New code assignments contained in this issue effective with discharges April 1, 2022.
Other coding advice or code assignments contained in this issue effective March 18, 2022.

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**Correction Notices**

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- Extraction of Bone Marrow from Other Sites | 54
APRIL 1, 2022 CODE UPDATE

In the fiscal year 2022 Hospital Inpatient Prospective Payment System final rule published on August 2, 2021, the Centers for Medicare & Medicaid Services (CMS) announced its adoption of an April 1 implementation date for ICD-10-CM and ICD-10-PCS code updates, in addition to the annual October 1 update, beginning with April 1, 2022. Please refer to Coding Clinic Fourth Quarter 2021, page 100, for additional information regarding the addition of April 1, 2022 maintenance of the ICD-10-CM and ICD-10-PCS Coding Systems.

NEW ICD-10-CM CODES

Summary explanations of the ICD-10-CM changes effective April 1, 2022 are provided below. Addenda changes demonstrating the specific revisions to the code titles or instructional notes are not included in the explanations below. Please note that a few addenda changes have been made in the Alphabetical Index and Tabular List unrelated to the new codes described below. 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.

Underimmunization for COVID-19 Status

Code Z28.3, Underimmunization status, has been expanded and three new codes are created to identify:

- Z28.310, Unvaccinated for COVID-19
- Z28.311, Partially vaccinated for COVID-19
- Z28.39, Other underimmunization status
Additional codes are assigned, if applicable, to provide further information on reasons for underimmunization, such as contraindication (Z28.0-), patient’s decisions for reasons of belief or group pressure (Z28.1), patient’s decision for other and unspecified reason (Z28.2-), or other reason (Z28.8-).

Codes in sub-subcategory Z28.31, Underimmunization for COVID-19 status, should not be assigned for individuals who are not eligible for the COVID-19 vaccines, as determined by the healthcare provider (e.g., infants too young to receive the COVID-19 vaccines). The ICD-10-CM Official Guidelines for Coding and Reporting have been updated with instructions determining usage of codes Z28.310 and Z28.311 in relation to COVID-19 vaccinations.

**Question:**
A patient presents to the physician’s office for an annual check-up and is noted to have received the first dose of a two-dose regimen (e.g., Moderna) COVID-19 vaccine, but has not received the second dose yet. How should the patient’s underimmunization status for COVID-19 be reported?

**Answer:**
Assign code Z28.311, Partially vaccinated for COVID-19, since the patient received the first dose of a two-dose regimen.

**NEW ICD-10-PCS CODES**

A summary of the ICD-10-PCS changes effective April 1, 2022 is provided below. The addenda changes demonstrating the specific revisions to the code titles are not included in the explanations below. The Code Tables, Index and related Addenda files are available on the Centers for Medicare & Medicaid Services (CMS) website at https://www.cms.gov/medicare/icd-10/2022-icd-10-pcs.

Nine new procedure codes are created to describe the introduction or infusion of therapeutics, including vaccines, monoclonal antibodies and a drug for COVID-19 treatment.
COVID-19 Vaccine Administration

Four new procedure codes are created for COVID-19 vaccines as shown below. Two codes were created for vaccines described as a third dose, and two codes were created for vaccines described as boosters.

**XW013V7**  
Introduction of COVID-19 vaccine dose 3 into subcutaneous tissue, percutaneous approach, new technology group 7

**XW013W7**  
Introduction of COVID-19 vaccine booster into subcutaneous tissue, percutaneous approach, new technology group 7

**XW023V7**  
Introduction of COVID-19 vaccine dose 3 into muscle, percutaneous approach, new technology group 7

**XW023W7**  
Introduction of COVID-19 vaccine booster into muscle, percutaneous approach, new technology group 7

A COVID-19 vaccine booster shot is an additional dose of a vaccine given after the protection provided by the original shot(s) has begun to decrease over time. The CDC recommendations for a COVID-19 booster vary based on the vaccine received (e.g., Pfizer-BioNTech, Moderna, or Janssen/Johnson & Johnson), the patient’s age, and the time after completion of the primary COVID-19 vaccination series. For example, at press time, the CDC recommended boosters for all patients 12 years and older who received the Pfizer-BioNTech vaccine at least 5 months after completing their primary COVID-19 vaccination series. Please refer to the CDC’s website at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/booster-shot.html for the current recommendations for COVID-19 boosters as the guidance is evolving.

A COVID-19 third dose refers to an additional vaccine dose administered to people with moderately or severely compromised immune systems to improve the response to the initial vaccine series. The term “third dose” can be used to refer to an additional dose of the two-dose vaccine regimens (e.g., Moderna or Pfizer-BioNTech), but the term “additional dose” may be used to describe doses given to individuals who received the Janssen/Johnson & Johnson single dose vaccine regimen that may also be eligible for another dose based on their immune systems.
Code assignment should be based on the documentation. Assign the code for dose 2 if it’s documented as the second dose, the code for dose 3 if it’s documented as the third dose, and the booster code if it’s documented as a booster.

**Introduction of New Therapeutic Substances**

New Substance values were added to code Table XW0, Anatomical Regions, Introduction, for the three substances listed below. Please note that all of the substances below have a qualifier of 7, New Technology Group 7.

<table>
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**Fostamatinib**

Three new codes have been created for the administration of fostamatinib (Tavalisse®). The drug may be administered orally or enterally. Fostamatinib is approved in the United States, Europe, and Canada as a treatment for adult chronic immune thrombocytopenia. A request for Emergency Use Authorization (EUA) for fostamatinib is under review by the U.S. Food and Drug Administration (FDA) for the treatment of hospitalized adult COVID-19 patients. The new ICD-10-PCS codes are listed below:

- **XW0DXR7** Introduction of fostamatinib into mouth and pharynx, external approach, new technology group 7
- **XW0G7R7** Introduction of fostamatinib into upper GI, via natural or artificial opening, new technology group 7
- **XW0H7R7** Introduction of fostamatinib into lower GI, via natural or artificial opening, new technology group 7

**Tixagevimab and Cilgavimab**

One new code has been created for the administration of tixagevimab and cilgavimab monoclonal antibody. (Evusheld™). The FDA granted Evusheld™ EUA for the pre-exposure prophylaxis of COVID-19 in adults and pediatric individuals:
who are not currently infected with SARS-CoV-2 and who have not had a known recent exposure to an individual infected with SARS-CoV-2 and who have moderate to severe immune compromise due to a medical condition or receipt of immunosuppressive medications or treatments and may not mount an adequate immune response to COVID-19 vaccination or

for whom vaccination with any available COVID-19 vaccine, according to the approved or authorized schedule, is not recommended due to a history of severe adverse reaction (e.g., severe allergic reaction) to a COVID-19 vaccine(s) and/or COVID-19 vaccine component(s).

One dose is administered as two separate, consecutive intramuscular injections. A single code would be reported for the full dose.

The new ICD-10-PCS code is as follows:

XW023X7 Introduction of tixagevimab and cilgavimab monoclonal antibody into muscle, percutaneous approach, new technology group 7

Other Monoclonal Antibody
One new code has been created for other new monoclonal antibody COVID-19 treatments that are administered intramuscularly that may become available and do not yet have a unique code. The ICD-10-PCS code is as follows:

XW023Y7 Introduction of other new technology monoclonal antibody into muscle, percutaneous approach, new technology group 7

For administration of “other monoclonal antibodies” used to treat neoplastic conditions rather than COVID-19, see ICD-10-PCS table 3E0. For example, code 3E0230M describes “Introduction of antineoplastic, monoclonal antibody, into muscle, percutaneous approach.”
Changes to the *ICD-10-CM Official Guidelines for Coding and Reporting*
FY 2022 -- UPDATED April 1, 2022
(October 1, 2021 - September 30, 2022)

Updates to the *ICD-10-CM Official Guidelines for Coding and Reporting* the new diagnosis codes that describe immunization status for COVID-19 are included below. The complete guidelines may be downloaded by visiting the following website: [https://www.cdc.gov/nchs/icd/icd10cm.htm](https://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, 2021 (e.g., *severe sepsis*). Deletions are shown as strikeouts (e.g., *severe sepsis*). Italics are used to indicate revisions to heading changes.

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

C. Chapter Specific Coding Guidelines . . .

Chapter 1: Certain Infectious and Parasitic Diseases (A00-B99), U07.1, U09.9 . . .

g. Coronavirus infections . . .

1) COVID-19 infection (infection due to SARS-CoV-2) . . .

(n) Underimmunization for COVID-19 Status Code Z28.310, Unvaccinated for COVID-19, may be assigned when the patient has not received at least one dose of any COVID-19 vaccine. Code Z28.311, Partially vaccinated for COVID-19, may be assigned when the patient has received at least one dose of a multi-dose COVID-19 vaccine regimen, but has not received the full set of doses necessary to meet the Centers for Disease Control and Prevention (CDC) definition of “fully vaccinated” in place at the time of the encounter. For information, visit the CDC’s website [https://www.cdc.gov/coronavirus/2019-ncov/vaccines/](https://www.cdc.gov/coronavirus/2019-ncov/vaccines/).
AHA's Central Office on ICD-10-CM/PCS has received numerous questions regarding the revised ICD-10-PCS guideline pertaining to a tubular body part (B4.1c). The guideline states, “If a procedure is performed on a continuous section of a tubular body part, code the body part value corresponding to the anatomically most proximal (closest to the heart) portion of the tubular body part.” For example, a procedure performed on a continuous section of artery from the femoral artery to the external iliac artery with the point of entry at the external iliac artery is also coded to the external iliac artery body part. The following questions and answers are provided to assist coding professionals in applying the guideline.

Question:
According to the updated guideline B4.1c, if a carotid endarterectomy is performed on a single continuous lesion involving both the common carotid artery and internal carotid artery, the common carotid artery would be the only body part coded, because it is closest to the heart. We are concerned that data involving carotid endarterectomies would be skewed and procedures performed on both the common carotid and internal carotid arteries would not reflect the complexity involved in the surgery. We are requesting that Coding Clinic clarify this issue.
Answer:
The procedure code would identify the common carotid artery only if it were a single procedure performed on one continuous lesion. If, however, the documentation states that separate lesions in separate vessels were identified and treated, multiple codes would be assigned to specify distinct procedures performed on multiple body parts.

Question:
The updated ICD-10-PCS Official Guidelines for Coding and Reporting, Guideline B4.1c, pertaining to procedures performed on a continuous section of a tubular body part appears to conflict with the multiple procedures guideline B3.2a. This guideline (B3.2a) states, “During the same operative episode, multiple procedures are coded if the same root operation is performed on different body parts as defined by distinct values of the body part character.” Guideline B4.1c does not indicate that it only applies to certain body parts/body systems. Could you please clarify?

Answer:
The updated guideline (B4.1c) does not conflict with the guideline for multiple procedures (B3.2a). However, guideline B4.1c will be clarified further by adding the terms “vascular” and “arterial/ venous” as well as “single” procedure.

Question:
Since the updated ICD-10-PCS Official Guidelines for Coding and Reporting guideline B4.1c specifies “tubular body part,” does this guideline apply to any tubular body part, such as the esophagus, stomach, large and small intestines, etc.?
Answer:
No, the *ICD-10-PCS Official Guidelines for Coding and Reporting*, Guideline B4.1c only applies to the vasculature, such as arteries and veins, not other tubular organs, such as esophagus, stomach, large and small intestines.

Question:
When applying the *ICD-10-PCS Official Guidelines for Coding and Reporting*, Guideline B4.1c, does the surgery need to involve a single lesion that spans across multiple body parts?

Answer:
Yes, this guideline (B4.1c) only applies to surgeries that involve a single lesion that spans across multiple body parts.

Question:
When assigning codes for procedures involving separate lesions, such as thrombus, clots, plaque, etc., within multiple body parts, rather than a single continuous lesion, should each procedure be coded separately?

Answer:
Yes, procedures involving separate lesions found in/on multiple body parts should be coded separately. The *ICD-10-PCS Official Guidelines for Coding and Reporting*, Guideline B3.2 states, “During the same operative episode, multiple procedures are coded if the same root operation is performed on different body parts as defined by distinct values of the body part character.”

Question:
According to the updated guideline B4.1c, if a carotid endarterectomy is performed on a single continuous lesion involving the common carotid artery and an internal carotid artery, only the
body part closest to the heart is coded. Based on this guideline, what body part is assigned when an endarterectomy is performed on one continuous lesion involving both the common carotid and internal carotid arteries?

**Answer:**
If the endarterectomy is performed on one continuous lesion involving the common carotid artery and an internal carotid artery, the body part identified in the procedure code assigned is the common carotid artery, which is closest to the heart.

**Question:**
A 51-year-old patient with severe protein calorie malnutrition due to extreme anorexia nervosa, binge-eating purging type, is admitted to the hospital for stabilization of her acute medical conditions and weight restoration, before being transferred to a residential treatment program specializing in eating disorders. The provider also documented that the patient’s end stage renal disease, dehydration and kidney stones are complications caused by the anorexia nervosa. Some coding professionals are questioning whether it is appropriate to sequence anorexia nervosa as the principal diagnosis when the admission is for medical stabilization. What is the appropriate principal diagnosis?

**Answer:**
Assign code E43, Unspecified severe protein-calorie malnutrition, as the principal diagnosis, as this condition is the reason for the admission. Code F50.02, Anorexia nervosa, binge eating/purging type, should be assigned as a secondary diagnosis. Since the admission was for treatment/stabilization of the patient’s acute medical conditions, it would not be appropriate to sequence anorexia nervosa as the principal diagnosis.
The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”

**Question:**
A 44-year-old presents with a palpable mass in the upper quadrant of the left breast. The patient underwent wide excision of the left breast mass, diagnostic left axillary lymphadenectomy, therapeutic reduction mammoplasty of the left breast and reduction mammoplasty on the right breast for symmetry. Based on documentation in the operative report of “left therapeutic reduction mammoplasty,” would the root operation “Excision” be appropriate for the therapeutic mammoplasty on the left since it was performed to excise the left breast mass? Would the root operation “Alteration” be assigned for the right mammoplasty performed to obtain symmetrical breasts?

**Answer:**
Yes, the root operation Excision is appropriate for the left therapeutic reduction mammoplasty performed to excise the breast mass, and the root operation Alteration is appropriate for the right mammoplasty performed to obtain symmetry. Assign the following procedure codes:

**0HBU0ZZ**   Excision of left breast, open approach, for the wide excision of the breast mass.
**Question:**
The patient is a 38-year-old with a history of left breast malignancy (Her2-negative) status post modified left radical mastectomy, antineoplastic and radiation therapy. She has previously undergone reconstruction of the left breast by means of a deep inferior epigastric perforator (DIEP) flap. The patient is now admitted for left nipple reconstruction and to address the asymmetrical right breast. During surgery, a new nipple was created on the reconstructed left breast and the right breast was reduced to obtain symmetry relative to the left breast. What are the appropriate root operations for the creation of a new nipple on the reconstructed left breast and the reduction mammoplasty of the right breast? Is the reduction mammoplasty “Excision” or “Alteration”?

**Answer:**
Assign the following procedure codes:

- **0HRX07Z** Replacement of left nipple with autologous tissue substitute, open approach, for the left nipple reconstruction; and
- **0H0T0ZZ** Alteration of right breast, open approach, for the breast reduction mammoplasty to obtain symmetry.
The root operation “Alteration” is appropriate for the right mammoplasty performed to obtain symmetry.

**Question:**
A patient with central nervous system 1a, B-cell acute lymphoblastic leukemia (B-ALL) is admitted for intrathecal consolidation chemotherapy. Immediately following chemotherapy, per protocol, an end of induction bone marrow biopsy is performed to evaluate the effectiveness of prior therapy and to determine whether the leukemia is in remission. The *Official Guidelines for Coding and Reporting* (I.C.2.a.) states, “When treatment is directed at a malignancy, the malignancy is sequenced as the principal diagnosis, except when the admission is solely for chemotherapy.” In this case, the provider clearly documents the reason for admission is the administration of chemotherapy and the bone marrow biopsy was part of the treatment protocol. When a patient is admitted for chemotherapy but also has a diagnostic test such as a biopsy, is the neoplasm assigned as the principal diagnosis instead of code Z51.11, Encounter for antineoplastic chemotherapy? What is the principal diagnosis in this case?

**Answer:**
Assign code Z51.11, Encounter for antineoplastic chemotherapy, as the principal diagnosis. Assign code C91.00, Acute lymphoblastic leukemia not having achieved remission, as a secondary diagnosis.

In this case, an end of induction bone marrow biopsy was performed to evaluate the effectiveness of prior chemotherapy, measuring for minimal residual disease. Although a bone marrow biopsy was performed, the administration of intrathecal consolidation chemotherapy was the reason for the
admission. Consolidation chemotherapy follows the induction (initial) phase of chemotherapy. The purpose is to destroy any remaining leukemia cells to “consolidate” the gains obtained and to prevent the cancer from returning.

**Question:**
A newborn delivered at term with Apgar scores of 9 and 9, was monitored for withdrawal symptoms due to intrauterine exposure of prescribed maternal Subutex®. Neonatal abstinence syndrome (NAS) monitoring was done daily; however, a urine drug screen was not performed. After five days of monitoring, the provider documented that the infant showed no symptoms, making withdrawal unlikely, so the infant was discharged. How should the newborn’s intrauterine drug exposure be coded?

**Answer:**
Assign code Z05.8, Observation and evaluation of newborn for other specified suspected condition ruled out, as a secondary diagnosis for the extended observation and NAS monitoring. The documentation stated that the infant showed no signs or symptoms of withdrawal or NAS. Codes from category Z05 are used for newborns within the neonatal period, who are suspected to have an abnormal condition, but without signs or symptoms, and which after examination and observation, is found not to exist.

Per the *Official Guidelines for Coding and Reporting*, section 16.b.1, category Z05, Encounter for observation and evaluation of newborn for suspected diseases and conditions ruled out, is to be used “to identify those instances when a healthy newborn is evaluated for a suspected condition that is determined after study not to be present.”
**Question:**
A 39-week old infant was born via spontaneous vaginal delivery to a mom who had a history of marijuana use, and subsequently stopped using once she found out about the pregnancy. Because of the history of maternal marijuana use, a urine drug screen (UDS) was ordered. The infant’s urine drug screen came back negative and social services cleared the infant to be discharged home. How should this infant’s possible intrauterine drug exposure be coded?

**Answer:**
Assign code Z05.8, Observation and evaluation of newborn for other specified suspected condition ruled out, as a secondary diagnosis. There was no provider documentation indicating that the infant had any signs or symptoms of cannabis withdrawal; was affected by the maternal use of cannabis, nor any future healthcare implications for the baby.

Per the *Official Guidelines for Coding and Reporting*, for suspected conditions ruled out (16.b.1.), “Category Z05, Encounter for observation and evaluation of newborn for suspected diseases and conditions ruled out, is to be used to identify those instances when a healthy newborn is evaluated for a suspected condition that is determined after study not to be present.

**Question:**
Quality measures at our facility may be affected when a patient is receiving palliative care and the present on admission (POA) indicator “N” (No) is reported. We are seeking official guidance from *Coding Clinic* regarding the appropriate POA indicator for patients receiving palliative care.
Answer:
Effective October 1, 2021, code Z51.5, Encounter for palliative care, was added to the Exempt from POA Reporting List by the Centers for Disease Control and Prevention’s National Center for Health Statistics.

Question:
A patient arrived at the Emergency Department (ED) with vaginal bleeding at 18 to 19 weeks gestation and had a spontaneous vaginal delivery of twin A, in the ED. Upon the initial assessment in Labor and Delivery, twin B had heart tones, but expelled spontaneously within the next few minutes. The placenta of twin A was removed intact without complication. The placenta of twin B was difficult to extract manually and remained in utero. Due to postpartum hemorrhage and retained placenta, a suction curettage was performed with removal of the remaining placenta. What are the diagnosis and procedure code assignments for this case?

Answer:
Assign codes O03.6, Delayed or excessive hemorrhage following complete or unspecified spontaneous abortion, for spontaneous delivery of twin A and O03.1, Delayed or excessive hemorrhage following incomplete spontaneous abortion, for the incomplete spontaneous abortion of twin B with retained placenta.

Assign the following ICD-10-PCS code:

10D17ZZ Extraction of products of conception, retained, via natural or artificial opening, for suction curettage removal of the retained placenta.

No delivery code is assigned for a spontaneous abortion.
**Question:**
A patient presents at 41-weeks of gestation and had an uncomplicated vaginal delivery. She was diagnosed with bacterial vaginitis and was treated with Flagyl. How should bacterial vaginitis in pregnancy be coded?

**Answer:**
Assign code O23.593, Infection of other part of genital tract in pregnancy, third trimester, for bacterial vaginitis in pregnancy. Use an additional code to identify the infectious organism, if known. This code assignment can be found in the Index to Diseases under Pregnancy, complicated by vaginitis or vulvitis O23.59-.

Effective October 1, 2022, the *Official Guidelines for Coding and Reporting* were revised as follows, “When the classification does not provide an obstetric code with an “in childbirth” option, it is appropriate to assign a code describing the current trimester.”

**Question:**
A 28-year-old pregnant patient with three previous cesarean deliveries was admitted due to placenta increta at 15 weeks 4 days gestation. The patient was counseled regarding the risks of continuing the pregnancy, including potential hemorrhage, possible death of the fetus, as well as increased risk to the mother. For the preservation of maternal life, the patient decided to have a hysterectomy. Would this be considered an elective termination of pregnancy, or would only the placenta increta be coded, as it is the condition, which required the gravid hysterectomy? What is the appropriate diagnosis code for this admission?
Answer:
Assign code O43.222, Placenta increta, second trimester, as the principal diagnosis, since the placenta increta was the reason for the admission as well as the condition that required the hysterectomy. The surgery was performed to preserve maternal life and the hysterectomy would not be classified as an elective abortion.

Question:
This same patient underwent gravid total abdominal hysterectomy and bilateral salpingectomy with fetus in situ. During the procedure, the uterine vessels were clamped. The placenta was found to be protruding from the lower uterine segment on the left side of the uterus. The uterus and cervix were amputated with fetus in situ and bilateral salpingectomy was performed. What are the appropriate ICD-10-PCS codes for gravid hysterectomy and bilateral salpingectomy performed due to placenta increta? Would this be considered an abortion or hysterectomy?

Answer:
Assign the following procedure codes:

0UT90ZZ  Resection of uterus, open approach, and

0UT70ZZ  Resection of bilateral fallopian tubes, open approach, for gravid hysterectomy performed to preserve maternal life.

The objective of the procedure was to remove the uterus to preserve maternal life due to placenta increta. The objective was not to abort the pregnancy, although the termination of pregnancy was an unavoidable outcome of the procedure.
Question:
What is the appropriate ICD-10-CM code assignment for a diagnosis of “tight nuchal cord” on the newborn record? Does “tight nuchal cord” indicate “with compression” or must the provider document “with compression” in order to assign code P02.5, Newborn affected by other compression of umbilical cord?

Answer:
A tight nuchal cord does not necessarily imply compression. When coding the newborn’s record, the health record documentation should indicate the infant was affected in some way by the tight nuchal cord (e.g., metabolic acidosis, late decelerations, low Apgar score, etc.). If the documentation is not clear whether the newborn was affected, query the provider for clarification.

A diagnosis of “tight nuchal cord” documented on the maternal record is not applicable to the newborn, since the provider would need to document the condition on the newborn’s record, as well as the fact that the infant has been affected by this condition.

Question:
A patient was admitted three hours following a colonoscopy with left upper quadrant (LUQ) pain and was found to have a grade 3 splenic laceration with hemoperitoneum, due to the colonoscopy. Is it appropriate to assign a code for the hemoperitoneum when it is associated with a splenic laceration or is the hemoperitoneum considered integral to the laceration and not coded separately?

Answer:
Assign codes D78.12, Accidental puncture and laceration of the spleen during other procedure, K66.1, Hemoperitoneum, and Y65.8, Other
specifies misadventures during surgical and medical care. Code D78.12 is assigned for the splenic laceration and code K66.1 is assigned to capture the hemoperitoneum. Both codes are needed to fully capture the patient’s diagnoses. Code S36.031A, Moderate laceration of spleen, initial encounter, is not appropriate, because a traumatic injury code should not be assigned for injuries that occur during, or as a result of, a medical intervention.

**Question:**
A patient presented with severe pelvic pain due to ruptured left ovarian cyst with hemoperitoneum. Is it appropriate to assign code K66.1, Hemoperitoneum, when it is associated with a ruptured ovarian cyst?

**Answer:**
Assign code N83.202, Unspecified ovarian cyst, left side and code K66.1, Hemoperitoneum. A code from subcategory N83.20-, Unspecified ovarian cyst, does not fully capture the condition; therefore, code K66.1 is needed to identify the hemoperitoneum.

**Question:**
A patient presented with lower abdominal pain due to left-sided ruptured corpus luteum cyst that resulted in a hemoperitoneum and acute blood loss anemia. Is it appropriate to assign code K66.1, Hemoperitoneum, when it is associated with a ruptured corpus luteum ovarian cyst?

**Answer:**
Assign codes N83.12, Corpus luteum cyst of left ovary, and K66.1, Hemoperitoneum. While “hemorrhagic” is a nonessential modifier when referencing corpus luteum cyst in the Index, both codes are needed to capture the severity of this patient’s condition.
Question:
A patient status post laparoscopic cholecystectomy for chronic biliary disease, was readmitted due to abdominal distention with nausea and vomiting. A computerized tomography scan of the abdomen demonstrated a large hematoma of the gallbladder fossa. Surgical exploration revealed no active bleeding and the liver bed was hemostatic. A large hematoma was found within the gallbladder fossa, and the space between the liver and duodenum, along with old blood in the abdomen. Evacuation of hematoma and old blood was performed. The postoperative diagnosis listed, “Postoperative accumulation of intra-abdominal hematoma with hemoperitoneum.” What are the correct code assignments to capture these conditions?

Answer:
Assign code K91.870, Postprocedural hematoma of a digestive system organ or structure following a digestive system procedure. Do not assign a separate code for the hemoperitoneum, because the documentation does not support a diagnosis of hemoperitoneum. The operative report did not describe any active bleeding (hemoperitoneum), only hematoma and old blood, which was essentially part of the hematoma. Although the postoperative diagnosis recorded “Postoperative hemoperitoneum,” coding professionals should review the full body of the operative note, rather than coding strictly from the title of the report. A hematoma is a collection of clotted or partially clotted blood in an organ, tissue or body space, which is typically due to inadequate hemostasis; whereas a hemoperitoneum is internal bleeding that accumulates in the peritoneum.
**Question:**
A patient presented to the hospital with complaints of dizziness with nausea and vomiting. Magnetic resonance imaging (MRI) of the head demonstrated a large right posterior inferior cerebral artery (PICA) infarction with no evidence of cerebral artery occlusion or high-grade stenosis and PICA origin is patent. Following diagnostic imaging, the provider’s diagnostic statement listed, “Right posterior inferior cerebral artery (PICA) infarction.” What is the appropriate ICD-10-CM code for an acute right PICA infarction when the location of the infarction is identified, without evidence of occlusion, stenosis, embolism or thrombus?

**Answer:**
Assign code I63.89, Other cerebral infarction, for the right PICA infarction since the location of the infarction is specified.

**Question:**
A patient with history of alcohol abuse diagnosed with alcoholic dementia presents to the clinic for a follow-up visit. The provider documented that the alcohol abuse is in remission and the patient’s memory is impaired due to alcoholic dementia. ICD-10-CM does not provide a specific code for alcoholic dementia due to alcohol abuse. What are the appropriate code assignments to capture this patient’s alcohol abuse in remission with alcoholic dementia?

**Answer:**
Assign codes F10.188, Alcohol abuse with other alcohol-induced disorder, and F02.80, Dementia in other diseases classified elsewhere without behavioral disturbance, for alcoholic dementia. Also assign F10.11, Alcohol abuse, in remission.
**Question:**
A patient presented for a spinal imaging exam and was diagnosed with a left far lateral disc bulge at level L5-S1. There is no Alphabetic Index entry for disc bulge. Is it appropriate to assume that disc bulge is the same as a herniated or displaced disc? What is the appropriate code assignment for a left L5-S1 far lateral disc bulge?

**Answer:**
Assign code M51.37, Other intervertebral disc degeneration, lumbosacral region, for a left L5-S1 far lateral disc bulge. A bulging disc is not the same as a herniated or displaced disc. A bulging disc happens over time, due to degeneration of the disc.

**Question:**
When a patient is admitted with diverticulitis of the colon and an intra-abdominal abscess, is code K65.1, Peritoneal abscess, assigned along with code K57.20, Diverticulitis of large intestine with perforation and abscess without bleeding?

**Answer:**
Yes. Assign code K57.20, Diverticulitis of large intestine with perforation and abscess without bleeding, followed by K65.1, Peritoneal abscess, to further specify the location of the abscess.

This code assignment is supported by the “code also” note located under both code categories. The note under category K57, Diverticular disease of intestines, instructs the coding professional to code peritonitis if applicable, and the note under category K65, Peritonitis, instructs to code if applicable diverticular disease of intestine (K57-).
**Question:**
A patient is admitted with peritonitis likely secondary to perforated sigmoid diverticulitis. Is code K65.9, Peritonitis, unspecified, assigned with code K57.20, Diverticulitis of large intestine with perforation and abscess without bleeding?

**Answer:**
Yes. Assign codes K57.20, Diverticulitis of large intestine with perforation and abscess without bleeding, and K65.9, Peritonitis, unspecified.

Please note, effective October 1, 2020, the inclusion term at subcategory K57.2- has been deleted. Therefore, it would be appropriate to report both codes for discharges on and after October 1, 2020.

**Question:**
A group home resident was found in acute distress after forcing a piece of cardboard into his mouth. Following removal of the cardboard at the group home, the patient presented to Hospital A and was treated for a pneumomediastinum. He was transferred to Hospital B, where he underwent diagnostic esophagogastroduodenoscopy (EGD) to evaluate for esophageal perforation. The postoperative diagnosis states healing cervical esophageal perforation. Is it appropriate to assign a code for a foreign body that was removed prior to any admission/encounter for medical care? What code should Hospital B assign for the esophageal perforation injury?

**Answer:**
Assign code S19.85XA, Other specified injuries of pharynx and cervical esophagus, initial encounter, for the healing cervical esophageal perforation, since in this case the foreign body is no longer present. Code X78.8XXA, Intentional self-harm by other sharp object,
initial encounter, would be assigned to describe the external cause of the injury. A code is not assigned for a foreign body, as Coding Clinic, First Quarter 2015, page 24, states, “an esophageal foreign body is any object that does not belong in the esophagus that becomes stuck there.”

Question:
A patient is diagnosed with hyperglycemic hyperosmolar ketotic state without acidosis, and new onset type 2 diabetes. Coding Clinic, Third Quarter 2013, page 20, states “Any combination of the diabetes codes can be assigned together, unless one diabetic condition is inherent in another.” Is code E11.65, Type 2 diabetes mellitus with hyperglycemia assigned as an additional diagnosis? What is the correct code assignment for this patient?

Answer:
Assign code E11.00, Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC). Hyperglycemia is inherent to code E11.00; therefore, do not separately report code E11.65.

Question:
A patient is diagnosed with uncontrolled type 1 diabetes mellitus (DM), hyperglycemia, and acute hyperglycemic hyperosmolar syndrome (HHS). Both hyperglycemia and hyperosmolarity are respective subterms at the Index entry for Diabetes, type 2, under the subterm “with.” However, only hyperglycemia appears as a subterm at the Index entry for Diabetes, type 1, under the subterm “with.” What is the correct code assignment for uncontrolled Type 1 DM with HHS?
Answer:
Assign codes E10.69, Type 1 diabetes mellitus with other specified complication, E10.65, Type I diabetes mellitus with hyperglycemia, and E87.0, Hyperosmolality and hypernatremia, for HHS. Since ICD-10-CM does not provide a specific code for type 1 diabetes with hyperosmolarity, code E10.69 is assigned. Further, code E10.65 captures the hyperglycemia, but not the hyperosmolality; therefore each code is needed to completely capture the patient’s condition. Although HHS most often affects individuals who have type 2 diabetes, it can also affect people with type 1 diabetes.

Question:
A patient with advanced untreatable right maxillary cancer presented to the emergency department (ED) with recurrent oral bleeding. The patient refused treatment and requested physician-assisted suicide while in the ED. The patient was already receiving palliative care, and a do not resuscitate (DNR) order was established. Would it be appropriate to assign code R45.851, Suicidal ideations, when a patient requests provider-assisted suicide?

Answer:
Do not assign code R45.851, Suicidal ideations, as suicidal ideation has a different connotation than a request for provider-assisted suicide. ICD-10-CM does not have a specific code to capture a patient’s request for provider-assisted suicide. In this case, the request for provider assistance to end life is related to the patient’s terminal cancer. Assign codes for the advanced maxillary cancer as the first-listed diagnosis since it is the underlying cause of the bleeding, which led to the ED encounter. Also assign codes for palliative care, the DNR status and any other conditions that meet the definition of secondary diagnosis.
**Question:**
A patient who presented due to low back pain was diagnosed with dextroconvex scoliosis at levels C7-T6 and levoconvex scoliosis at levels T11-L1. When referencing scoliosis in the Index, there are no subentries for dextroconvex and levoconvex scoliosis. Is it appropriate to assume that these are types of scoliosis and assign codes from subcategory M41.8, Other forms of scoliosis? What are the appropriate code assignments for dextroconvex and levoconvex scoliosis?

**Answer:**
Assign code M41.9, Scoliosis, unspecified, for dextroconvex scoliosis and levoconvex scoliosis. These terms describe the curvature/shape of the scoliosis rather than the type or cause of the scoliosis.

**Question:**
What is the correct diagnosis code for scintillating scotoma? The Index entry under Scotoma, scintillating leads to code H53.19, Other subjective visual disturbances. However, “scintillating scotoma” is also an inclusion term in the Tabular List under subcategory H53.12-, Transient visual loss. Furthermore, the cross reference at the Index entry Scotoma instructs see also Defect, visual field, localized, scotoma, which leads to code H53.419, Scotoma involving central area, unspecified eye.

**Answer:**
Assign the appropriate code from subcategory H53.12-, Transient visual loss, depending on which eye is affected. The Centers for Disease Control and Prevention’s National Center for Health Statistics will consider modifications to address Index and Tabular discrepancies through the ICD-10 Coordination and Maintenance (C&M) process.
**Question:**
A patient presents with possible recurrent E. coli urinary tract infection, bacteremia and ongoing left hip/groin pain. A pubic symphysis aspirate demonstrated E. coli, likely the same E. coli in the blood. The provider confirmed a diagnosis of septic arthritis/osteomyelitis of pubic symphysis/ pubic bone. What are the ICD-10-CM diagnosis code assignments for pubic symphysis osteomyelitis and septic arthritis?

**Answer:**
Assign codes M86.8X8, Other osteomyelitis, other site, for osteomyelitis of the pubic symphysis joint, and B96.20, Unspecified Escherichia coli [E. coli] as the cause of diseases classified elsewhere, to identify the infectious agent. Currently, ICD-10-CM does not have a specific code for septic arthritis of the pubic symphysis joint. The Centers for Disease Control and Prevention’s National Center for Health Statistics has agreed to consider a future ICD-10 Coordination and Maintenance (C&M) proposal to create a new code for septic arthritis, affecting other joints.

**Question:**
This same patient underwent an aspiration fluid biopsy of the pubic symphysis joint. During the procedure, a guide needle was passed percutaneously under CT guidance into the pubic symphysis joint. Aspiration was attempted; however, there was no return of fluid. After approximately 2cc's of sterile saline was administered into the pubic symphysis joint, the joint was re-aspirated and serous sinus fluid was retrieved for analysis. What is the appropriate root operation and body part value for an aspiration fluid biopsy of the pubic symphysis joint?
Answer:
Assign the following procedure codes:

0Q933ZX Drainage of left pelvic bone, percutaneous approach, diagnostic, and

0Q923ZX Drainage of right pelvic bone, percutaneous approach, diagnostic, for aspiration biopsy of the pubic symphysis joint.

In ICD-10-PCS, there is no specific body part value for drainage of the “pubic symphysis joint”. The pubic symphysis lies midline to the right and left pubic bones. Therefore, the body part values “3”, Pelvic bone, left, and “2”, Pelvic bone, right, would be appropriate in this case. When the physician describes the pelvic symphysis as the body part, assign codes for both the left and right pelvic bones.

Question:
A six-year-old with gross motor function classification system (GMFCS) 5 spastic quadriplegic cerebral palsy (CP), who has had progressive subluxation of both hips, presents for surgical intervention to avoid worsening of his subluxation. The provider’s final diagnosis indicates "Spastic quadriplegic cerebral palsy with progressive subluxation of bilateral hips". What is the ICD-10-CM code for progressive hip subluxation?

Answer:
Assign codes M24.351, Pathological dislocation of right hip, not elsewhere classified, and M24.352, Pathological dislocation of left hip, not elsewhere classified, for the bilateral hip subluxation.
**Question:**
A patient presents due to spontaneous rupture of the left eye globe, which required emergency surgery. The patient underwent an enucleation with subsequent implant of the left eye. There is no mention of trauma in the health record documentation. What is the correct code assignment for a spontaneous (non-traumatic) rupture of the left eye globe?

**Answer:**
Assign code H44.89, Other disorders of globe, for the spontaneous (non-traumatic) rupture of the left eye globe.

**Question:**
A patient was admitted for treatment of a malleolus fracture of the right ankle. The provider documented “Alcohol abuse - monitor for withdrawal symptoms.” The patient also had a history of anxiety and was prescribed Cymbalta during hospitalization. Based on the “with” convention, I.A.15, should we assume a link between anxiety and alcohol abuse and assign code F10.180, Alcohol abuse with alcohol-induced anxiety disorder?

**Answer:**
Do not assume a relationship between alcohol abuse and/or dependence and anxiety. Although the Alphabetic Index links “alcohol with anxiety disorder” and “alcohol-induced anxiety disorder” is part of the code narrative, an alcohol-induced anxiety disorder is not the same as having anxiety and alcohol use/abuse/dependence. Further, the Tabular narrative for codes in subcategory F10.18-, Alcohol abuse with other alcohol-induced disorders, indicates these codes are assigned for “alcohol-induced disorders,” and such a relationship must be documented by the provider. While chronic alcohol dependence, abuse or use may lead to
an alcohol induced anxiety disorder, there can be other underlying causes of anxiety. These conditions should not be linked, unless the provider clearly documents a relationship.

**Question:**
Should combination codes be assigned from categories F10-F19, Mental and behavioral disorders due to psychoactive substance use, any time a patient with a substance abuse or dependence diagnosis also has documented anxiety, mood disorder, sleep disorder, or sexual dysfunction based on the “with” guideline?

**Answer:**
Do not assume a relationship between substance abuse and/or dependence and anxiety, mood disorder, sleep disorder, or sexual dysfunction. Although these conditions are terms that are located under “with” in the Index, the narrative in the Tabular indicates these codes are reported when the condition is documented as an “alcohol-induced” disorder and such a relationship is documented by the provider.

**Question:**
A patient with a history of traumatic brain injury, status post bilateral craniectomies is admitted for skull reconstruction due to bilateral frontoparietal cranial defects. Cranioplasty was performed on the right side, however during the recovery phase the patient became obtunded, encephalopathic and bradycardic. The physician noted the previous left-sided skull flap appeared sunken, consistent with sunken flap syndrome and paradoxical brain shift, which required left-sided reconstruction. What are the correct code assignments for sunken flap syndrome?
Answer:
Assign codes G97.82, Other postprocedural complications and disorders of nervous system, and M95.2, Other acquired deformity of head, for post craniectomy sunken flap syndrome. Based on the “use additional code” note located at subcategory G97.8, Other intraoperative and postprocedural complications and disorders of nervous system, assign additional codes to further specify the condition.

Question:
A patient presents to the Emergency Department (ED) with abdominal pain, chills, and severe low back pain, after not being able to retrieve a tampon used for menstruation. After admission, the workup showed leukocytosis, white blood count (WBC) of 24 and the patient was started on sepsis protocol. The final diagnoses were sepsis and suspected toxic shock syndrome (TSS). Code A48.3, Toxic shock syndrome and category A41, Other sepsis, have conflicting Excludes notes. Depending on which note is referenced, coding professionals are instructed to assign one or two codes. What codes are assigned for TSS with sepsis?

Answer:
Assign only code A48.3, Toxic shock syndrome, for TSS with sepsis. TSS is a systemic infection with inherent shock. The Excludes1 note at code A48.3 refers to unspecified sepsis. Code A48.3 describes the systemic infection and shock more accurately than code A41.9, Sepsis unspecified organism. Therefore, only code A48.3 should be assigned.
**Question:**
A patient stopped taking his prescribed dose of Amlodipine after running out of the antihypertensive medication several days ago. The provider documented that the patient’s blood pressure was stable. Would it be appropriate to assign a code for underdosing of Amlodipine when there is no documentation of an exacerbation or an issue with the patient’s chronic hypertension?

**Answer:**
Assign codes T46.5X6A, Underdosing of other antihypertensive drugs, initial encounter, I10, Essential (primary) hypertension, and Z91.14, Patient’s other noncompliance with medication regimen, to capture the fact that the patient was not taking the medication as prescribed.

The underdosing guideline (I.C.19.e.5.c) does not preclude the assignment of underdosing codes if the health record documentation does not specifically state a change in the patient’s condition. Documentation that the patient had discontinued the prescribed medication on his/her own is sufficient for code assignment.

**Question:**
My facility has interpreted new HIV coding guideline I.C.1.a.2.i “History of HIV managed by medication” to mean that code B20, HIV disease, should be reported for any HIV positive patient on antiretrovirals, regardless of whether the documentation states the patient has ever had an HIV-defining illness or has HIV disease. Could you please clarify if this was the intent of this new guideline?

**Answer:**
The intent of the guideline is to provide guidance that code B20 is appropriate for patients documented with HIV disease on
antiretrovirals and to align with the guidance published in *Coding Clinic*, Fourth Quarter 2020, pages 97-98, that clarified HIV disease is specifically classified to code B20. It would not be appropriate to report code B20 without provider documentation of an HIV related illness, HIV disease or AIDS. A diagnosis of “HIV” or “HIV positive” without documentation of HIV disease, an HIV related illness, or AIDS should be assigned code Z21, Asymptomatic human immunodeficiency virus [HIV] infection status.” However, the provider should be queried for clarification when the documentation is unclear regarding the patient’s HIV status. This is also consistent with the advice published in *Coding Clinic*, First Quarter 2019, pages 8-11.

**Question:**
A 63-year-old male status post open-heart repair of an ascending aortic aneurysm was found to have a large mass in his left atrium that was obstructing blood flow. The patient underwent drainage of the hematoma. Under transesophageal echocardiogram (TEE) guidance, approximately 100 ml of blood was aspirated from the hematoma; however, after several minutes, the hematoma started to re-accumulate.

An Amplatzer device was then inserted to keep the hematoma compressed. The wall of the hematoma was punctured into the left atrium and a 35mm Amplatzer Cribriform Occluder device was inserted with a disc placed in the left atrium, the neck of the device placed through the hematoma and the interatrial septum, and the second disc placed into the right atrium. What is the appropriate root operation and body part value for this procedure?
**Answer:**
Assign the following ICD-10-PCS code:

**02U73JZ**  
Supplement left atrium with synthetic substitute, percutaneous approach, for insertion of Amplatzer device.

The Amplatzer device was placed to repair/compress the left atrium. In ICD-10-PCS, the root operation “Supplement” can function where needed as a “Repair with device NEC option,” when a more specific code is not available.

**Question:**
A patient presented for aortic root and valve replacement, mitral valve replacement and reconstruction of the aorto-mitral curtain (AMC) with bovine pericardium for treatment of severe aortic valve stenosis and moderate to severe mitral valve stenosis and regurgitation. For the AMC portion of the procedure, the reconstruction of the AMC was performed from trigone to trigone using a piece of bovine pericardium. The AMC was created by folding over the bovine pericardium with a Prolene suture in running 2-layer fashion leaving approximately 1 to 2 cm from the mechanical mitral valve sewing cuff. What is the appropriate root operation and body part value for reconstruction of the AMC using bovine pericardium?

**Answer:**
Assign the following procedure code:

**02UA08Z**  
Supplement heart with zooplastic tissue, open approach, for the reconstruction of the AMC
The AMC is located at the junction between the base of the anterior mitral leaflet and the aortic root. Therefore, the heart is the closest available body part value since this is neither the mitral valve nor the aortic valve. In ICD-10-PCS, the root operation “Supplement” can function where needed as a “Repair with device NEC option,” when a more specific code is not available.

**Question:**
A patient with a femoral neck fracture underwent an open left total hip arthroplasty. Following removal of the femoral head, trial femoral head and neck metal on polyethylene components were placed. At the acetabulum, a shell was trialed for fit, followed by placement of the acetabular component. A temporary acetabular liner was placed in addition. Suddenly, the patient decompensated and was not stable to continue the surgery. The temporary acetabular liner and femoral trials were left in place, to be exchanged for final implants at a later date. Would ICD-10-PCS codes be assigned for placement of the trial joint components, not intended to remain at the end of the procedure? If so, what are the correct root operations and device values?

**Answer:**
Assign the following ICD-10-PCS code:

0SRB02A Replacement of left hip joint with metal on polyethylene synthetic substitute, uncemented, open approach, for the provisional total hip arthroplasty.

In this case, a total hip replacement procedure was performed, as both the acetabular and the femoral portions of the joint were replaced with prosthetic components.
**Question:**
A 5-1/2 month-old infant, who was diagnosed with moderate-to-severe common atrioventricular (AV) valve regurgitation, underwent complex common AV valve repair. The patient was also noted to have tricuspid valve regurgitation. At surgery, a midline sternotomy was performed. Attention was directed to the common AV valve after atrial stay sutures had been placed. The common AV valve was floated with saline and there were multiple jets of regurgitation through the right-sided component of the AV valve. A series of horizontal mattress sutures were placed to pex the superior bridging leaflet to the rudimentary septal leaflet, and an Alfieri stitch was placed between the superior and inferior bridging leaflet, incorporating a portion of the septal leaflet. Upon saline testing, the valve appeared to be dramatically improved. According to *Coding Clinic*, Fourth Quarter 2017, pages 35-36, Alfieri stitch procedures are assigned the root operation “Restriction,” however there is no body part value for AV valve under root operation “Restriction.” What is the appropriate body part value and root operation to capture a repair of the common AV valve with sutures and Alfieri stitch?

**Answer:**
Assign the following ICD-10-PCS code:

02QA0ZZ  Repair heart, open approach

The common atrioventricular valve is a congenital heart defect and is neither the mitral nor the tricuspid valve. Therefore, repair of the heart is the closest available option.
Question:
A 3-month-old baby with moderate atrioventricular (AV) valve regurgitation, presented for a common AV valve repair. During surgery, median sternotomy was performed; the common AV valve was entered and commissuroplasty sutures were placed. The valve was evaluated, which was fairly competent. What is the appropriate ICD-10-PCS body part value to capture a common atrioventricular valve (AV) repair with commissuroplasty sutures?

Answer:
Assign the following ICD-10-PCS codes:

02QA0ZZ Repair heart, open approach

The common atrioventricular valve is a congenital heart defect and is neither the mitral nor the tricuspid valve. Therefore, heart is the closest available ICD-10-PCS body part value.

Question:
A 28-year-old pregnant patient with a history of three prior cesarean deliveries was transferred to our facility, for management of a C-section scar ectopic pregnancy. Due to the patient’s desire for future fertility, she deferred surgical management in favor of medical management. Multi-dose injections of systemic methotrexate were initiated on admission. An ultrasound confirmed pregnancy in the anterior lower uterine segment with positive fetal cardiac activity. An intrauterine Cook balloon was placed to compress the gestational sac and expedite fetal demise, as well as a tamponade for potential bleeding. During the procedure, a Cook balloon catheter was passed through the cervix and into the uterine cavity. The balloon was inflated with saline to maintain
the balloon in the uterus. An additional balloon was then inflated just below the level of the visualized gestational sac. Both balloons were inflated further until the gestational sac was compressed and no clear sac was visualized or fetal cardiac activity was detected. What is the appropriate ICD-10-PCS code for the Cook balloon catheter placement for an ectopic pregnancy?

**Answer:**
Assign the following procedure code:

10A07ZZ Abortion of products of conception, via natural or artificial opening, for intrauterine Cook balloon catheter placement.

The procedure was performed to compress the gestational sac to terminate the ectopic pregnancy.

**Question:**
A woman with a pelvic abscess and pancreatic head necrosis presented for surgery. A flank incision was made with division into the retroperitoneum. Malodorous semi-solid material typical of fat necrosis was found. The area of the retroperitoneum up toward the head of the pancreas was gently debrided with fingers and sponge stick. A resectional debridement was carried out until all remaining necrotic fat and tissue were removed. For the pelvic abscess, a lower midline incision was made near the symphysis pubis until the abscess cavity was entered. This too looked like fat necrosis in the space of Retzius. This was scooped out with fingers and a sponge stick. What are the root operations and body part values for removal of fat necrosis near the pancreas and within the pelvic abscess cavity?
Answer:
Assign the following procedure codes:

0WCH0ZZ  Extirpation of matter from retroperitoneum, open approach, for the removal of fat necrosis from the retroperitoneum near the pancreatic head and surrounding tissue.

0WCJ0ZZ  Extirpation of matter from pelvic cavity, open approach, for the fat necrosis removal from the abscess cavity. Per the ICD-10-PCS body part key, the space of Retzius is a retropubic space, classified to the pelvic cavity.

The provider documented that the necrotic tissue was semi-solid material and removed by use of fingers and sponge stick. This meets the definition of Extirpation - taking or cutting out solid material from a body part.

Question:
The patient underwent thrombectomy of the M1 segment of the middle cerebral artery due to acute occlusion. During the thrombectomy, a stent retriever was used with aspiration. Although the stent retriever deployment was not successful, some of the clot was removed by aspiration. What is the appropriate ICD-10-PCS code for this procedure?

Answer:
Assign the following ICD-10-PCS code:

03CG3ZZ  Extirpation of matter from intracranial artery, percutaneous approach, for the aspiration of thrombus.
Code assignment is based on the procedure performed, and in this case the stent retriever was unable to be deployed successfully and therefore, not used to remove any of the thrombus.

**Question:**
A patient was admitted and underwent a mediastinal washout and endoluminal vacuum application (EVAC) utilizing an endosponge, due to a near complete esophagogastric anastomotic disruption. Under direct endoscopic visualization, a gastroscope was advanced through the oropharynx into the esophagus identifying the location of the previous anastomosis. Posteriorly, there was an ulcer base and gastric mucosa located near the esophageal mucosa but the remainder of the anastomosis demonstrated a wide gap. Because of this large gap, essentially in the patient’s mediastinal cavity, there were large amounts of contamination and purulent material, which was suctioned and evacuated via the scope. The scope was then advanced down to the third portion of the duodenum with no relevant findings. The surgeon elected to place an endoluminal endosponge to assist in cleaning up the contamination. What is the ICD-10-PCS code assignment for the initial insertion of the EVAC?

**Answer:**
Assign the following ICD-10-PCS code:

0DH08YZ  Insertion of other device into upper intestinal tract via natural or artificial opening endoscopic, for the placement of the endoluminal endosponge across the esophagogastric anastomotic disruption.
**Question:**
This same patient underwent removal and replacement of the endosponge, which was used to treat the esophagogastric anastomotic leak. Diagnostic endoscopy was performed, and the endosponge was removed. The scope was advanced through the oropharynx into the esophagus and fluid within the leaking cavity was aspirated. There was granulation tissue of the lateral wall and continued closure of the right-sided defect. A nasogastric (NG) tube was placed through the patient’s naris and brought out through the mouth. Utilizing a small portion of endosponge, a suture was used to secure the endosponge to the NG tube. A suture loop was placed at the distal end, using biopsy forceps to drag it into position endoscopically. The endosponge was placed into the defect, collapsing the extraluminal pocket and the scope was withdrawn. What are the ICD-10-PCS code assignments for the removal and replacement of the endosponge?

**Answer:**
Assign the following ICD-10-PCS code:

0D20XYZ  Change other device in upper intestinal tract, external approach, for the removal and replacement of the endosponge.

The *ICD-10-PCS Official Guidelines for Coding and Reporting*, B4.8 states:

“In the Gastrointestinal body system, the general body part values Upper Intestinal Tract and Lower Intestinal Tract are provided as an option for the root operations Change, Inspection, Removal and Revision. Upper Intestinal Tract includes the portion of the gastrointestinal tract from the esophagus down to and including the duodenum and Lower
Intestinal Tract includes the portion of the gastrointestinal tract from the jejunum down to and including the rectum and anus.”

In ICD-10-PCS, all Change procedures are coded using the approach external.

**Question:**
A patient with atrial fibrillation, underwent external cardioversion with no conversion and remained in atrial flutter with a ventricular rate of 120. The patient was brought to the electrophysiology (EP) lab for an internal cardioversion. A decapolar catheter was placed into the distal coronary sinus and a second one in the right atrium. This was confirmed by electrogram analysis. The patient was cardioverted internally at 20 joules between the two sites using the Booker Box unipolarizer. The patient was promptly converted to a normal sinus rhythm, and was hemodynamically stable. The catheters and sheaths were then removed. What is the appropriate ICD-10-PCS code assignment for the internal cardioversion?

**Answer:**
Assign the following ICD-10-PCS codes:

- 5A2204Z Restoration of cardiac rhythm, single, for the internal cardioversion, and
- 4A0234Z Measurement of cardiac electrical activity, percutaneous approach, for the electrogram analysis, if desired.

Restoration of normal sinus rhythm was the objective of the procedure. Both the external and internal cardioversion are coded to root operation Restoration which is defined as returning, or attempting to return,
a physiological function to its original state by extracorporeal means. Currently, there is no ICD-10-PCS code to distinguish the difference between and internal and external cardioversion.

**Question:**
A patient with chondral lesions of the lateral trochlea and patella presents for placement of matrix-induced autologous chondrocyte implantation (MACI) in the right knee via arthrotomy, into the chondral defects. Fulkerson osteotomy was performed and the damaged cartilage and fibrocartilage were then debrided back to the calcified cartilage layer. The autograft patch was removed from sterile packaging and cut to fit the two defects. The patches were placed onto the defects using fibrin glue. What is the appropriate root operation for the MACI procedure?

**Answer:**
Assign the following ICD-10-PCS code:

0SUC07Z  Supplement right knee joint with autologous tissue substitute, open approach, for the matrix-induced autologous chondrocyte implant of the right knee.

The autologous patch grafts were placed to augment the chondral defects. Supplement is defined as putting in or on biological or synthetic material that physically reinforces and/or augments the function of a portion of a body part. Matrix-induced autologous chondrocyte implantation (MACI) is a surgery where the patient’s own cells are used to regrow new cartilage in the knee joint. It is a two-part surgery to treat cartilage defects. During the first part of the procedure, cartilage
is removed arthroscopically and sent to the lab to be grown on a collagen matrix. In the second step, the cartilage implant is affixed onto the knee joint defect.

**Question:**
An infant had umbilical cord blood collected for blood typing and testing of blood gases shortly following birth. Would it be appropriate to assign code 6A550ZT, Pheresis of cord blood stem cells, single, for the collection of umbilical cord blood for sampling? If not, what is the appropriate ICD-10-PCS code assignment?

**Answer:**
It is not appropriate to assign code 6A550ZT, Pheresis of cord blood stem cells, single, for umbilical cord blood sampling. Collection of umbilical cord blood is a routine part of the newborn’s care and an ICD-10-PCS code is not assigned. This is not the same as pheresis of cord blood stem cells, and is not a separately reportable service.

**Question:**
A patient with a bullet wound to the right forehead sustained a fracture of the anterior and posterior table of the frontal sinus, fracture of the right superior orbital roof, and interruption of the nasofrontal outflow tract. He underwent open reduction and internal fixation of the frontal sinus fractures, obliteration of the frontal sinus with sealing of the nasofracture ducts, pericranial flap for sealing of the anterior cranial base from the sinuses, and bifrontal craniotomy. What are the correct root operation and body parts for open reduction with internal fixation of frontal sinus fracture, sealing of nasofracture ducts, and pericranial flaps to create a seal of the cranial base?
**Answer:**
The appropriate root operations in this case are Reposition (0NS), Supplement (09U), and Transfer (0JX).

Assign the root operation Reposition of the orbit body part, for the open reduction with internal fixation of the anterior and posterior table of the frontal sinus and fracture of the right superior orbital roof. The ICD-10-PCS Body Part Key directs the coding professional to left/right orbit for procedures to the orbital portion of the frontal bone.

The root operation Supplement of the frontal sinus body part is assigned for use of the temporalis muscle to plug the left nasofrontal duct.

The root operation Transfer and the body part scalp subcutaneous tissue and fascia is assigned for the pericranial flaps used to create a seal of the cranial base.

**Question:**
A patient underwent robotic-assisted low anterior colon resection for treatment of cancer. At surgery, pneumoperitoneum was established; robotic ports were placed; and the splenic flexure was mobilized laparoscopically, followed by robotic excision. A Pfannenstiel incision was made; the sigmoid colon was pulled through the incision; and skeletonized extracorporeally. Anastomosis was then performed and inspected via proctoscope. What is the appropriate approach value for this procedure?

**Answer:**
Assign the approach value “4, Percutaneous Endoscopic” for the robotic-assisted sigmoid colectomy with primary anastomosis. In this
case, surgery was performed laparoscopically; towards the end of the procedure, a small Pfannenstiel incision was made to divide, skeletonize and remove the specimen. According to the ICD-10-PCS guideline B5.2b, “Procedures performed using the percutaneous endoscopic approach, with incision or extension of an incision to assist in the removal of all or a portion of a body part or to anastomose a tubular body part to complete the procedure, are coded to the approach value Percutaneous Endoscopic.”

**Question:**
A patient presented with left-sided refractory trigeminal neuralgia, and underwent a left percutaneous ganglion balloon compression. The compression was performed by advancing a 4F Fogarty catheter into the Meckel’s cave, confirmed with fluoroscopy. The Fogarty catheter was inflated with 0.75cc of omnipaque, until ideal pear-shape of the balloon was acquired. This was maintained for 60 seconds and then deflated. The Fogarty catheter was then withdrawn. What is the appropriate root operation for the balloon compression of the trigeminal ganglion to treat trigeminal neuralgia?

**Answer:**
Assign the following ICD-10-PCS code:

005K3ZZ  Destruction of trigeminal nerve, percutaneous approach

This procedure is consistent with the root operation definition of Destruction, which states, “Physical eradication of all or a portion of a body part by the direct use of energy, force, or a destructive agent.” The balloon uses physical force to compress the trigeminal ganglion, disrupting the neural pathway that causes pain.
Clarifications

Intraoperative Serosal Tear

Question:
Please clarify the advice published in Coding Clinic Second Quarter 2021, page 8, regarding intraoperative serosal tear. The advice appears to conflict with the Official Guidelines for Coding and Reporting for documentation of complication of care (1.B.16.) since the provider explicitly documented that no complication occurred. In addition, because the tear occurred during a laparoscopic salpingo-oophorectomy, code K91.72, Accidental puncture and laceration of a digestive system organ or structure during other procedure, should have been assigned, rather than code K91.71, Accidental puncture and laceration of a digestive system organ or structure during a digestive system procedure.

Answer:
The advice previously published in Coding Clinic Second Quarter 2021, page 8, does not conflict with the Official Guidelines for Coding and Reporting for documentation of complication of care (1.B.16.) since a cause and effect relationship was documented between the surgery and the serosal tear. This guideline was not intended to mean that the surgeon must specifically document the term “complication.” The surgeon’s documentation of the serosal tear and the subsequent procedure for repairing the tear is sufficient documentation to report a complication code. Furthermore, the term “complication” does not imply inappropriate/inadequate care, and/or an unplanned outcome. Some issues or conditions occurring as a result of surgery are classified by ICD-10-CM as a complication whether stated or not. Although the surgeon stated that the
serosal tear was unavoidable, it does not mean that the tear is not a surgical complication. For example, a serosal tear can range from a small nick requiring no treatment at all, to a major tear requiring removal of a portion of the small intestine. Serosal tears alone do not qualify as reportable diagnoses. If, however, the degree of a serosal tear alters the course of the surgery as supported by the medical record documentation, then the tear should be reported.

Although not explicitly stated in the Q&A, the patient had undergone multiple procedures including salpingo-oophorectomy, reduction and repair of an incarcerated ventral hernia with mesh and lysis of adhesions. The serosal tear occurred during the part of the surgery to repair the ventral hernia and lysis of adhesions of the small intestine. Therefore, code K91.71, Accidental puncture and laceration of a digestive system organ or structure during a digestive system procedure, is the correct code assignment.

**Toxic Metabolic Encephalopathy due to Hepatic Encephalopathy**

**Question:**
*Coding Clinic*, First Quarter 2021, page 13, states that it is appropriate to assign code G92, Toxic encephalopathy, for toxic metabolic encephalopathy (TME) due to acute on chronic hepatic encephalopathy. However, this advice does not seem correct since the provider did not document an associated toxic substance or an adverse effect of medication. Is it appropriate to assign code G92, when there is no external agent associated with the encephalopathy? It would appear that toxic metabolic encephalopathy or any other specified type of encephalopathy should only
be reported when linked to another condition besides hepatic encephalopathy or hepatic failure. In this case, it appears that the encephalopathy should be inherent and not separately reported since it is linked to the liver encephalopathy.

**Answer:**
The encephalopathy that occurs with liver failure is metabolic in nature from toxins generated within the body, not from external toxins. When the provider has confirmed the diagnosis of toxic metabolic encephalopathy, assign code G92.8, Other toxic encephalopathy. This code assignment does not imply external toxins and a toxin does not have to come from outside the body in order to assign this code.

The Alphabetic Index for Encephalopathy, toxic, metabolic, leads to code G92.8 and the inclusion term “Toxic metabolic encephalopathy” confirms that this is the correct code assignment. Code assignment is based on the provider’s documentation of the condition, and is not based on a particular clinical definition or criterion.

A “code first” note instructs that two codes may be required to fully describe this condition, if applicable. Toxic metabolic encephalopathy is not inherent to hepatic encephalopathy, therefore code G92.8 should be assigned separately to specifically capture the TME.

Code K72.90, Hepatic failure, unspecified without coma, should be assigned if the only documentation in the medical record is “hepatic encephalopathy,” without any further specification of the underlying cause. In this case, the underlying cause of the toxic metabolic encephalopathy was acute on chronic hepatic encephalopathy.
Correction Notices

Coronary Artery Bypass Graft Surgery

*Coding Clinic* Third Quarter 2021, page 23, contained a typographical error. The Q&A pertaining to coronary artery bypass graft surgery cited Section B3.6a of the *ICD-10-PCS Official Guidelines for Coding and Reporting*. However, this was not correct. The correct citation should have been Section B3.6b, as this guideline pertains to bypass of coronary arteries.

Extraction of Bone Marrow from Other Sites

*Coding Clinic* Fourth Quarter 2021, page 47, contained a misprint. The correct Qualifiers in the ICD-10-PCS table 07D should have been X Diagnostic and Z No Qualifier, not T Bone Marrow as follows:

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q Bone Marrow, Sternum</td>
<td>0 Open</td>
<td>Z No Device</td>
<td>X Diagnostic</td>
</tr>
<tr>
<td>R Bone Marrow, Iliac</td>
<td>3 Percutaneous</td>
<td></td>
<td>Z No Qualifier</td>
</tr>
<tr>
<td>S Bone Marrow, Vertebral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T Bone Marrow</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>