Eighth Edition Education Workshop FAQs (Parts 1 and 2)

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Respiratory failure, type I acute and chronic

Q:

If a patient has acute and chronic type I respiratory failure should both be coded?

A:

Where the type I respiratory failure is documented as both acute and chronic during an episode of care, assign a code for each (see ACS 0001 *Principal diagnosis, Acute and chronic conditions*).

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Respiratory failure, mixed type I and type II

Q:

What code should be assigned where the clinician documents mixed type I and type II respiratory failure? Can both codes be assigned?

A:

Respiratory failure results in abnormal blood gases and is always the consequence of another condition. Clinical advice confirms that type I and type II respiratory failure cannot occur at the same time, as in type I respiratory failure the carbon dioxide levels are normal or low, in contrast to type II respiratory failure where carbon dioxide levels are high.

However, type I and type II respiratory failure could occur at separate times during the course of an admission. Therefore codes for type I and type II respiratory failure can be assigned according to the documentation in the episode of care, noting that they cannot occur at the same time.

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ACS 0048 Condition onset flag

Q:

Could Condition Onset Flag (COF) value of 1 be assigned to a patient who is admitted with diabetes and develops uncontrolled diabetes during the episode of admitted patient care?

A:

Clinical advice indicates that diabetes can become uncontrolled during the course of an admission, therefore COF 1 should be assigned for E1-.65 *** *diabetes mellitus with poor control* where it is clearly documented that controlled diabetes develops into poorly controlled or unstable diabetes during the episode of care. (see ACS 0048 *Condition onset flag, Guide For Use, Point 5.*)

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ACS 0048 *Condition onset flag*

Q:

Where a patient with chronic obstructive pulmonary disease develops pneumonia during the episode of care, what COF would be assigned to the pneumonia code?

A:

A COF of 1 should be assigned to the pneumonia code as this condition arose during the episode of admitted patient care.

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ACS 0048 *Condition onset flag*

Q:

What COF should be assigned where a patient is admitted with chronic obstructive pulmonary disease and develops an acute respiratory infection during the episode of care?

A:

When two conditions are described within a combination code, such as J44.0 *Chronic obstructive pulmonary disease with acute lower respiratory infection*, assign COF 1 if one of those conditions meets the criteria for assignment of COF 1 and the condition is not represented by another code with a COF value of 1 (refer ACS 0048 *Condition onset flag, Guide for use, point 5*)

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ACS 0048 *Condition onset flag*

Q:

Why can't a COF 1 be assigned to J44.1 *Chronic obstructive pulmonary disease with acute exacerbation, unspecified* where the acute exacerbation arises during the episode of care?

A:

A chronic disease that is present on admission and is exacerbated during the episode of care should be assigned a COF of 2 (refer ACS 0048 *Condition onset flag, Permissible values*).

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ACS 0020 *Bilateral/multiple procedures* – skin lesions

Q:

If one lesion is excised but the histopathology report indicates that there was more than one morphological type in the excised tissue, how many times should the ACHI code be assigned?

A:

The ACHI code should be assigned as many times as the procedure is performed. Where one lesion is excised, the procedure code should be assigned once only, regardless of the number of morphological types reported.

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ACS 2114 *Prophylactic surgery*

Q:

Patients who have neoplastic bone disease sometimes have a nail inserted into the diseased bone to assist in the prevention of fractures. As the clinicians refer to this as prophylactic surgery should a code from Z40.- Prophylactic surgery be assigned?

A:

ACS 2114 *Prophylactic surgery* principally provides instruction for assigning ICD-10-AM codes where prophylactic surgery is performed on healthy organs in patients who have known risks for the development of malignant disease. The standard does not currently provide specific guidelines for the assignment of an additional diagnosis of Z40.-, for other types of prophylactic surgery. However, consideration will be given to expanding this standard in the future to address other scenarios where surgery is considered prophylactic.

Therefore, for this scenario assign the neoplastic bone disease as the principal diagnosis and a code from Z40.- is not currently required.

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Jaundice:

Q:

Where a neonate is readmitted for phototherapy, does the procedure code for phototherapy need to be assigned in addition to the ICD-10-AM code for jaundice?

A:

The code for phototherapy of the newborn, 90677-00 [1611] *Other phototherapy, skin,* should only be assigned where the phototherapy is sustained for >12 hours as per the specific instructions contained within ACS 1615 *Specific diseases and interventions related to the sick neonate*.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS

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Resistance to antimicrobial and antineoplastic drugs

Q:

Can a code for resistance to antibiotics be assigned where the resistance is not documented by the clinician, however the information is in the pathology report and the antibiotic treatment is changed?

A:

The clinician must document the drug resistance in the record in order to assign a code from Z06.- *Resistance to antimicrobial drugs* (see ACS 0112 *Infection with drug resistant microorganisms*).

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Resistance to antimicrobial and antineoplastic drugs

Q:

Where MRSA is documented by the clinician, can the information from the pathology report be used where it provides the information about whether the MRSA is multi resistant or methicillin resistant?

A:

The guidelines in ACS 0010 *General abstraction guidelines*, direct that diagnostic results should be used to add specificity to already documented conditions that meet the criteria for code assignment. As it is important to establish whether MRSA is referring to methicillin resistance as opposed to the less specific and less common usage 'multi resistance' the diagnostic results should be referenced (see ACS 0112 *Infection with drug resistant microorganisms*).

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Haemorrhoids

Q:

Where there is no degree specified for the haemorrhoids but the clinician has documented 'retract spontaneously', can the haemorrhoids be assumed to be second degree, as in the inclusion term in the Tabular List at K64.1 *Second degree haemorrhoids*?

A:

Following the coding process, the code for second degree haemorrhoids can be assigned in this case by following the index entry first:

Haemorrhoids

- 2nd degree (grade/stage II) (with prolapse but retracts spontaneously)

then by reference to the inclusion term at K64.1 *Second degree haemorrhoids* in the Tabular List, where it specifies 'Haemorrhoids that prolapse on straining but retract spontaneously.' (refer to Tabular List of Diseases, *Guidance in the use of ICD-10-AM*).

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Haemorrhoids

Q:

What haemorrhoid code should be assigned when a patient is admitted for banding of haemorrhoids?

A:

ACS 0942 *Banding of haemorrhoids* was deleted for Eighth Edition as the banding related to internal haemorrhoids, which is no longer relevant now that haemorrhoids are classified by degree. Therefore code assignment is determined by the clinical documentation.

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Haemorrhoids

Q:

What code(s) should be assigned when multiple grades of haemorrhoids are documented or terminology such as grade II-III haemorrhoids is used?

A:

While there is currently nothing in the classification to preclude the assignment of multiple codes to reflect different stages of haemorrhoids, clinical advice indicates that it is only necessary to assign one code for the most severe haemorrhoid grade.

Improvements to the classification will be considered in the future to reflect this advice.

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Haemorrhoids

Q:

If haemorrhoids are documented as either ‘internal’ or ‘external’ do they still have to be assigned a code for unspecified?

A:

The classification of haemorrhoids is by degree. If the degree is not specified, the correct code to assign is K64.9 *Haemorrhoids, unspecified* following the index entry:

Haemorrhoids (bleeding) (external) (internal) (without mention of degree) K64.9

The terms ‘internal’ and ‘external’ are nonessential modifiers that do not affect the code assignment.

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Single event multilevel surgery (SEMLS)

Q:

Can the codes from block [1580] *Single event multilevel surgery [SEMLS*] be assigned where a child with cerebral palsy has the multiple procedures performed as in the Tabular List, however the clinician has not documented SEMLS?

A:

Single event multilevel surgery, or SEMLS, needs to be documented in order to assign the codes from block [1580] *Single event multilevel surgery [SEMLS]*. If there is uncertainty as to whether it is SEMLS being performed then the clinical coder should clarify with the clinician.

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Minimally invasive procedures proceeding to open procedures

Q:

If a patient has a diagnostic laparoscopy performed and then proceeds to have an open procedure, should a code be assigned for the diagnostic laparoscopy?

A:

A code for the diagnostic laparoscopy should be assigned in addition to the open procedure code(s). It is only appropriate to assign 90343-01 *Laparoscopic procedure proceeding to open procedure* where the procedure was intended to be performed using a minimally invasive technique but then is converted to an open procedure due to a complication or other unplanned circumstance. These codes should not be used for diagnostic endoscopy/laparoscopy/arthroscopy.

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