Independent Hospital Pricing Authority

Frequently Asked Questions (FAQs)

ICD-10-AM/ACHI/ACS Ninth Edition

IHPA

Frequently Asked Questions (FAQs) –
ICD-10-AM/ACHI/ACS Ninth Edition

Contents

Ninth Edition FAQs

Frequently Asked Questions (FAQs) are provided as an implementation material for ICD-10-AM/ACHI/ACS Ninth Edition to assist clinical coders in understanding classification updates made between Eighth Edition and Ninth Edition.

For the purposes of episodes coded in Australian hospitals, the Ninth Edition FAQs are not considered current classification advice. Therefore FAQs in this document are listed as ‘Retired’.

While the Ninth Edition FAQs may still appear to be applicable for future editions of ICD-10-AM/ACHI/ACS, clinical coders should exercise caution in applying the advice in these FAQs as there may be more recent advice that should be applied to that area of the classification.

Please note that any links or references in this document are not maintained.

Ref No: TN907 | Published On: 15-Sep-2015 | Status: Retired

SUBJECT: Facial droop with hemiplegia

Ninth Edition Education FAQs

Q:

In the absence of exclusion notes at G81.9 *Hemiplegia, unspecified* and G83.81 *Facial paralysis due to cerebrovascular accident,* can these codes both be assigned, or should G83.81 only be assigned for facial droop in the absence of hemiplegia?

A:

Facial paralysis (droop) is inherent in hemiplegia. Therefore, G83.81 *Facial paralysis due to cerebrovascular accident* should not be assigned in addition to G81.9 *Hemiplegia, unspecified*. Indexing improvements to support this advice have been included as part of the second errata to Ninth Edition.

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SUBJECT: Ulcer of lower limb, ankle

Ninth Edition Education FAQs

Q:

With more specific site codes at L97.-, should an ulcer of the ankle be coded to L97.0 *Ulcer of foot* or L97.8 *Ulcer of lower limb, other sites*?

A:

Only assign L97.0 *Ulcer of foot* as per the specific index pathways. For example:

Ulcer/foot ***or***

Ulcer/lower limb/foot

For documentation of ulcer of ankle, assign L97.8 *Ulcer of lower limb, other sites* by following the index pathways:

Ulcer/lower limb/specified site NEC ***or***

Ulcer/skin/lower limb/specified site

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SUBJECT: ACS 1221 *Pressure injury*

Ninth Edition Education FAQs

Q:

The ACS notes that pressure injuries that improve or deteriorate during hospitalisation should be assigned a code to reflect the highest stage for that site.

Does this include when treatment for a pressure injury continues after a care type change?

A:

Where a pressure injury continues after a care type change, assign an appropriate code from category L89 for the stage of a pressure injury with reference to the documentation within each episode of care. For example, where a patient has a pressure injury stage I in an acute episode of care, which progresses to stage II in a subsequent (eg, palliative) episode of care, assign stage I for the acute episode and stage II for the palliative care episode.

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SUBJECT: ACS 2104 *Rehabilitation*

Ninth Edition Education FAQs

Q:

Could you please clarify whether Z51.5 *Palliative care* can be used with Z50.9 *Care involving use of rehabilitation procedure, unspecified*. Occasionally oncology patients are changed to rehabilitation but the intention of treatment is palliative. Do the changes for Ninth Edition restrict assignment of both codes?

A:

As noted in ACS 2104 *Rehabilitation* and ACS 2116 *Palliative care*, these codes may be assigned independent of the admitted patient care type. Therefore, if a patient meets the criteria for assignment of both Z51.5 *Palliative care* and Z50.9 *Care involving use of rehabilitation procedure unspecified* in the same episode of care, both Z51.5 and Z50.9 may be assigned as additional diagnoses.

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SUBJECT: ACS 2104 *Rehabilitation*

Ninth Edition Education FAQs

Q:

What condition onset flag (COF) value should be assigned to Z50.9 *Care involving use of rehabilitation procedure, unspecified* as an additional diagnosis in an acute care episode?

A:

Follow the classification advice in ACS 0048 *Condition onset flag*, which specifies that a condition (or diagnosis) arising after admission should be assigned COF 1 *Condition with onset during the episode of admitted patient care*. As per dot point six, this includes disease or administrative codes arising during the episode of admitted patient care. Therefore, where Z50.9 *Care involving use of rehabilitation procedure, unspecified* is assigned as an additional diagnosis in an acute episode of care, assign COF 1.

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SUBJECT: ACS 2104 *Rehabilitation*

Ninth Edition Education FAQs

Q:

In small rural hospitals, can the rehabilitation code still be assigned even when there is no formal rehabilitation program?

A:

ACS 2104 *Rehabilitation* provides classification criteria that Z50.9 *Care involving use of rehabilitation procedure, unspecified* should only be assigned as an additional diagnosis where there is documented evidence that the patient has been provided with rehabilitation care. Do not assign Z50.9 when a rehabilitation care assessment has been performed but no actual rehabilitation care has been given.

Note that in acute episodes of care, routine allied health interventions alone (such as those that occur post surgery or in preparation for a rehabilitation transfer) should not be interpreted as rehabilitation. The patient must have clinical documentation that they are part of a formal rehabilitation program. Documented evidence of rehabilitation may be in the form of clinician entries or a care plan within the clinical record.

Where these classification criteria are met, Z50.9 *Care involving use of rehabilitation procedure, unspecified* may be assigned independent of the admitted patient care type.

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SUBJECT: ACS 0110 *SIRS, sepsis, severe sepsis and septic shock*

Ninth Edition Education FAQs

Q:

Could you please explain why sepsis rather than pneumonia was selected as the principal diagnosis in example 3?

A:

In all sepsis examples, a principal diagnosis decision is made on a case by case basis.

In example 3, the discharge summary states sepsis due to pneumonia. Therefore, the principal diagnosis has been identified and assigned as sepsis.

Principal diagnosis in some clinical episodes can be difficult to identify, particularly in episodes of sepsis with infection. Therefore, it is necessary to continue to reference the criteria in ACS 0001 *Principal diagnosis* in order to ensure correct principal diagnosis selection.

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SUBJECT: ACS 0110 *SIRS, sepsis, severe sepsis and septic shock*

Ninth Edition Education FAQs

Q:

In ACS 0110, why does example 5 assume that bronchopneumonia is due to *Streptococcus pneumoniae* but example 4 does not assume that the sepsis is due to *Coagulase-negative staphylococcus*?

A:

In example 5, sepsis is documented as due to bronchopneumonia and *Streptococcus pneumoniae* was identified as the source of sepsis from the blood culture, therefore A40.3 *Sepsis due to Streptococcus pneumoniae* is assigned.

Example 4 has a clinical diagnosis of sepsis as the blood cultures were negative. Therefore A41.9 *Sepsis unspecified* is assigned for blood culture negative sepsis. Sepsis should not be assumed to be *Coagulase-negative* sepsis based on the wound swab or documentation of sepsis due to IV site infection alone. If the blood cultures were positive for *Coagulase-negative staphylococcus*, or a clinician confirms the specific type of sepsis, it would be appropriate to assign A41.1 *Sepsis due to other specified staphylococcus* but this is not the case in this example.

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SUBJECT: ACS 0003 *Supplementary codes for chronic conditions*

Ninth Edition Education FAQs

Q:

When should conditions which can be cured, such as obesity or depression, be assigned a supplementary code for chronic conditions?

A:

Supplementary codes for chronic conditions were designed to capture some medical conditions which are or tend to chronicity, or are prevalent health conditions in Australia. It is acknowledged that some of the U code conditions such as obesity and depression are not always chronic and may resolve or be cured. For such conditions, a decision on whether to assign a U code should be made according to the documentation in the current episode of care. Where it is unclear if the condition is current, follow the classification advice in ACS 0003 and do not assign a U code. (Coding Rule, September 2015)

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SUBJECT: ACS 0003 *Supplementary codes for chronic conditions*

Ninth Edition Education FAQs

Q:

Can more specific conditions be assigned as supplementary codes for chronic conditions (U codes)? For example, can conditions such as portal hypertension, conditions listed in code range I20-I25 or manic depressive bipolar disorder be assigned U codes?

A:

Supplementary codes were designed to capture chronic conditions documented in the medical history often in generalised terms. The aim for hypertension was to collect primary (essential) hypertension not otherwise specified (NOS) not secondary hypertension, but for schizophrenia the aim was to capture any type of schizophrenia documented.

To make this explicit the second errata to Ninth Edition includes an update to the alphabetic index with code ranges applicable to a number of supplementary codes for chronic conditions. Where it was not intended to capture specific forms of the chronic condition, code ranges have not been supplied.

The specific terms listed in the alphabetic index must be followed, and the code range can be referenced to inform code assignment.

For example, where paranoid schizophrenia is documented, follow the index pathway:

Supplementary

- codes for chronic conditions

- - schizophrenia (conditions in F20.-) U79.2

and assign U79.2 *Schizophrenia*.

For supplementary codes without explicit code ranges, only assign codes from U78-U88 for conditions with no further specification.

For example, where hypertension is documented, follow the index pathway:

Supplementary

- codes for chronic conditions

- - hypertension U82.3

and assign U82.3 *Hypertension*.

More specific forms of the chronic condition should not be assigned a U code unless indicated by the alphabetic index.

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SUBJECT: ACS 0003 *Supplementary codes for chronic conditions*

Ninth Edition Education FAQs

Q:

In type 2 diabetes mellitus with obesity (E11.72) or type 2 diabetes mellitus with chronic kidney disease (CKD) (stage 3-5) (E11.22), should the U code be assigned where obesity or CKD (stage 3-5) does not meet ACS 0002 *Additional diagnoses*?

When assigning U codes in a delivery episode, is it necessary to also assign an O code from Chapter 15 *Pregnancy, childbirth and the puerperium*?

A:

When coding diabetes and either obesity or CKD (stage 3-5) are present and do not meet the criteria for assignment in ACS 0002 *Additional diagnoses*, the appropriate U codes should be assigned.

Where a U code is applicable in a delivery episode of care, an accompanying code from Chapter 15 *Pregnancy, childbirth and the puerperium* should not be assigned.

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SUBJECT: ACS 0003 *Supplementary codes for chronic conditions*

Ninth Edition Education FAQs

Q:

Should supplementary codes be assigned for all episodes of care, including same day dialysis?

A:

Supplementary codes should be assigned for all episodes of care where additional diagnoses are routinely assigned. This includes multi-day and same-day episodes of care. As per the Coding Rule *Diabetes and day only admissions* (June 2005), where coding is autogenerated (such as for dialysis episodes) and the full record is not available to inform the coding process, it may not be possible for some hospitals to comply with ACS 0003 *Supplementary codes for chronic conditions* in these episodes.

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SUBJECT: ACS 0003 *Supplementary codes for chronic conditions*

Ninth Edition Education - FAQs

Q:

What documentation can be used to assign supplementary codes for chronic conditions (U codes)?

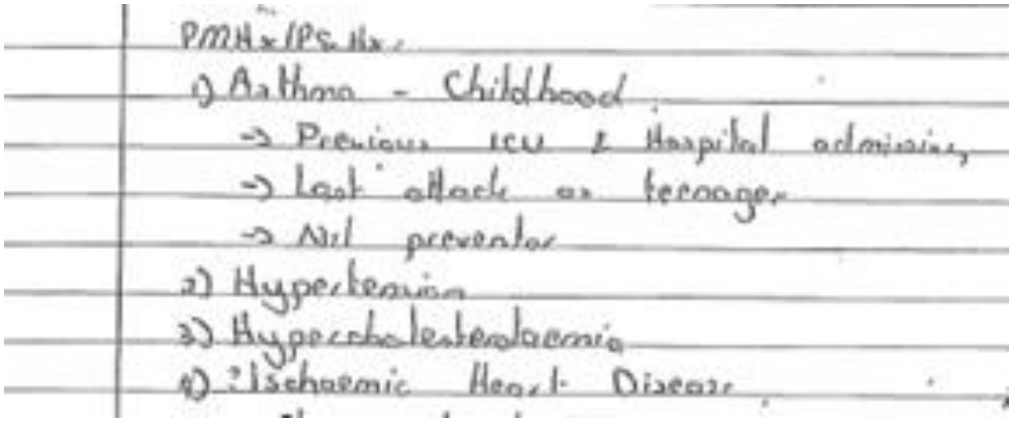
- Do conditions listed under the heading of 'past history' or 'background/problems' qualify?
- Do conditions need to be medicated to prove they are current?

A:

Clinicians may use the heading 'past history' to represent conditions or procedures etc. occurring in the past, including the recent past. Therefore, conditions listed under such headings may be part of the current health status of the patient and should not be excluded based on the heading. However, conditions listed in previous admissions and correspondence, but not listed in the current episode of care are not to be used (as per Coding Rule *Coding from documentation in previous admissions*).

Not all chronic conditions are managed with ongoing medication and so it is not necessary to review medication charts to inform code assignment. ACS example 5 highlights asthma as a child with no further documentation as to its relevance for the adult.

Where a patient episode is documented with a past medical history of hypertension, IHD and OA, all of these conditions should qualify. However, where it is unclear if the condition is continuing in the patient, follow the guidelines in ACS 0003 *Supplementary codes for chronic conditions* and do not assign a U code.



In the example above, a U code would only be assigned for hypertension as childhood asthma has not occurred since a teenager and ischaemic heart disease is only queried.

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SUBJECT: ACS 0110 *SIRS, sepsis, severe sepsis and septic shock*

Ninth Edition Education FAQs

Q:

ACS 0110 *SIRS, sepsis, severe sepsis & septic shock* example 6 describes the patient as having acute multiple organ dysfunction from septic shock. Does this mean that any conditions documented as organ dysfunction equate to an organ failure as the index does not link dysfunction to failure via any index pathway?

Also, the classification instructions for SIRS due to infectious aetiology require clinical coders to follow the instructions for sepsis, but the classification instructions for sepsis requires sepsis to be documented.

A:

Clinical advice provided during revision of ACS 0110 confirmed that for severe sepsis or septic shock, documentation of organ dysfunction can be considered as interchangeable with organ failure where it is unexplained by any other cause. This has been included in the definitions for severe sepsis and septic shock.

This instruction should be applied in relation to sepsis only, and not applied to any other diagnoses.

The ACS classification instructions should be applied in totality. There is a statement in ACS 0110 under *Classification, Systemic inflammatory response syndrome [SIRS]*:

> *"Where there is documentation of SIRS due to infectious aetiology, follow the classification guidelines for Sepsis…".*

Therefore, all references to *sepsis* in the standard also apply to *SIRS of infectious origin*.

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SUBJECT: ACS 0003 *Supplementary codes for chronic conditions*

Ninth Edition Education FAQs

Q:

Can abbreviations, symbols and synonymous terms be used to assign supplementary codes for chronic conditions (U codes)? For example,

- can ↑BMI be assigned as U78.1 *Obesity?*
- can hemiparesis be assigned as U80.5 *Hemiplegia?*

A:

Abbreviations such as ↑BMI are not to be used alone to assign a code for obesity, as there are no supporting index entries to assign obesity on this basis. However, synonymous terms (such as BMI 40 and hemiparesis) which are indexed and classified to obesity and hemiplegia respectively may be used for code assignment.

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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SUBJECT: Coronary angiography

Ninth Edition Education FAQs

Q:

Patients routinely present for coronary angiography/catheterisation and then undergo percutaneous transluminal coronary angioplasty (PTCA) in the same visit. Should both PTCA and coronary angiogram/catheterisation be coded? When should a code for coronary angiogram be assigned?

A:

As per the Coding Rule *Catheter based cardiac intervention with angiogram* (September 2014), when a catheter is inserted into coronary arteries to evaluate the coronary arteries, it is termed coronary angiogram. When a coronary angiography is performed in addition to a catheter based cardiac intervention i.e. not for access alone, assign 38215-00 *Coronary angiography*.

The code also when performed instruction for coronary angiography has been deleted from a number of percutaneous cardiac procedures to avoid confusion with catheter access for percutaneous procedures, which should not be assigned a separate code. If a diagnostic coronary angiography (classified to block **[668]**) is performed in conjunction with these procedures, then an additional code from block **[668]** is assigned and an instructional note is unnecessary.

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