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Farewell *Coding Clinic for ICD-9-CM*

With this final issue, as we transition to ICD-10-CM/PCS, we bid a fond farewell to *Coding Clinic for ICD-9-CM* after nearly 30 years of publishing coding advice. In its inaugural issue, back in May-June 1984, the publication was introduced with the goal to "*provide coding advice, official coding decisions, and news related to the use of ICD-9-CM.*"

The American Hospital Association's Central Office on ICD-9-CM is proud to uphold the mission of the original founders to "help everyone who is interested in and dedicated to improving the accuracy and uniformity of medical records." We would like to express our sincere gratitude to the current and previous editors, Editorial Advisory Board (EAB) members and the Practitioner Review Group members for their dedication and commitment to improving the accuracy and uniformity of health information.

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We would also like to thank you, the *Coding Clinic for ICD-9-CM* subscribers and AHA members, for your continued support over the past 30 years. We look forward to serving you for many more years as we transition to *Coding Clinic for ICD-10-CM and ICD-10-PCS*.

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Ask the Editor

Question:
A patient was admitted to the hospital for treatment of an infected total knee arthroplasty and wound dehiscence. During the hospitalization the wound culture grew *Corynebacterium diphtheriae*. The specific culture results showed, "Corynebacterium species heavy growth, no anaerobes isolated." The patient's wound was treated with antibiotics, wet/dry dressings and wound vac. The provider's final diagnostic statement listed, "Dehiscence and wound infection with corynebacterium of right total knee replacement." How should this case be coded?

Answer:
Assign code 996.66, Infection and inflammatory reaction due to internal prosthetic device, implant, and graft, due to internal joint prosthesis, as the principal diagnosis. Codes 998.32, Disruption of external operation (surgical) wound; 032.85, Cutaneous diphtheria; V46.65, Organ or tissue replaced by other means, Joint, knee; and E878.1, Surgical operation and other surgical procedures as the cause of abnormal reaction of patient or of later complication, without mention of misadventure at the time of operation, Surgical operation with implant of artificial internal device, should be assigned as additional diagnoses. The infection of the wound with *Corynebacterium diphtheriae* resulted in the release of toxin, which caused local tissue destruction, and was likely responsible for the wound dehiscence.

Question:
The provider documented stage IIIA neuroendocrine small cell carcinoma of the cervix with extension to the anterior vagina, and right parametrium, with right internal iliac nodal involvement. What is the correct code assignment for neuroendocrine small cell carcinoma of the cervix with metastases?

Answer:
Assign code 209.30, Malignant poorly differentiated neuroendocrine carcinoma, any site, for the neuroendocrine small cell carcinoma of the cervix. Assign also codes 209.71, Secondary neuroendocrine tumor of distant lymph nodes, for the iliac nodal involvement, and 209.79, Secondary neuroendocrine tumor of other sites, for the metastases to the anterior vagina and right parametrium.

When the neuroendocrine carcinoma is described as small cell carcinoma, it is considered poorly differentiated.

Question:
If a physician documents heart failure with preserved ejection fraction (HFpEF), or heart failure with preserved systolic function, or alternatively heart failure with reduced ejection fraction (HFrEF), heart failure with low ejection fraction, heart failure with reduced systolic function, or other similar terms, can the coder assume the physician means "diastolic heart failure" or "systolic heart failure," respectively, and apply the proper ICD-9-CM code based on the documented clinical circumstances?

Answer:
No, the coder cannot assume either diastolic or systolic failure or a combination of both, based on these newer terms. Therefore, query the provider to clarify whether the patient has diastolic or systolic heart failure.

Question:
The patient has pain and swelling associated with bilateral great saphenous vein reflux and right anterior accessory saphenous vein (AASV) reflux. The patient underwent heat ablation and the right saphenofemoral junction and AASV were treated at 120 degrees Celsius. The first segment at the saphenofemoral junction of the left leg was also

treated at 120 degrees Celsius. What is the code assignment for heat ablation of the saphenous vein?

Answer:
Assign code 38.89, Other surgical occlusion of vessels, lower limb veins, for the heat ablation of the saphenous veins. Radiofrequency ablation occludes the vessel via thermal tissue destruction.

Question:
When a patient has both immune thrombocytopenic purpura and pancytopenia, are both conditions coded? Or, does the rule for not coding thrombocytopenia with pancytopenia apply?

Answer:
Assign both codes 287.31, Immune thrombocytopenic purpura, and 284.19, Other pancytopenia, for immune thrombocytopenic purpura and pancytopenia. Although code 284.19 includes a deficiency in the number of platelets in the body, it does not identify that the patient has immune thrombocytopenic purpura. Therefore, code 287.31 is needed to identify this condition.

Question:
Our facility will soon begin performing the LINX Reflux Management System procedure to treat patients with gastroesophageal reflux disease (GERD). This surgery involves implanting a device with the same standard laparoscopic approach that is used for a Nissen fundoplication. What is the appropriate code assignment for LINX procedure for GERD?

Answer:
Assign code 44.67, Laparoscopic procedures for creation of esophagogastric sphincteric competence, for the LINX procedure.

The LINX procedure, also referred to as LINX Reflux Management System, consists of a surgically

implanted device that is used to treat symptoms associated with gastroesophageal reflux disease, and is an alternative to more invasive surgery. During the procedure the esophagus is accessed via a laparoscopic approach through several small incisions in the abdomen. The system includes an implanted ring, and a series of titanium beads, with a magnetic core, connected by titanium wires to form a ring shape, and is implanted at the lower esophageal sphincter (LES). The force of the magnetic beads is designed to provide additional strength to keep a weak LES closed. Upon swallowing, the magnetic force between the beads is overcome by the higher pressures of swallowing forces, and the device expands to accommodate a normal swallow of food or liquid. Once the food passes though the LES, the device returns to its resting state.

Question:
Our facility has recently begun participating in a trial for treating hypertension with renal denervation. The procedure is performed via the renal artery with radiofrequency or ultrasound ablation. How is this procedure coded?

Answer:
Assign code 04.2, Destruction of cranial and peripheral nerves, for the renal denervation. Radiofrequency ablation is an inclusion term under code 04.2. The ablation destroys the renal nerve and the objective of the procedure is to ablate the nerve, not the kidney. Therefore, code 04.2 is the most appropriate option.

Question:
The patient is a three-year-old toddler, who is admitted with a diagnosis of progressive familial intrahepatic cholestasis type 2 (PFIC2). How is PFIC2 coded?

Answer:
Assign code 277.4, Disorders of bilirubin excretion, as the principal diagnosis. Assign codes 573.8, Other specified disorders of liver, and 576.8, Other specified disorders of biliary tract, as secondary diagnoses.

Progressive familial intrahepatic cholestasis (PFIC), formerly described as Byler syndrome, is a chronic cholestasis disorder. The condition is inherited in an autosomal recessive pattern. The disorder results in bile salt accumulation in hepatocytes with ongoing severe hepatocellular damage. In individuals with PFIC2, liver cells are not able to secrete bile. The accumulation of bile results in liver disease, leading to liver failure. The disorder can progress rapidly or may progress gradually. PFIC2 usually starts in infancy and signs and symptoms may include severe itching, jaundice, failure to thrive, portal hypertension, and hepatosplenomegaly. There are three known types of PFIC: PFIC1, PFIC2, and PFIC3. Each type has a different genetic cause.

Question:
A patient with hypoplastic left heart syndrome, who has previously undergone a neonatal Norwood procedure followed by a bidirectional Glenn procedure, now presents for an extracardiac Fontan procedure.

ICD-9-CM's Index to procedures leads to code 35.94, when referencing the Fontan procedure. This code describes creation of a conduit between the atrium and pulmonary artery. However, in this case the main purpose of the operation was to connect the inferior vena cava with the right pulmonary artery via a prosthetic conduit, and code 35.94 does not seem right. What is the appropriate ICD-9-CM procedure code?

Answer:
Assign code 35.94, Creation of conduit between atrium and pulmonary artery, for the Fontan procedure. Although there are various ways to accomplish the procedure, ultimately the procedure is performed for blood flow to bypass the right ventricle and have the blood go from the inferior vena cava around the right atrium to the pulmonary artery.

Even in cases where the atrium is bypassed in an extracardiac conduit style of Fontan procedure, the purpose of the surgery is the same, and is appropriately captured with code 35.94.

Question:
What is the correct ICD-9-CM code assignment for multifocal motor neuropathy (MMN)?

Answer:
Assign code 357.89, Other inflammatory and toxic neuropathy, for MMN.

Multifocal motor neuropathy is a commonly recognized form of inflammatory neuropathy that is similar to chronic inflammatory demyelinating polyneuropathy (CIDP); however, it is a distinct condition. Unlike CIDP, MMN is slowly progressive, affects only motor nerves, and there is no paraspinous denervation on EMG.

Question:
Working at a psychiatric hospital, we often come across the diagnosis of "complicated bereavement." What is the correct code for "complicated bereavement" when there is no mention of adjustment reaction/disorder?

Answer:
Assign code 309.0, Adjustment disorder with depressed mood, for complicated bereavement. A complicated bereavement is also referred to as grief (adjustment) reaction to loss.

According to research, during the first few months after a loss, several signs and symptoms of normal bereavement are similar to those of complicated bereavement. However, symptoms of normal grief typically diminish after several months, whereas signs and symptoms of a complicated bereavement are more prolonged.

Question:
The patient with history of splenectomy was admitted with abdominal pain. Multiple abdominal densities were seen on CT of the abdomen. Exploratory laparotomy showed implants of the omentum and the anterior parietal abdominal wall. The implants were excised and sent to pathology. Pathology report was negative for malignancy and dysplasia but consistent with splenosis. What is the diagnosis code assignment for splenosis?

Answer:
Assign code 289.59, Other diseases of spleen, other, for splenosis. Splenosis involves implantation and subsequent growth of splenic tissue in an ectopic location.

Question:
What is the appropriate diagnosis code for electrical status epilepticus of sleep (ESES)?

Answer:
ESES is an uncommon form of nonconvulsive epilepsy that occurs in childhood. The diagnosis is based on whether the electroencephalogram pattern is generalized or focal. If the provider documents the electrical status epilepticus of sleep as "focal motor," assign code 345.7X, Epilepsia partialis continua. If it's documented as "generalized" electrical status epilepticus of sleep, assign code 345.2, Petit mal status. Assign code 345.8X, Other forms of epilepsy and recurrent seizures, when it's not specified as either "focal" or "generalized."

The "x" denotes that you should select the appropriate 5th digit for with or without mention of intractable epilepsy.

Question:
What is the code assignment for refractory nonconvulsive status epilepticus?

Answer:
Assign code 345.01, Generalized nonconvulsive epilepsy, with mention of intractable epilepsy, for nonconvulsive status epilepticus.

Question:
A patient with known echinococcal infection of the femur with pain and a large mass of the femur underwent a radical resection of the femur and a replacement with a MOST prosthetic reconstruction. The MOST Options® System provides modular knee and hip options for severe bone loss, trauma and revision surgery. In this case, the MOST prosthetic involves knee and tibia replacements. A portion of the tibia was removed, a bone plug was placed in the canal and a #1 tibia cemented in place. How should this procedure be coded?

Answer:
Assign codes 81.54, Total knee replacement, 77.95, Total ostectomy, femur, and 84.48 Implantation of prosthetic device of leg, for the procedures performed. The surgeon performed a knee replacement without acetabular component, removal of the entire femur, and placement of a prosthetic limb. Code 84.48 captures the insertion of the prosthetic limb.

Question:
The patient was admitted to the hospital for treatment of multiple injuries. In the emergency department (ED), the patient experienced a urethral injury as a result of unsuccessful traumatic Foley

catheter insertion. This resulted in bloody output from the urethra, and urology was consulted for this issue. In the final diagnostic statement the provider listed, "Traumatic Foley catheterization." How should this diagnosis be coded?

Answer:
In this case, injury to the urethra was a result of the procedure. Assign codes 997.5, Urinary complications, and 867.0, Injury of pelvic organs, bladder and urethra, without mention of open wound into cavity, and E870.8, Misadventures to patient during surgical and medical care, Other specified medical care. A traumatic catheterization would not be coded unless there is documentation of a specific complication or injury. If the extent of the traumatic catheterization is questionable, query the physician as to the extent of the injury to the urethra. Additionally, the bleeding would not be coded separately since it is considered inherent to the injury. This is a different situation than that published in *Coding Clinic*, November-December 1985, page 15, where the patient pulled out his or her own catheter, and an injury code was assigned instead of a complication code.

Question:
The patient was admitted for surgical treatment of rectosigmoid cancer. A Foley catheter was inserted prior to surgery. After surgery, the provider noted red blood cells in the urinalysis. However, there was no documentation of a complication or injury related to the catheter insertion. How would this be coded?

Answer:
Do not assign a complication or injury code. Although red blood cells may be present in the urinalysis following urinary catheter insertion, this does not necessarily indicate a complication and/or injury. Unless the physician documents traumatic catheterization with a specific injury or complication, it is not coded as such.

Question:

The patient underwent emergent low transverse cesarean section due to non-reassuring fetal heart rate and persistent bradycardia. At delivery, the infant was pronounced dead after 21 minutes of attempted resuscitation. Sponge counts during surgery were deferred as there was no initial count, with plans for post-operative x-ray. The postoperative x-ray was notable for findings suggestive of retained laparotomy sponge. The patient was reopened in the operating room and a retained lap sponge was removed without complication. At the beginning of the Complications of surgical and medical care NEC (996-999) categories, there is an instructional note excluding complications of surgical procedures during abortion, labor and delivery (630-676.9). Therefore, is code 998.4, Foreign body accidentally left during a procedure, reported, or would a code from Chapter 11 Complications of pregnancy, childbirth, and the puerperium (630-679) be more appropriate? How should this case be coded?

Answer:

Assign code 659.71 Abnormality in fetal heart rate or rhythm, delivered with or without mention of antepartum condition, as the principal diagnosis. Codes 669.42, Other complications of obstetrical surgery and procedures, delivered with mention of postpartum condition, 998.4, Foreign body accidentally left during a procedure, and V27.0, Single liveborn, should be assigned as additional diagnoses. Code 669.42 does not provide specific information as to the nature of the complication. Therefore, code 998.4 is assigned, because it is more explicit regarding the specific complication. The “excludes note” does not preclude ever assigning codes from the Complication section when an obstetric procedure is involved.

Question:
A four-year-old boy presents to our facility due to imperforate anus and intractable constipation. Laparoscopic-assisted Malone Antegrade Continence Enema (MACE) procedure was performed with V-Q-Y skin flap. During the procedure, the appendix was mobilized up to the umbilicus and delivered. The tip of the appendix was amputated and the appendix was then cannulated with the mentor catheter. The surgeon then made a subserosal tract in the tenia of the cecum with cautery and buried the appendix in this tract. Once this was completed, the appendix and cecum was returned to the abdomen and the appendiceal tip was delivered through the right lower quadrant incision. The incision was modified to create a V-Q-Y skin flap. The end of the appendix was spatulated and the skin flap anastomosed to the spatuled end to splay it open. The remainder of the flap was then closed and the Mentor catheter was secured to the skin.

Coding Clinic, Third Quarter 2001, page 16, advises coders to assign code 47.99 for the MACE procedure. However, the MACE, Malone procedure and appendicostomy are all synonymous. What is the appropriate code assignment for this surgery?

Answer:
Assign code 47.91, Appendicostomy, for the MACE procedure.

Question:
A six-month-old patient with hypoplastic left heart syndrome, status post Norwood operation with modified Blalock-Taussig shunt, presents for a second stage reconstruction. The surgeon documented hemi-Fontan procedure and bilateral pulmonary artery augmentation with allograft tissue. How are the hemi-Fontan procedure and bilateral pulmonary artery augmentation coded?

Answer:
Assign code 35.94, Creation of conduit between atrium and pulmonary artery, for hemi-Fontan procedure, and code 39.56, Repair of blood vessel with tissue patch graft, for the bilateral pulmonary artery augmentation.

During a hemi-Fontan procedure, the Blalock-Taussig shunt is removed. The superior vena cava (SVC) is joined to the right pulmonary artery. A patch of tissue is used to augment the branch pulmonary arteries, to cover the venae cavae-to-pulmonary artery anastomoses, and to occlude flow from the SVC into the atrium.

Question:
We have babies that were born alive at 20.5 and 22.2 weeks. The provider has documented that the babies are "previable." In this case, the baby only weighed 136 grams. What is the appropriate ICD-9-CM diagnosis code to identify the previability?

Answer:
Assign code 765.01, Extreme immaturity, less than 500 grams, for a diagnosis of "previable." Assign also code 765.21, Less than 24 completed weeks of gestation.

Question:
What is the appropriate ICD-9-CM code for a patient with atypical meningioma, World Health Organization (WHO) grade II?

Answer:
Assign code 237.6, Neoplasm of uncertain behavior of endocrine glands and nervous system, Meninges, to describe an atypical meningioma.

Question:
A 56-year-old patient was admitted to the hospital with shortness of breath, orthopnea, fatigue, paroxysmal nocturnal dyspnea and edema. On admission, his calculated body mass index (BMI) was 32.5. However, during the stay the patient's BMI fluctuates and at discharge the BMI value is 34. The provider's final diagnostic statement listed, "Fluid overload due to acute on chronic diastolic heart failure." The patient was discharged and advised to monitor his body weight, reduce salt intake and restrict fluid intake. When the BMI varies during the admission due to fluid overload or other factors, how should it be coded?

Answer:
If the body mass index (BMI) fluctuation is linked to a clinically significant condition, such as malnutrition, anorexia nervosa, etc., code the most severe BMI value recorded during the admission. However, the BMI codes were not intended to be reported for changes in BMI caused by fluid overload/retention. BMI fluctuation caused by excess fluid is not the same as that due to weight loss or gain, since excess fluid can overestimate the BMI, making it inaccurate.

Clarification

Bacteremia due to Peripherally Inserted Central Catheter (PICC Line)

Question:
Coding Clinic, Second Quarter 2011, pages 7-8, advises the coder to assign codes 999.31, Infection due to central venous catheter; 790.7, Bacteremia; and 041.19, Other Staphylococcus, as additional diagnoses, for "probable bacteremia due to PICC line", where the blood cultures were positive for Staphylococcus epidermidis. However, code 999.32, Bloodstream infection due to central venous catheter, became effective October 1, 2011. The coders at our facility are questioning whether code 999.32, Bloodstream infection due to central venous catheter, would be more appropriate, for probable bacteremia due to PICC line. Could you please clarify the appropriate code assignment for bacteremia due to a peripherally inserted catheter?

Answer:
Currently, code 999.32, Bloodstream infection due to central venous catheter, is used to describe an infection (including bacteremia) due to a central venous catheter, including a peripherally inserted central catheter (PICC). Code 999.32 became effective October 1, 2011, and information regarding the use of this new code was published in *Coding Clinic,* Fourth Quarter 2011. However, the advice provided in *Coding Clinic,* Second Quarter 2011 was prior to the creation of code 999.32. Therefore coders were advised to use codes 999.31 and 790.7 in the Second Quarter issue. At that time, code 999.31 did not indicate bloodstream infection; therefore both codes were needed to fully capture this condition.

Preterm Premature Rupture of the Membranes with Delivery

Question:
The patient presented to the hospital at 32 weeks gestation after reportedly experiencing preterm premature rupture of the membranes (PPROM), six days prior to admission. She completed a course of latency antibiotics as well as betamethasone for fetal lung maturity. The patient did not develop infection or go into active labor; however she continued to leak fluid. Low cervical cesarean section was performed at 34 weeks, due to the PPROM. Based on information published in *Coding Clinic,* Third Quarter 2011, page 3, external auditors have told us code 644.21 is not appropriate since there was no preterm labor. We contend that the scenario published in *Coding Clinic* was entirely different. In this case, the preterm delivery occurred because of PPROM. Please clarify whether code 644.21 would be assigned to describe the preterm delivery?

Answer:
Assign code 658.21, Delayed delivery after spontaneous or unspecified rupture of membranes, delivered, with or without mention of antepartum condition, as the principal diagnosis. Code 658.21 is assigned since the rupture of the membranes was prolonged. The difference between this example and that previously published is that labor was not induced in this case. The cesarean section was performed due to prolonged rupture and the ongoing risk of infection. While the patient was not in natural labor per se, it was not an induced labor in the same manner as in the case described in *Coding Clinic*. Code 644.2X, Early onset of delivery, is only intended for use in cases of spontaneous labor, even though the term "spontaneous" is a nonessential modifier. The fact that the baby was premature will be captured with codes assigned to the baby's record.

Corrections

Methicillin Resistant *Staphylococcus Aureus* (MRSA) Sepsis
Coding Clinic, Third Quarter 2011, page 15, contained a typographical error. The code title should read Methicillin resistant *Staphylococcus aureus* (MRSA) septicemia, instead of Methicillin susceptible *Staphylococcus aureus* (MSSA) septicemia.

Traumatic Internal Carotid Artery Dissection
Coding Clinic, Fourth Quarter 2013, page 92, contained a typographical error. The correct code assignment for traumatic internal carotid artery dissection is 900.03, Injury to blood vessels of head and neck, internal carotid artery, rather than code 900.00.

Notice

Update—Foreign Body Left During Surgery

Question:
While drilling one of the transosseous suture holes, during the procedure, a drill bit broke off inside the trochanter. The documentation indicates it seemed to be quite deep into the bone and was not retrievable; and as such, it was left in place.

The National Quality Forum (NQF) revised information on Serious Reportable Events in Healthcare. In Appendix A, on surgical or invasive procedure events, Event 1D Unintended retention of a foreign object in a patient after surgery or other invasive procedure currently excludes objects not present prior to surgery/procedure that are intentionally left in when the risk of removal exceeds the risk of retention (such as microneedles, broken screws).

In light of the NQF update, is code 998.4, Foreign body accidentally left during a procedure, still appropriate when the provider intentionally leaves a foreign body during surgery so that the patient is not subject to the added risk of removal?

Answer:
Do not assign code 998.4, Foreign body accidentally left during a procedure, when the provider intentionally leaves a foreign body during surgery as to not subject the patient to the additional risk of removal. Assign instead code E871.0, Foreign object left in body during procedure, surgical operation, to show that there was a problem with a foreign body left during the procedure. The advice previously published in *Coding Clinic* is now being updated to reflect the NQF Update.

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The AHA Central Office will not respond to the following types of questions for ICD-10-CM/PCS or HCPCS:

- Questions related to payment or coverage issues
- Questions related to interpretation of medical record documentation, such as identifying the principal diagnosis—unless it relates to the application of specific coding guidelines or specific previously published coding advice
- Questions related to missing or incomplete documentation or validation of what is appropriate documentation (paper or electronic)
- Questions related to clinical issues or clinical criteria for diagnoses or procedures
- Questions related to mediating differences of opinion between providers and auditors or payers or any other third party reviewers—unless it relates to the application of specific coding guidelines or specific previously published coding advice
- Requests for the Central Office to code the entire medical record or operative report or to validate code assignment
- Questions or recommendations related to ICD-10-CM Index or Tabular List problems or conflicting instructions. Such questions should be sent to: Donna Pickett, RHIA, Medical Classification Administrator, Office of Planning and Extramural Programs, National Center for Health Statistics, Centers for Disease Control, 3311 Toledo Road, Hyattsville, MD 20782
- Questions or recommendations regarding ICD-10-PCS Index entries, ICD-10-PCS device definitions, ICD-10-PCS Reference manual or the General Equivalence Mappings (GEMS) should be sent to: Patricia Brooks, RHIA, Technical Advisor, Centers for Medicare and Medicaid Services (CMS), Division of Acute Care, Mail Stop C4-08-06, 7500 Security Boulevard, Baltimore, MD 21244-1850

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