder (ADHD) and significant cognitive delays is being evaluated by the speech-language pathologists. The evaluation summary indicates autism with generalized developmental delays and ADHD. The provider documented that his problems with short attention span and distractibility were related to the ADHD. Would it be appropriate to assign code 799.52, Attention or concentration deficit, as an additional diagnosis along with codes for the autism and ADHD?

**Answer:**
Assign code 299.00, Autistic disorder, current or active state, as the first-listed diagnosis. Code 314.01, Attention deficit disorder, with hyperactivity, should be assigned as an additional diagnosis. Do not assign code 799.52 since attention and concentration deficits are integral to ADHD. The “excludes note” at category 799.5 indicates that signs and symptoms associated with a confirmed diagnosis of attention deficit disorder (314.00-314.01) would not be coded separately.

**Question:**
A three-year-old boy was seen on consultation by the early childhood development team at the medical center. The patient has a history of speech-language, cognitive, and motor delays as well as difficulties with attention and behavior. He is currently receiving services to address his delays. The evaluation
summary indicates autism and generalized developmental delays, and that his behavior and attention difficulties are related to his diagnosis of autism. Can a code in category 799.5x, Signs and symptoms involving cognition, be the first-listed as the reason for the consultation or should code 299.0x, Autistic disorder, be the first-listed diagnosis?

**Answer:**
Assign code 299.00, Autistic disorder, current or active state, as the first-listed diagnosis. Codes from category 799.5x, Signs and symptoms involving cognition, may be assigned as additional codes because they provide additional information regarding the type of cognitive impairment. The exception is code 799.52, Cognitive communication deficit, since this is integral to autism. As stated in *Coding Clinic*, Fourth Quarter 2010, pages 95-97, cognitive impairments, such as problems with memory, concentration, attention, communication, and executive function are intended to be used as a supplementary code when the cause of the deficit is known and they are not integral to this condition.

**Question:**
A 30-year-old male is being evaluated by the speech therapist for cognitive problems involving impaired executive functioning, communication difficulties, and concentration and attention impairments due to an intracranial injury that occurred during military combat several years ago. Since the speech therapy encounter is for cognitive/communication deficits due to a traumatic brain injury (TBI), is the first-listed diagnosis the cognitive/communication deficits, or the TBI which is the underlying cause?

**Answer:**
Assign codes 799.52, Cognitive communication deficit, 799.51, Attention or concentration deficit, and 799.55, Frontal lobe and executive function deficit, to describe the cognitive disabilities responsible for the encounter. Codes 907.0, Late
effect of intracranial injury without mention of skull fracture, and E999.0, Late effects of injury due to war operations and terrorism, should be assigned as additional codes. In this case, the acute TBI would not be coded because the cognitive deficits are the residual or late effects of the intracranial injury.

**Question:**
A two-year-old child who is a delayed talker with no definitive diagnosis is seen by the speech language pathologist for evaluation. How should this encounter be coded?

**Answer:**
Assign code 799.52, Cognitive communication deficit, as the first-listed diagnosis since the underlying condition is not known.

**Question:**
A patient presents to the Emergency Department (ED) due to an overdose of Ambien and is intubated and placed on mechanical ventilation. The attending physician admits the patient to the intensive care unit (ICU) and documents that the patient was intubated for airway protection because of the drug overdose. There was no documentation of respiratory failure and the patient was weaned from the ventilator the following next day. Can the coder assume that the patient was in respiratory failure and report code 518.81, Acute respiratory failure, based on the fact that the patient was intubated and placed on mechanical ventilation for airway protection?

**Answer:**
Do not assign code 518.81, Acute respiratory failure, simply because the patient was intubated and received ventilatory assistance. Documentation of intubation and mechanical ventilation is not enough to support assignment of a code for respiratory failure. The condition being treated (e.g., respiratory failure) needs to be clearly documented by the provider.
**Question:**
The patient presented to the Emergency Department (ED) in full cardiac arrest and respiratory failure due to an acute myocardial infarction. He was resuscitated, transtracheally intubated and placed on mechanical ventilation. The patient was admitted to the intensive care unit and after a short period he expired. The ED physician documented acute respiratory failure. However, the attending physician did not document acute respiratory failure in the health record. Is acute respiratory failure a codeable secondary diagnosis based on the ED physician’s documentation of this condition?

**Answer:**
Yes, code 518.81, Acute respiratory failure, should be assigned based on the ED physician’s diagnosis, as long as there is no other conflicting information in the health record. Whenever there is any question as to whether acute respiratory failure is a valid diagnosis, query the provider.

**Question:**
This patient presented with a five day history of abdominal pain, nausea, vomiting and diarrhea. EGD was performed, however no obvious cause for her symptoms were identified. It was felt that the patient was most likely suffering from a visceral hypersensitivity syndrome. How is visceral hypersensitivity syndrome coded?

**Answer:**
Assign code 564.89, Other functional disorders of intestine, for visceral hypersensitivity syndrome.

Visceral hypersensitivity is believed to cause functional gastrointestinal disorders (e.g., dyspepsia and irritable bowel syndrome), but can also simulate other diseases. In a patient with visceral hypersensitivity, the nerves surrounding the stomach,
intestines and the gut become hypersensitive and interpret normal occurrences, such as muscle contractions in the colon, normal amounts of air in the intestines, as extreme pain. Triggers can include stress, or eating. The etiology is unknown.

**Question:**
How is fecal transplant coded?

**Answer:**
Currently, ICD-9-CM does not have a unique procedure code to describe fecal transplant. If the fecal matter is administered via enema, endoscopy or by nasogastric tube, assign the appropriate procedure code for the route of delivery. For example, assign code 96.39, Other transanal enema, if the fecal transplant is infused via enema. Assign code 96.08, Insertion of (naso) intestinal tube, if the fecal transplant is administrated via nasogastric tube. If a colonoscopy is carried out, assign code 45.23, Colonoscopy.

Fecal transplantation also known as fecal bacteriotherapy, or human probiotic infusion, is a medical treatment for patients with Clostridium difficile (C. difficile) enteritis or ulcerative colitis. C. difficile infection occurs in patients who have been administered antibiotics for a long period of time. The antibiotics destroy important disease-fighting bacterial flora in the intestine. Fecal transplants are believed to restore the bacteria back to normal and the patient can recover. The fecal transplant works by repopulating friendly flora in the infected intestines. The donated feces is screened for disease and then mixed with a saline solution to the consistency of a “milkshake.” The fecal material is administered by enema, nasogastric tube or endoscopy.
Clarification

Question:
What is the procedure code for Talc instillation that is performed for the purpose of sclerosing of the pleura? Is code 34.6, Scarification of pleura, assigned for this procedure?

Answer:
No, assign code 34.92, Injection into thoracic cavity, for talc instillation that is performed for sclerosing the pleura with the intent to fuse the visceral with the parietal pleura. As stated in Coding Clinic, First Quarter 2007, page 14, “Scarification refers to surgical abrasion and is used primarily in treatment of recurrent spontaneous pneumothorax.” Code 34.6 is reserved for scarification of the pleura. However, the provider may mention the term “scarification”, but is actually injecting a chemical agent for pleurodesis. The most common approach to pleurodesis is the chemical pleurodesis as described in code 34.92.
1. A woman was readmitted 2 to 3 months postpartum due to peripartum cardiomyopathy. She developed congestive heart failure, dyspnea, edema of the lower extremity, and episodes of near syncope while pregnant. The symptoms worsened following delivery, although the patient was on ACE inhibitors and beta blockers for cardiac protection. **Assign the appropriate diagnosis code assignments for this admission.**

2. A 54-year-old patient who is status post Apligraf application is admitted for treatment after failure of the graft. **Assign the appropriate complication code for failure of the Apligraf.**

3. A 28-year-old male with newly diagnosed soft tissue Ewing’s sarcoma of the left lower distal extremity was admitted for his first cycle of chemotherapy. The MRI of the left lower extremity revealed a soft tissue mass adjacent to, but not invading, the posterior medial aspect of the left distal tibia. Bone marrow aspiration and biopsy revealed no metastatic involvement. The bone scan is also negative for distal bony metastasis. **Assign the appropriate diagnosis code for soft tissue Ewing’s sarcoma of the left lower extremity with no bone involvement.**

4. The patient is an 18-year-old female admitted secondary to bradycardia. The provider documented bradycardia secondary to malnutrition due to bulimia nervosa. The consultant’s diagnostic impression indicates bulimia nervosa, binge-purge type, and bradycardia secondary to malnutrition. **Assign and sequence the correct diagnosis codes.**

5. A 35-year-old male was admitted with sepsis and cellulitis of the lower leg. Blood cultures grew Pasteurella multocida and the final diagnosis was documented as sepsis due to Pasteurella multocida. **Assign the code assignments for sepsis due to Pasteurella multocida.**

6. A patient with end-stage renal disease received a unilateral transplant of two kidneys. The surgeon described it as a 2-pack kidney transplant from a donor after cardiac death (DCD). Both donor kidneys were prepared and transplanted to the right iliac fossa of the recipient. **Assign the appropriate procedure code(s).**

7. An 8-year-old boy with autism, attention deficit hyperactivity disorder (ADHD) and significant cognitive delays is being evaluated by the speech-language pathologists. The evaluation summary indicates autism with generalized developmental delays and ADHD. The provider documented that his problems with short attention span and distractibility were related to the ADHD. **Assign the appropriate diagnosis code(s).**

8. The patient presented for treatment of sepsis due to urinary tract yeast (Candida albicans) infection. She has an obstructing kidney stone and hydronephrosis. Since the patient was not a candidate for surgical removal of the stones, a nephrostomy tube was placed prior to the current admission. **Assign and sequence the appropriate diagnosis code(s).**

9. A patient with refractory ulcerative colitis receives a fecal transplant via enema. **Assign the appropriate procedure code for fecal transplant performed via enema.**

10. Assign the appropriate diagnosis code(s) for pediatric autoimmune neuropsychiatric disorders associated with post streptococcal infections (PANDAS).
Coding Clinic
Continuing Education Quiz
Due on or before April 30, 2013

Instructions
Registered Health Information Technicians, Registered Health Information Administrators, Certified Coding Specialists and Certified Coding Specialists—Physician-based may earn one hour of continuing education credit toward AHIMA’s continuing education requirement by completing this test with a minimum score of 70%. This test is available to both personal subscribers and employees of institutions that subscribe to Coding Clinic. Complete the quiz, fill in information on both sides, and type or print clearly your name and mailing address in the space provided. Fold the insert on the dotted lines on this page, and mail to the following address:

Central Office on ICD-9-CM
Attention: Continuing Education
American Hospital Association
P.O. Box 92247
Chicago, IL 60675-2247

For your return address: Please type or print clearly the information within the dotted box below.

Name
Address
City/state/zip

Enclose check or money order for $20 (handling fee). Make check payable to the American Hospital Association. Do not send cash.

The quiz will not be graded and the $20 fee will be forfeited if the quiz is not postmarked on or before the date indicated on each test.

No credit will be given if the score is less than 70%, the test is incomplete, postmarked after the designated date, or submitted without the $20 handling fee.

Forms may be photocopied for use by directors of medical records or coding supervisors for assessment of coding staff’s understanding of topics presented in Coding Clinic.

Note: The Central Office on ICD-9-CM will not retain records of achievement. The practitioner is responsible for retaining the verification form returned by AHA and reporting the credit on AHIMA’s official continuing education reporting form.

Do not send the AHA verification form to the American Health Information Management Association.

Please duplicate your completed Continuing Education Quiz and retain the copy for your purposes.
Briefing Series

ICD-10-PCS SURGICAL APPROACHES

The majority of the procedures that would normally be reported in an inpatient setting can be found in the Medical and Surgical Section. The technique or approach used to reach the procedure site is identified by character 5 in the seven-character ICD-10-PCS codes.

Seven approaches are listed in the Medical and Surgical Section. Approaches can be external, through the skin or mucous membrane, or through an orifice. The following list breaks down the approaches.

- External
- Through the skin or mucous membrane
  - Open
  - Percutaneous
  - Percutaneous endoscopic
- Through an orifice
  - Via natural or artificial opening
  - Via natural or artificial opening endoscopic
  - Via natural or artificial opening with percutaneous endoscopic assistance

As with root operations, each approach is precisely defined in the classification. The table below identifies the Medical and Surgical Section approaches along with the ICD-10-PCS definitions and corresponding values.

<table>
<thead>
<tr>
<th>Value</th>
<th>Approach</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>External</td>
<td>Procedures performed directly on the skin or mucous membrane and procedures performed indirectly by the application of external force through the skin or mucous membrane</td>
</tr>
<tr>
<td>0</td>
<td>Open</td>
<td>Cutting through the skin or mucous membrane and any other body layers necessary to expose the site of the procedure</td>
</tr>
</tbody>
</table>

(continued)
### Medical and Surgical Section Approaches (continued)

<table>
<thead>
<tr>
<th>Value</th>
<th>Approach</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Percutaneous</td>
<td>Entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and/or any other body layers necessary to reach the site of the procedure</td>
</tr>
<tr>
<td>4</td>
<td>Percutaneous endoscopic</td>
<td>Entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and/or any other body layers necessary to reach and visualize the site of the procedure</td>
</tr>
<tr>
<td>7</td>
<td>Via natural or artificial opening</td>
<td>Entry of instrumentation through a natural or artificial external opening to reach the site of the procedure</td>
</tr>
<tr>
<td>8</td>
<td>Via natural or artificial opening endoscopic</td>
<td>Entry of instrumentation through a natural or artificial external opening to reach and visualize the site of the procedure</td>
</tr>
<tr>
<td>F</td>
<td>Via natural or artificial opening with percutaneous endoscopic assistance</td>
<td>Entry of instrumentation through a natural or artificial external opening, and entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to aid in the performance of the procedure</td>
</tr>
</tbody>
</table>

### RESOURCES

Here are some additional resources for you and your ICD-10 team:

- Introduction to the Basics of ICD-10-CM Diagnosis Coding (Audio CD)
- Introduction to the Basics of ICD-10-PCS Procedure Coding (Audio CD)
- Understanding ICD-10-PCS Official Coding Guidelines (Audio CD)
- ICD-9-CM and ICD-10-CM: Coding of Common Diagnoses (Audio Seminar scheduled for broadcast November 14, 2012)

For more information, please visit the AHA Central Office website — [www.ahacentraloffice.org](http://www.ahacentraloffice.org)