Fall 2017

RADIOLOGY CODING CERTIFICATION BOARD

CODINGSTRATEGIES

RCC UPDATE

Radiology Coding Certification Board

From the President

Renée Engle, RCC, FRBMA,
President,
RCCB Board of Directors

Hello Autumn!

It might not feel like it yet, but Fall is upon us and I'd like to wish all the examinees sitting for the exam next week good luck! We have one more exam week open in 2017, and if you haven't yet signed up to take your exam, the next testing window is November 13 – 17, 2017 with an application deadline of October 9th. You will not regret the decision!

Looking for resources to help prepare for the exam, click here (https://rccb.org/study-resources).

Stay tuned for 2018 exam dates and a new 2018 RCC Essentials Handbook ready to ship from Coding Strategies on December 18, 2017. Click here to reserve your copy (https://training.codingstrategies.com/Online-Store/Products/Product-Detail/radiology-specialty/2018-rcc-essentials-handbook).

Sincerely,
Renée Engle, RCC, FRBMA
"Success is the sum of small efforts, repeated day in and day out." -Robert Collie

Medicare

Mixed News in 2018 MPFS Proposed Rule

On July 13 the Centers for Medicare & Medicaid Services (CMS) released the Proposed Rule for the Medicare Physician Fee Schedule (MPFS). The Proposed Rule was published in the Federal Register on July 21, and public comments are due by September 11. The Final Rule will be released by early November.

CMS estimates a 2018 conversion factor of $35.99, up from $35.89 in 2017. The estimated conversion factor reflects the 0.5% update specified by the Medicare Access and CHIP Reauthorization Act (MACRA), a legislatively mandated misvalued code adjustment, and a budget neutrality adjustment.

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In This Issue

RCC Update is a quarterly publication reporting on radiology coding developments and the latest news from the Radiology Coding Certification Board (RCCB). RCC Update is made possible with our partners at Coding Strategies, Inc.
Tell us what you think at info@rccb.org

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Appropriate Use Criteria

CMS proposes to delay until January 1, 2019, the requirement for ordering physicians to consult Appropriate Use Criteria (AUC) when ordering advanced diagnostic imaging exams and the requirement for furnishing professionals to report the results of these consultations on their Medicare claims. These requirements had been scheduled to go into effect January 1, 2018. CMS states the delay will allow ordering physicians time to select a Clinical Decision Support Mechanism (CDSM), which is the electronic portal through which the ordering physician accesses the AUC. In conjunction with the release of the Proposed Rule, CMS has posted a list of qualified CDSMs on its website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program/CDSM.html

CMS proposes that beginning in 2019, furnishing professionals (including both the imaging facility and the interpreting physician) will be required to report on their Medicare claims the specific CDSM that the ordering physician consulted; whether the service adhered to the applicable AUC; and the provider number of the ordering physician. CMS plans to create G codes for the CDSMs. HCPCS modifiers will be used to indicate whether the ordered exam adheres to AUC and whether any reporting exceptions apply.

CMS proposes that calendar year 2019 will be an education and testing period during which ordering professionals will consult AUC, and imaging providers will report AUC information on their claims, but claims will be paid regardless of correct reporting.

Mammography

In the 2017 MPFS Final Rule CMS stated that it was not adopting the new CPT® codes or the recommended RVUs for mammography services because this could result in a technical component payment cut of as much as 50%. The 2018 MPFS Proposed Rule does not discuss payment for mammograms. However, the mammogram CPT® codes appear in Addendum B of the Proposed Rule with the existing 2017 RVUs, so it appears CMS plans to begin paying for the CPT® codes with no payment cuts.

Computed Radiography

Beginning in 2018, the Consolidated Appropriations Act of 2016 requires a 7% payment reduction for the technical component (TC) of x-rays performed using computed radiography. (This is separate from the current 20% TC payment reduction for film x-rays.) CMS defines computed radiography as "cassette-based imaging that utilizes an imaging plate to create the image involved." The payment reduction will apply both to TC-only claims and to the TC portion of global claims. CMS proposes to establish a new modifier to identify computed radiography services.

Site Neutral Payment

The site-neutral payment policy, which was implemented in 2017, applies to non-excepted off-campus provider-based hospital departments (PBDs), such as a physician office that is owned by a hospital and maintained as a hospital outpatient department, is remote from the hospital campus, and did not begin providing services until November 2, 2015, or later.

Medicare currently pays for services provided in non-excepted PBDs under the MPFS at 50% of the Outpatient Prospective Payment System (OPPS) payment rate for the service. For 2018 CMS proposes to lower the payment to 25% of the OPPS rate to "encourage fairer competition between hospitals and physician practices."

PQRS

2016 was the final reporting period for the Physician Quality Reporting System (PQRS), and successful reporting required 9 measures across 3 National Quality Strategy domains. Eligible professionals who did not report successfully during 2016 will be subject to a 2% reduction in payments for their 2018 services. CMS is now proposing to retroactively relax the reporting requirements to only 6 measures with no domain requirements. Providers reporting via claims or qualified registry will no longer be required to report a cross-cutting measure, and those reporting via QCDR will no longer be required to report an outcome or high priority measure.

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No additional data submission will be required; CMS will base its determinations on the data already submitted.

Evaluation and Management Services

CMS recognizes that the 1995 and 1997 Documentation Guidelines for Evaluation and Management (E/M) Services are "potentially outdated and need to be revised, especially the history and exam components." The agency is considering possibly eliminating the documentation requirements for the history and exam for all E/M services, in the belief that medical decision making and service time are "the more significant factors in distinguishing visit levels." Public comments are requested.

Patient Relationship Categories

MACRA requires establishment of patient relationship categories to identify a patient's relationship with the physician who is billing for services. CMS released a draft of these categories in 2016. They include continuous/broad services; continuous/focused services; episodic/broad services; episodic/focused services; and services ordered by another clinician only. MACRA requires physician claims to include patient relationship data beginning January 1, 2018. CMS proposes to use 5 new HCPCS modifiers to convey this information on the claim. Initially claims will be paid regardless of whether the modifiers are included.

- Article by Coding Strategies® Staff

Global Surgery

Data Collection on Global Surgery

Starting July 1, 2017, physicians and nonphysician practitioners in 9 states are required to report data to Medicare on postoperative visits furnished during the global period of specific procedures. The requirement applies to groups of 10 or more physicians and/or practitioners located in Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island. Other groups are encouraged to report on a voluntary basis but are not required to do so.

The reporting requirement applies to 293 procedure codes, including some that may be performed by interventional radiologists. Examples include:

- Incision and drainage of fluid collection (10140)
- Percutaneous vertebral augmentation (22513-22514)
- Venous sclerotherapy (36470-36471)
- Insertion, replacement, and removal of tunneled central venous catheter (36558, 36561, 36581, 36589, 36590)
- Fluoro-guided gastrostomy tube placement (49440)

The complete code list can be downloaded from the CMS website at:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Global-Surgery-Data-Collection-.html

The requirement applies only to postoperative visits with Medicare fee-for-service patients within the global period of procedures performed on or after July 1, 2017. It does not apply to preoperative visits or to visits with Medicare Advantage patients. It applies regardless of where the postop visit occurs, including in the hospital inpatient setting.

Groups will report their postop visits by submitting code 99024 *[Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure]* on the claim. CMS states that the claim may include a charge for the postop visit. However, no payment will be made as code 99024 is not payable under the Medicare Physician Fee Schedule.

For more information about the reporting requirements, please see the CMS Frequently Asked Questions document:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Global-Surgery-FAQs.pdf

- Article by Coding Strategies® Staff

Attention Coders Preparing for the RCC Exam

Reminder, the next RCC Exam testing window is November 13-17, 2017. The application deadline for this exam window is October 9, 2017.

Now, new tools are available to help you prepare and succeed. Coding Strategies has partnered with the Radiology Coding Certification Board (RCCB®) to create a duo of resources designed to prepare radiology coders for the RCC Exam. The new RCC Essentials Handbook and the RCC Examination Prep Courses offer a cost-effective, in-depth and complete review of the RCC Exam content areas and will have you ready to pass with flying colors.

Diagnosis Coding

October 1 Brings New and Revised Diagnosis Codes

Starting October 1, radiology coders will have over 300 new diagnosis codes to choose from, as well as hundreds of revised codes. In this article we'll review some of the changes that are most important to radiology. You can find the complete ICD-10-CM code set for Fiscal Year 2018 on the website of the National Center for Health Statistics (NCHS):
https://www.cdc.gov/nchs/icd/icd10cm.htm

Please see the separate article in this issue for a discussion of the 2018 changes to the ICD-10-CM guidelines.

Myocardial infarction

Some of the most important changes involve the cardiovascular system. First, there are major changes to the codes for myocardial infarction (MI) to reflect the most recent clinical classification system from the Third Global MI Task Force. See Table 1 for the types of MI recognized by this new system. You can learn more about the new classification system at:
http://circ.ahajournals.org/content/126/16/2020.long

Type	Description
1	Spontaneous MI Example: MI due to rupture of an atherosclerotic plaque
2	MI secondary to an ischemic imbalance Example: MI due to lack of myocardial oxygen supply related to anemia, arrhythmia, respiratory failure, hypotension, etc.
3	MI resulting in death when biomarker values are unavailable Example: Patient does not live long enough for labs to document a rise in cardiac biomarkers
4a	MI related to percutaneous coronary intervention (PCI) Example: MI occurring during coronary artery stent placement
4b	MI related to stent thrombosis Example: MI caused by clot formation in a coronary artery stent
5	MI related to coronary artery bypass grafting Example: MI occurring during or following CABG

Table 1

Type 1 is the most common type of MI. If the MI is type 1, you will assign one of the codes in Table 2. Use I21.0- through I21.3 for ST elevation MI (STEMI) or I21.4 for non-ST elevation MI (NSTEMI). If the record does not indicate whether the infarction is STEMI or NSTEMI, you will assign the new code I21.9 *(Acute myocardial infarction, unspecified)*.

There are 2 new codes for other types of MI. Use code I21.A1 *(Myocardial infarction type 2)* for type 2 MI. For types 3, 4a, 4b, and 5 MI, use code I21.A9 *(Other myocardial infarction type)*.

Code	Description
I21.0-	ST elevation (STEMI) myocardial infarction of anterior wall
I21.1-	ST elevation (STEMI) myocardial infarction of inferior wall
I21.2-	ST elevation (STEMI) myocardial infarction of other sites
I21.3	ST elevation (STEMI) myocardial infarction of unspecified site
I21.4	Non-ST elevation (NSTEMI) myocardial infarction
I21.9	Acute myocardial infarction, unspecified

Table 2

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Heart Failure

A new subcategory (I50.81-) has been added for right heart failure, which was previously reported with the code for unspecified heart failure (I50.9). There are codes for acute, chronic, and acute on chronic right heart failure, as well as right heart failure due to left heart failure. There are also new codes for biventricular heart failure (I50.82) and high output heart failure (I50.83). Instructional notes state to "code also" the left ventricular failure when the patient has both left and right ventricular failure. Unspecified congestive heart failure is still reported with I50.9.

The 2018 Index contains new entries for the stage of heart failure, as defined by the American College of Cardiology and American Heart Association.

- In Stage A the patient does not yet have heart failure but is at high risk of developing it. This condition is reported with code Z91.89 *(Other specified personal risk factors, not elsewhere classified)* rather than with a heart failure code.
- Stages B and C do not have specific code assignments. The Index tells you to assign a code for systolic or diastolic heart failure if specified, and otherwise assign code I50.9.
- Stage D is the most severe form of heart failure. It is reported with code I50.84 *(End stage heart failure)*. Also code the type of heart failure if specified, such as I50.2- for systolic heart failure.

Pulmonary Hypertension

Six new codes have been created in subcategory I27.2 *(Other secondary pulmonary hypertension)* for unspecified pulmonary hypertension (I27.20), secondary pulmonary arterial hypertension (I27.21), pulmonary hypertension due to left heart disease (I27.22), pulmonary hypertension due to lung diseases and hypoxia (I27.23), chronic thromboembolic pulmonary hypertension (I27.24), and other secondary pulmonary hypertension (I27.29).

Chronic Obstructive Pulmonary Disease

The note under code J44.0 *(Chronic obstructive pulmonary disease with acute lower respiratory infection)* to "Use additional code to identify the infection" has been changed to read, "Code also to identify the infection." This means the infection can now be either primary or secondary to the COPD code.

Gastrointestinal

The following 4 codes for intestinal obstruction have been subdivided to create individual codes for complete obstruction, partial obstruction, and unspecified obstruction:

K56.5	Intestinal adhesions [bands] with obstruction (postinfection)
K56.60	Unspecified intestinal obstruction
K56.69	Other intestinal obstruction
K91.3	Postprocedural intestinal obstruction

Non-Pressure Chronic Ulcers

The codes in category L97 *(Non-pressure chronic ulcer of lower limb, not elsewhere classified)* have been subdivided into new codes that indicate whether the ulcer includes muscle involvement without necrosis; bone involvement without necrosis; or other specified severity. The same change was made to codes in subcategory L98.4- *(Non-pressure chronic ulcer of skin, not elsewhere classified)*, which includes ulcers of the buttock, back, and other sites. The codes in these categories are used as secondary diagnoses to indicate the severity of an ulcer caused by arteriosclerosis or diabetes.

Lumbar Spinal Stenosis

Code M48.06 *(Spinal stenosis, lumbar region)* has been subdivided into 2 new codes for stenosis without neurogenic claudication (M48.061) and with neurogenic claudication (M48.062). Neurogenic claudication is similar to the pain on walking that is experienced by patients with peripheral vascular disease, except that neurogenic claudication is caused by compression of the spinal nerve roots rather than vessel disease.

Breast Lump

Code N63 *(Unspecified lump in breast)* has been subdivided into 15 new codes to indicate the laterality (right or left breast) and location (quadrant, axillary tail, or subareolar).

Pregnancy

The codes for tubal pregnancy (O00.1-) and ovarian pregnancy (O00.2-) have been subdivided into 12 new codes that reflect laterality (right or left side) and whether there is concurrent intrauterine pregnancy. Also, 4 new codes have been created in subcategory O36.83- for maternal care due to abnormalities of the fetal heart rate or rhythm.

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Congenital Conditions

Six new codes have been created in category Q53 *(Undescended and ectopic testicle)* to indicate whether the testicle is intra-abdominal, inguinal, or in the high scrotum.

Signs and Symptoms

New codes have been created for acute respiratory distress (R06.03) and non-palpable testicle(s) (R39.8-). Also, inclusion terms have been added to the coma scale codes in R40.22- through R40.23- to guide code assignment in young children.

Injuries

A note has been added to category S06 *(Intracranial injury)* to indicate that 7th character D (subsequent encounter) and S (sequela) should not be applied to codes in this category that have a 6th character of 7 (death due to brain injury prior to regaining consciousness) or 8 (death due to other cause prior to regaining consciousness). For example, only 7th character A should be applied to code S06.308 *(Unspecified focal traumatic brain injury with loss of consciousness of any duration with death due to other cause prior to regaining consciousness).*

The codes in subcategory S62.6- *[Fracture of other and unspecified finger(s)]* have been revised to indicate middle phalanx rather than medial phalanx. The same change was made to subcategory S92.5 *[Fracture of lesser toe(s)]*.

The thumb only has a single interphalangeal joint, so the codes in subcategory S63.1 *(Subluxation and dislocation of thumb)* for proximal and distal IP joints have been deleted.

The codes in subcategory S73.0 *(Subluxation and dislocation of hip)* have been revised to specifically mention subluxation as well as dislocation.

Categories T07 *(Unspecified multiple injuries)* and T14 (Injury of unspecified body region) now require a 7th character for the encounter.

Antenatal Screening

At the request of the American Congress of Obstetricians and Gynecologists, code Z36 *(Encounter for antenatal screening of mother)* has been subdivided to create 17 new codes representing specific reasons for screening, as shown in Table 3. A note under code Z36.2 states that this code includes "Non-visualized anatomy on a previous scan."

Code	Description
Z36.0	Encounter for antenatal screening for chromosomal anomalies
Z36.1	Encounter for antenatal screening for raised alphafetoprotein level
Z36.2	Encounter for other antenatal screening follow-up
Z36.3	Encounter for antenatal screening for malformations
Z36.4	Encounter for antenatal screening for fetal growth retardation
Z36.5	Encounter for antenatal screening for isoimmunization
Z36.81	Encounter for antenatal screening for hydrops fetalis
Z36.82	Encounter for antenatal screening for nuchal translucency
Z36.83	Encounter for fetal screening for congenital cardiac abnormalities
Z36.84	Encounter for antenatal screening for fetal lung maturity
Z36.85	Encounter for antenatal screening for Streptococcus B
Z36.86	Encounter for antenatal screening for cervical length
Z36.87	Encounter for antenatal screening for uncertain dates
Z36.88	Encounter for antenatal screening for fetal macrosomia
Z36.89	Encounter for other specified antenatal screening
Z36.8A	Encounter for antenatal screening for other genetic defects
Z36.9	Encounter for antenatal screening, unspecified

Table 3

- Article by Coding Strategies® Staff

Medicare

Proposed OPPS Policies to Impact Hospitals

On July 13 the Centers for Medicare & Medicaid Services (CMS) released the Proposed Rule for the Hospital Outpatient Prospective Payment System (OPPS). The Proposed Rule was published in the Federal Register on July 20 and public comments are due by September 11. The Final Rule will be released by early November.

Payment Structure for Imaging Services

CMS proposes to add a fifth APC (Level 5) to the 4 existing APCs for imaging exams without contrast, to accommodate exams with higher resource costs.

CMS is not proposing any changes to the composite APC payment for multiple imaging services, which provides a single payment when the hospital performs 2 or more exams from the same family on the same date of service. Also, CMS is not proposing to add any new comprehensive APCs (C-APCs) for 2018.

In response to industry concerns, CMS proposes to delay for 1 more year its use of CT and MR cost data from all providers in setting APC rates. For 2018 CMS will not include data from providers who use the square foot cost allocation method, thus preventing inappropriate payment cuts for these services.

Issues Covered in the MPFS Proposed Rule

Proposed changes to the Appropriate Use Criteria program and the site neutral payment policy were discussed in the Proposed Rule for the Medicare Physician Fee Schedule (MPFS) rather than the OPPS Proposed Rule. Please see the article about the MPFS Proposed Rule on page 1 of this issue for more information.

Computed Radiography

Beginning in 2018, the Consolidated Appropriations Act of 2016 requires a 7% reduction in the OPPS payment for x-rays performed using computed radiography. (This is separate from the current 20% payment reduction for film x-rays.) CMS defines computed radiography as "cassette-based imaging that utilizes an imaging plate to create the image involved." CMS proposes to establish a new modifier to identify computed radiography services. The agency notes that the payment reduction does not apply when payment for an x-ray is packaged into the payment for another item or service, since there is then no payment amount that can be attributed to the x-ray.

Non-HEU Radioisotopes

CMS proposes to continue paying hospitals an additional $10 for Tc-99m isotopes produced using non-highly enriched uranium.

Pass-Through Devices

Medicare makes an additional payment for certain new devices that meet specific criteria. "Pass-through" status for a device category lasts at least 2 years but not more than 3 years. There are currently 3 devices with pass-through status, including C2623 *(Catheter, transluminal angioplasty, drug-coated, non-laser)*, but their status will expire at the end of 2017. CMS received several applications for new devices but none were approved, so there are no new pass-through devices scheduled for January 1.

Device-Intensive Procedures

A procedure is designated as device-intensive when the cost of the device represents a significant portion of the procedure cost. CMS proposes to continue its current claims edits, which require a device code to be present on the claim for a device-intensive procedure. Any device code will pass the edit, even if the device is not one that would be used in that procedure.

When the hospital receives a credit for a replaced device that is 50% or greater of the cost of the device, the hospital must report the amount of the credit on its claim in the amount portion for value code FD. This policy applies only to implantable devices used in device-intensive procedures. CMS is not proposing any changes for 2018.

Pass-Through Drugs and Radiopharmaceuticals

Florbetapir F-18 (A9586) and sulfur hexafluoride lipid microspheres (Q9950) will lose pass-through status at the end of 2017. Pass-through status will continue for C-11 choline (A9515), gallium-68 dotatate (A9587), fluciclovine F-18 (A9588), flutemetamol F-18 (Q9982), and florbetaben F-18 (Q9983).

Physician Supervision

CMS proposes to reinstate the "nonenforcement" of the requirement for direct supervision of outpatient therapeutic services in critical access hospitals (CAHs) as well as in small

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rural hospitals (SRHs) with 100 or fewer beds. The nonenforcement will be in effect during 2018 and 2019.

Brachytherapy

CMS proposes to implement claims edits that will require a brachytherapy treatment code such as 77778 or 77763 to be included on the claim whenever a brachytherapy insertion code such as 19296 or 57155 is reported. CMS also proposes to delete composite APC 8001 for low dose rate prostate brachytherapy and instead to designate code 55875 as status indicator J1 and assign it to a comprehensive APC. Claims edits will require code 77778 to be included on the claim together with 55875.

Stereotactic Radiosurgery

For 2018 CMS proposes to delete modifier CP *(Adjunctive service related to a procedure assigned to a comprehensive ambulatory payment classification [C-APC] procedure)* and discontinue its required use with planning and preparation services related to delivery of cranial stereotactic radiosurgery (codes 77371 and 77372). CMS also proposes to continue to make separate payments for the 10 designated planning and preparation services related to delivery of Cobalt-60 or LINAC SRS, when the services are furnished within 1 month of the SRS treatment.

- Article by Coding Strategies® Staff

Diagnosis Coding

ICD-10-CM Guidelines Undergo Revisions for 2018

The National Center for Health Statistics (NCHS) has issued the 2018 edition of the ICD-10-CM Official Guidelines for Coding and Reporting, and there are some changes that will affect code assignment for radiology services. This article highlights the most important points, and you can download the complete guidelines (117 pages) from the NCHS website at:
https://www.cdc.gov/nchs/icd/icd10cm.htm

"With" and "In"

The guideline regarding the term "with" has been revised to include the word "in." It has also been revised to indicate that the two conditions linked by "with" or "in" should not be automatically coded as related if another guideline requires documentation of a cause-and-effect relationship. The 2018 guideline states:

> The word "with" or "in" should be interpreted to mean "associated with" or "due to" when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List. The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated or when another guideline exists that specifically requires a documented linkage between two conditions (e.g., sepsis guideline for "acute organ dysfunction that is not clearly associated with the sepsis").

Code Also

A sentence has been added to the guidelines about "Code also" notes to indicate that the sequencing of the two conditions depends on the circumstances of the encounter.

Multiple Coding for a Single Condition

The words "if known" have been added to the instructions for "Use additional code" notes and "Code first" notes (page 15). That is, when there is a "Use additional code" note, a secondary code should be added "if known." Likewise, when there is a "Code first" note, the underlying condition should be sequenced first "if known."

Encounters for Brachytherapy Source Insertion

The neoplasm guidelines have been revised to restrict the use of code Z51.0 *(Encounter for antineoplastic radiation therapy)* to encounters for external beam radiation therapy. Encounters for insertion of brachytherapy sources are to be reported using the cancer code rather than code Z51.0. The new guideline states, "If a patient admission/encounter is for the insertion or implantation of radioactive elements (e.g., brachytherapy) the appropriate code for the malignancy is sequenced as the principal or first-listed diagnosis. Code Z51.0 should not be assigned."

Likewise, if the encounter is for insertion of brachytherapy sources and the patient develops complications, the guidelines state that the cancer code is primary and the complication codes are secondary.

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Diabetes Mellitus

The guidelines on use of insulin and oral drugs in diabetes have been revised to clarify that:

- Codes Z79.4 and Z79.84 are for long-term use of insulin or oral hypoglycemic drugs and should not be assigned for temporary use of these drugs to bring a patient's blood sugar under control during an encounter.
- If the patient receives both long-term insulin and long-term oral hypoglycemic drugs, only the insulin use (Z79.4) should be coded.

Substance Use

The guidelines for substance use disorders in remission have been revised to indicate that the "in remission" codes should be assigned only on the basis of the guidelines, "unless otherwise instructed by the classification" (for example, if an Index entry or instructional note refers you to the "in remission" code).

A new guideline has been added to indicate that mild substance use disorder in remission is coded as substance abuse in remission, and moderate or severe substance use disorder in remission is coded as substance dependence in remission. This change was made to allow consistency between ICD-10-CM and the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5®).

The guidelines for psychoactive substance use have been retitled "Psychoactive Substance Use Disorders," and the term "disorders" has been added to the first sentence of the guideline. Also, the guidelines now permit use of these codes when patients have physical disorders related to substance use, as well as mental or behavioral disorders.

Hypertensive Heart Disease

The guideline for hypertensive heart disease (page 43) has been revised to indicate that more than one category I50 code may be required as a secondary diagnosis to indicate the type of heart failure. This reflects the new instructional notes in category I50 that call for an additional code in some cases, such as when the patient has biventricular heart failure or end stage heart failure.

Pulmonary Hypertension

A new guideline has been added for pulmonary hypertension. It states that for secondary pulmonary hypertension (I27.1, I27.2-) you should code also "any associated conditions or adverse effects of drugs or toxins," with the sequencing being determined by the reason for the encounter.

Myocardial Infarction

The guidelines have been revised to reflect the new classification system for myocardial infarction (MI), which classifies MI as type 1, type 2, type 3, type 4, or type 5.

The new guidelines state that existing codes I21.0-I21.4 should be used only for type 1 MI. These codes identify the site of the MI and whether it is an ST elevation MI (STEMI) or a non-ST elevation MI (NSTEMI). If a type 1 NSTEMI evolves to STEMI, it is coded as STEMI, but if a type 1 STEMI converts to NSTEMI due to thrombolytic therapy, it is still coded as STEMI.

Type 2 MI, which is caused by demand ischemia, is reported with new code I21.A1 *(Myocardial infarction type 2)*. This same code is used regardless of whether the type 2 MI is described as STEMI or NSTEMI. Code I21.A1 should be reported together with a code for the underlying cause, and sequencing is dependent on the circumstances. Code I24.8 *(Other forms of acute ischemic heart disease)* should not be assigned to represent the demand ischemia in a type 2 MI.

Types 3, 4, and 5 MI are reported with new code I21.A9 *(Other myocardial infarction type)*. The guidelines tell you to follow the "Code also" and "Code first" notes in the Tabular List with regard to postprocedural MIs.

The guidelines state that new code I21.9 *(Acute myocardial infarction, unspecified)* is the default for an unspecified acute MI, which was previously reported with code I21.3 *[ST elevation (STEMI) myocardial infarction of unspecified site]*.

The guidelines also state that the subsequent MI codes in category I22 are to be used for subsequent MI following a type 1 or unspecified MI. Other types of subsequent MI should be reported with new codes I21.A1 *(Myocardial infarction type 2)* and I21.A9 *(Other myocardial infarction type)*.

Non-Pressure Chronic Ulcers

A new guideline section was created for non-pressure chronic ulcers, such as those caused by arteriosclerosis or di-

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abetes. It states that the ulcer should not be coded if it is documented as completely healed. If it is described as "healing," it should be coded based on the documentation in the medical record, or as unspecified severity if the severity is not documented. There are additional ulcer guidelines that are relevant primarily to inpatient hospital coding.

Pathologic Fractures

The pathologic fracture guidelines have been revised to clarify that subsequent encounters occur after completion of active treatment *for the fracture* (not for the underlying condition). The guidelines state, "7th character D is to be used for encounters after the patient has completed active treatment for the fracture and is receiving routine care for the fracture during the healing or recovery phase."

Abortion

The guidelines have been revised to clarify that if the patient is found on a subsequent encounter to have retained products of conception following a spontaneous abortion, but there are no complications, code O03.4 *(Incomplete spontaneous abortion without complication)* should be assigned. This applies even if the previous encounter was coded as a complete spontaneous abortion. If the patient has complications from the abortion, assign the appropriate complication code from category O03 and do not assign O03.4. The same guideline applies in the case of an elective pregnancy termination, but the code is O07.4 *(Failed attempted termination of pregnancy without complication)*.

The guideline on complications leading to abortion has been revised to state that Chapter 15 (Pregnancy) codes may be assigned to identify pregnancy complications in conjunction with codes in category O04 *[Complications following (induced) termination of pregnancy]* as well as categories O07 and O08.

Z Codes

The guidelines for the counseling Z codes have been revised by deleting the following sentence: "They [the counseling Z codes] are not used in conjunction with a diagnosis code when the counseling component of care is considered integral to standard treatment."

Category Z40 *(Encounter for prophylactic surgery)* has been added to the list of Z codes that may only be used as the principal/first-listed diagnosis. There is an exception to this rule in the unlikely circumstance that two encounters must be combined for billing purposes.

- Article by Coding Strategies® Staff