Independent Hospital Pricing Authority

Frequently Asked Questions (FAQs)

ICD-10-AM/ACHI/ACS Tenth Edition

IHPA

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

Contents

Tenth Edition FAQs

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

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

While the Tenth 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: TN1248 | Published On: 15-Sep-2017 | Status: Retired

Subject: Tenth Edition FAQs Part 1: Obesity and BMI

Q:

What code is assigned for obesity without a BMI documented?

A:

For obesity NOS, assign E66.90 *Obesity, not elsewhere classified, body mass index [BMI] not elsewhere classified.*

Follow the Alphabetic Index:

Obesity (morbid) (simple) E66.9-

Assign a fifth character by referring to the Tabular List:

E66 Obesity and overweight

Note: BMI is not an accurate measure of obesity in childhood/adolescence (those under 18 years of age).

Excludes: adiposogenital dystrophy (E23.6)

lipomatosis:

- dolorosa [Dercum] (E88.2)
- NOS (E88.2)

Prader-Willi syndrome (Q87.14)

The following fifth character subdivisions are for use with subcategories E66.1, E66.2 and E66.9:

Fifth characters 1, 2 and 3 are assigned for patients 18 years of age and above.

For patients under 18 years of age, assign fifth character 0.

0 body mass index [BMI] not elsewhere classified

1 body mass index [BMI] >= 30 kg/m^2 to <= 34.99 kg/m^2

Obese class I

2 body mass index [BMI] >= 35 kg/m^2 to <= 39.99 kg/m^2

Obese class II

3 body mass index [BMI] >= 40 kg/m^2

Clinically severe obesity

Extreme obesity

Obese class III

Note: The terms ‘not elsewhere classified’ apply to residual or unspecified categories; ‘not otherwise specified’ means unspecified or unqualified. Where there is no information regarding the BMI, assign the fifth character ‘0’.

With reference to E66 *Obesity and overweight*, where there is no documentation of a BMI applicable to the fifth characters 1, 2, or 3 then 0 serves as the default character to assign.

Q:

Can a code from category E66 *Obesity and overweight* be assigned for a patient with a documented body mass index of 28, but no documentation of 'obese' or 'overweight'?

A:

As per the ICD-10-AM Alphabetic index:

BMI (body mass index)

- >= 25 kg/m^2 to <= 29.99 kg/m^2 E66.3

- >= 30 kg/m^2 — *see Obesity*

The Alphabetic Index under the lead term *BMI (body mass index)* indicates that the terms obesity and overweight do not need to be documented for a code from category E66 *Obesity and overweight* to be assigned.

Q:

Can coders use documentation of a patient's height and weight to calculate BMI when there is documentation such as "increased BMI"?

A:

There are no index entries for increased BMI:

BMI (body mass index)

- >= 25 kg/m^2 to <= 29.99 kg/m^2 E66.3

- >= 30 kg/m^2 — *see Obesity*

The terms obesity or overweight, or specific BMI values must be documented to assign a code from category E66 *Obesity and overweight.* It is not the responsibility of the clinical coder to calculate the BMI. Where documentation is incomplete (eg documentation of increased BMI without specific values), seek clarification from the clinician.

Published 15 September 2017,
for implementation 01 October 2017.

Ref No: TN1248 | Published On: 15-Sep-2017 | Status: Retired

Subject: Tenth Edition FAQs Part 1: FFR (Fractional Flow Reserve)

Q:

Is Fractional flow reserve (FFR) assigned with a cardiac catheterisation with angiogram code OR coronary angiogram only (ie no catheterisation) code?

A:

In previous editions, FFR was inherent in codes from block **[668]**, as it was commonly performed in conjunction with coronary interventions and there was no appropriate ACHI code. A unique code for FFR was created for Tenth Edition.

The *code also* instruction at 38241-00 **[668]** states:

> *Code also when performed:*
>
> • coronary:
>
> • angiography (38215-00, 38218-00, 38218-01, 38218-02 **[668]**)
>
> • angioplasty (see blocks **[669]**, **[670]** and **[671]**)

Therefore, assign 38241-00 **[668]** *Coronary artery blood flow measurement* (for FFR) in addition to any other procedures listed in the *code also* instruction, as appropriate to the documented case.

Published 15 September 2017,
for implementation 01 October 2017.

Ref No: TN1248 | Published On: 15-Sep-2017 | Status: Retired

Subject: Tenth Edition FAQs Part 1: Passive smoking

Q:

Does passive smoking need to meet the criteria in ACS 0002 *Additional diagnoses*, or is it assigned whenever documented similar to Z72.0 *Tobacco use, current*?

A:

ACS 2118 *Exposure to tobacco smoke* states:

> Assign Z58.7 *Exposure to tobacco smoke* when exposure to secondhand tobacco smoke is documented by a clinician, except if the patient is a current or ex-smoker.

Therefore, exposure to secondhand tobacco smoke (passive smoking) does not have to meet the criteria in ACS 0002 *Additional diagnoses* to assign Z58.7 *Exposure to tobacco smoke.*

See also Tenth Edition FAQs *Application of ACS 0001 and ACS 0002 in conjunction with specialty ACS*

Published 15 September 2017,
for implementation 01 October 2017.

Ref No: TN1248 | Published On: 15-Sep-2017 | Status: Retired

Subject: Tenth Edition FAQs Part 1: Deep Venous Thrombosis (DVT)

Q:

What code is assigned when there is documentation of DVT at multiple levels? For example, DVT extending inferiorly into the popliteal and posterior tibial veins.

A:

There is nothing to preclude assignment of multiple codes from category I80 *Phlebitis and thrombophlebitis,* as there is no hierarchy within the category. Therefore, where the site of a DVT is documented as 'extending inferiorly into the popliteal and posterior tibial veins, assign:

I80.22 *Phlebitis and thrombophlebitis of popliteal vein*

and

I80.23 *Phlebitis and thrombophlebitis of tibial vein.*

Published 15 September 2017,
for implementation 01 October 2017.

Ref No: TN1248 | Published On: 15-Sep-2017 | Status: Retired

Subject: Tenth Edition FAQs Part 1: Adoption

Q:

Is Z76.22 *Health supervision and care of other infant/child NEC* assigned for babies/infants when a Family and Community Services (FACS) evaluation is undertaken?

A:

Assign Z76.22 *Health supervision and care of other infant/child NEC* for infants receiving care or assessment for the purposes of adoption, foster placement, or family supervision.

Published 15 September 2017,
for implementation 01 October 2017.

Ref No: TN1248 | Published On: 15-Sep-2017 | Status: Retired

Subject: Tenth Edition FAQs Part 1:

Application of ACS 0001 and ACS 0002 in conjunction with specialty standards

ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses* are general standards applicable to ICD-10-AM. Unless specifically indicated, the general classification principals in ACS 0001 and ACS 0002 apply to all conditions listed in the specialty standards.

ACS 0002 lists a number of specialty standards that include guidelines to assign codes for certain conditions as additional diagnoses, regardless of whether or not they meet the criteria (see ACS 0002 *Additional diagnoses/Additional diagnosis reporting referred to in other standards*). Note that the list in ACS 0002 is not exhaustive as standards are added or changed over time, and not all applicable specialty standards may be contained in this list.

Therefore, after selecting the principal diagnosis, all other conditions documented in an episode of care must meet the criteria in ACS 0002, unless there are specific guidelines in a specialty standard indicating otherwise (eg (condition) “should always be coded”).

Published 15 September 2017,
for implementation 01 October 2017.

Ref No: TN1248 | Published On: 15-Sep-2017 | Status: Retired

Subject: Tenth Edition FAQs Part 1: Mental health interventions

Q:

Are mental health intervention codes mandatory?

A:

ACS 0534 Specific interventions related to mental health care services states:

> For admitted episodes of care **it is not mandatory** to assign code(s) for mental health care interventions with the exception of electroconvulsive therapy. **However, their use is encouraged in specialist mental health care facilities and units to better represent care provided to these patients**. It should also be noted that these interventions are not exclusive to mental health and may be assigned outside of this context.

This applies the same logic as in ACS 0032 *Allied health interventions* which states:

> For inpatient coding it is only necessary to assign the general code(s) from block **[1916]** *Generalised allied health interventions*. **However, clinical coders are encouraged to use the more specific codes for allied health interventions to better represent the interventions performed.**

Published 15 September 2017,
for implementation 01 October 2017.

Ref No: TN1248 | Published On: 15-Sep-2017 | Status: Retired

Subject: Tenth Edition FAQs Part 1: ACS deleted for Tenth Edition

A coding standard is evaluated for clinical and classification currency or redundancy before the decision is made to delete it from the ACS.

When a coding standard is deleted from the ACS, the content is relocated to either another standard or incorporated into the Tabular List and/or Alphabetic Index, as applicable.

In some instances, a specialty standard is considered redundant if the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses* (or other general/specialty standards) are applicable to the topic.

For example, ACS 1436 *Admission for trial of void* was deleted for Tenth Edition as the following principles apply:

- Follow the Alphabetic Index: *Trial of void/admission for*
- Assign a code for urinary retention when it meets the criteria in ACS 0002
- Assign codes for intervention(s) as per the guidelines in ACS 0042 *Procedures normally not coded/Classification/Dot point 2*)

Note: Information regarding ACS deletion is documented in the *Chronicle* available on the ACCD website (https://www.accd.net.au/Downloads.aspx).

Published 15 September 2017,
for implementation 01 October 2017.

Ref No: TN1248 | Published On: 15-Sep-2017 | Status: Retired

Subject: Tenth Edition FAQs Part 1: Administration of agents (Alphabetic Index)

Q:

Is there a hierarchy at the lead term *Administration* for the subterms *indication, specified site* and *type of agent*?

A:

There is no hierarchy for *Administration/indication, Administration/specified site* and *Administration/type of agent.* Cross-references are included to direct clinical coders to other subterms, as appropriate.

For example, to classify steroid injection into a joint (NOS), assign 50124-01 **[1552]** *Administration of agent into joint or other synovial cavity, not elsewhere classified,* follow the Alphabetic Index:

Administration

- specified site

- - joint NEC 50124-01 **[1552]**

…

- type of agent

- - steroid NEC — *code to block* **[1920]** *with extension -03 (see also Administration/specified site)*

Published 15 September 2017,
for implementation 01 October 2017.

Ref No: TN1248 | Published On: 15-Sep-2017 | Status: Retired

Subject: Tenth Edition FAQs Part 1: Multiple condition coding convention

The concept of 'translate medical statement into code' in the classification and coding standards has been revised to 'classify the clinical concept' in line with the purpose of ICD-10 as a classification.

Key points regarding the *multiple condition coding* convention are highlighted below:

The ICD-10-AM Conventions used in the Tabular List of diseases/*Multiple condition coding* state:

> In Australia, multiple condition coding (meaning that multiple conditions may be assigned in an episode of care) is used to provide the necessary specificity to fully describe the episode of care. **This does not mean multiple codes are assigned to describe a single condition (unless otherwise instructed).**
>
> It is unnecessary for conditions to be explicit in a code title or *Inclusion* term to be correctly classified. **Do not assign an additional code to further classify a condition unless directed by an *Instructional* note in the Tabular List or an Australian Coding Standard.**
>
> If, by following the Alphabetic Index, a residual code is assigned (ie other or unspecified), **do not assign an additional code to further classify the condition unless directed by an *Instructional* note in the Tabular List or an Australian Coding Standard.**
>
> In classifying a condition with an underlying cause, if the Alphabetic Index or *Excludes* note… results in a code for one of the clinical concepts not being assigned, follow the guidelines in ACS 0001 *Principal diagnosis/Problems and underlying conditions* and assign codes for **both** the condition and the underlying cause.

Published 15 September 2017,
for implementation 01 October 2017.

Ref No: TN1248 | Published On: 15-Sep-2017 | Status: Retired

Subject: Tenth Edition FAQs Part 1: Chronic pain

Q:

Will there be amendments to chronic pain in Errata 2?

A:

Errata 2 incorporates amendments to ICD-10-AM code R52.2 *Chronic pain* and ACS 1807 *Acute and chronic pain* with regard to the classification of chronic pain.

Q:

What codes are assigned for chronic pain with underlying conditions?

A:

The ICD-10-AM Conventions used in the Tabular List of diseases/Multiple condition coding state:

> In classifying a condition with an underlying cause, if the Alphabetic Index or *Excludes* note… results in a code for one of the clinical concepts not being assigned, follow the guidelines in ACS 0001 *Principal diagnosis/Problems and underlying conditions* and ACS 0002 *Additional diagnoses* and assign codes for **both** the condition and the underlying cause.

ACS 1807 *Acute and chronic pain* states:

> To classify chronic pain with a documented underlying cause and/or site:
>
> - code first the underlying cause and/or site and,
> - assign R52.2 *Chronic pain* as an additional diagnosis

Note: the amendments made to ACS 1807 in Errata 2 are included in the text above

Scenario:

Chronic low back pain due to bone metastases

Assign: C79.5 *Secondary malignant neoplasm of bone and bone marrow* (ie the underlying cause of the chronic low back back)

> M54.5 *Low back pain* (ie the site of the chronic pain)
>
> R52.2 *Chronic pain* (ie to identify the chronicity)

Note: R52.2 *Chronic pain* is always where there is underlying cause and/or site documented.

> R52.2 *Chronic pain* may be assigned as a principal diagnosis if there is no documentation of an underlying cause or site.
>
> *Sequence codes as per the guidelines in ACS 0001 and ACS 0002.

Q:

What documentation of terminology for chronic pain is used for code assignment?

A:

To assign R52.2 *Chronic pain*, documentation within the clinical record must state any of the following terms:

- neoplastic (or cancer) pain
- neuropathic pain
- nociceptive pain
- chronic pain

Notes: 'Nerve pain' is not synonymous with 'neuropathic pain'

The guidelines under the Classification section in ACS 1807 are applicable for code assignment. The remaining information/definitions contained within ACS 1807 is provided for clinical coder reference only.

Scenario:

Pain due to osteoarthritis of the hip.

Assign: M16.1 *Other primary coxarthrosis*

Note: * R52.2 is not assigned as there is no documentation of 'chronic pain' or 'nociceptive pain'

Q:

What codes are assigned for chronic pain with external causes?

A:

Where chronic pain is the sequelae of an external cause, follow the guidelines in ACS 0008 *Sequelae* or ACS 1912 *Sequelae of injuries, poisoning, toxic effects and other external causes* as appropriate to the case.

Published 15 September 2017,
for implementation 01 October 2017.

Ref No: TN1248 | Published On: 15-Sep-2017 | Status: Retired

Subject: Tenth Edition FAQs Part 1: ACS mutual exclusivity

Mutual exclusivity does not apply to coding standards; however, multiple standards may apply to a particular case.

- Apply first the general standards for diseases and interventions.

  For example, ACS 0001 *Principal diagnosis*, ACS 0002 *Additional diagnoses*, ACS 0010 *General abstraction guidelines* (see also the list of *General standards for diseases* in the ACS) and ACS 0042 *Procedures normally not coded*.

- Apply the guidelines in the specialty standards on a case by case basis.

For example, ACS 0051 *Same-day endoscopy – diagnostic* and ACS 0052 *Same-day endoscopy – surveillance* may apply to the same episode of care, in addition to the general standards for diseases.

Note: There may be a *See* instruction within an ACS to indicate that there may be applicable guidelines in another ACS.

For example, ACS 0001 *Principal diagnosis/Residual condition or nature of sequela* includes a cross reference to ACS 0008 *Sequelae* and ACS 1912 *Sequelae of injuries, poisoning, toxic effects and other external causes.*

Published 15 September 2017,
for implementation 01 October 2017.

Ref No: TN1248 | Published On: 15-Sep-2017 | Status: Retired

Subject: Tenth Edition FAQs Part 1: Use of definitional information

A clinical coder **cannot** use definitional information contained in any ACS for classification purposes.

This information is provided for coder education only.

For example:

- ACS 0533 *Electroconvulsive therapy (ECT)* includes definitional information regarding pulse width such as percentages and duration periods.
- ACS 1807 *Acute and chronic pain* includes definitional information for neoplastic (cancer), neuropathic and nociceptive pain types.

If documentation is lacking in specific detail, this should be discussed with the clinicians involved.

Published 15 September 2017,
for implementation 01 October 2017.

Ref No: TN1248 | Published On: 15-Sep-2017 | Status: Retired

Subject: Tenth Edition FAQs Part 1: Abnormal coagulation profile due to anticoagulants

Q:

Are Z92.1, R79.83 and D68.3 mutually exclusive?

A:

Z92.1 *Personal history of long term (current) use of anticoagulants,* R79.83 *Abnormal coagulation profile* and D68.3 *Haemorrhagic disorder due to circulating anticoagulants* are mutually exclusive, as evidenced by the *Excludes* notes at R79.83 and D68.3. Long term use of anticoagulants is inherent in D68.3 and R79.83.

Q:

Does INR monitoring need to be documented to assign Z92.1 and R79.83?

A:

INR/anticoagulant level monitoring is required to assign Z92.1 *Personal history of long term (current) use of anticoagulants and R79.83 Abnormal coagulation profile*, as per the guidelines in ACS 0303 *Abnormal coagulation profile due to anticoagulants/Classification* which states:

- If patients on long term anticoagulants require anticoagulant level monitoring during an episode of care and the INR level is within the target therapeutic range (ie no supratherapeutic or subtherapeutic INR is documented), assign Z92.1 *Personal history of long term (current) use of anticoagulants* as an additional diagnosis
- If the INR value is outside the patient's normal/usual therapeutic range (eg supratherapeutic or subtherapeutic INR is documented) but no bleeding occurs, assign R79.83 *Abnormal coagulation profile* together with appropriate external cause codes to indicate that the abnormal coagulation profile is related to the administration of an anticoagulant.

Note: The second dot point infers that the INR level (value) is being monitored during an episode of care, as multiple values are required to demonstrate a trend.

Published 15 September 2017,
for implementation 01 October 2017.

IHPA

Ref No: TN1248 | Published On: 15-Sep-2017 | Status: Retired

Subject: Tenth Edition FAQs Part 1: Revision of Type 1 and Type 2 Excludes notes

Key points

The structure of ICD-10-AM has not changed.

Some *Excludes* notes have been removed due to redundancy, but chapter structure has not changed.

As per the Reference to Changes document, a high level review at chapter level was undertaken to remove redundancy. In the review, it was noted that *Excludes* notes served a multitude of purposes, including (but not limited to) addition during development of ICD-10 (to enable tabular browsing during development), and to support mortality single condition coding purposes (ie direct the coder to the underlying cause).

Australia (ICD-10-AM) utilises the multiple condition coding convention to identify both the underlying cause and manifestation(s), and as such a number of *Excludes* notes were determined to be redundant. It was also noted that some Alphabetic Index entries supported the mortality coding purpose (ie single condition coding).

As a result, *Excludes* notes (at the chapter level) identified as redundant for ICD-10-AM purposes were removed for Tenth Edition.

The review of *Excludes* notes at the category and code level will continue for Eleventh Edition.

The areas of pre-coordination (ie mortality direction for underlying cause coding) in the Alphabetic Index and Tabular List have been highlighted, and as work continues on this topic for Eleventh Edition, the indexing and tabular *Inclusion* terms will be assessed and amended (where appropriate).

Problems and Underlying conditions

The ICD-10-AM *Conventions used in the Tabular List of diseases/Multiple condition coding* state:

> In classifying a condition with an underlying cause, if the Alphabetic Index or *Excludes* note… results in a code for one of the clinical concepts not being assigned, follow the guidelines in ACS 0001 *Principal diagnosis/Problems and underlying conditions* and ACS 0002 *Additional diagnoses* and assign codes for both the condition and the underlying cause.

Scenario:

Neurogenic bladder due to cauda equina syndrome

Assign:

N31.9 *Neuromuscular dysfunction of bladder, unspecified*

G83.4 *Cauda equina syndrome*

* Sequence codes as per the guidelines in ACS 0001 and ACS 0002.

Note:

ICD-10-AM *Conventions used in the Tabular List of diseases/Multiple condition coding* state:

> If, by following the Alphabetic Index, a residual code is assigned (ie other or unspecified), do not assign an additional code to further classify the condition unless directed by an *Instructional* note in the Tabular List or an Australian Coding Standard.

Published 15 September 2017,
for implementation 01 October 2017.

Ref No: TN1248 | Published On: 15-Sep-2017 | Status: Retired

Subject: Tenth Edition FAQs Part 1: Difficult intubation

Q:

What codes (including external cause codes) are assigned for difficult intubation?

A:

Assign:

T88.42 *Difficult intubation*

Y84.8 *Other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of unintentional events at the time of the procedure*

Y92.24 *Health service area, this facility*

Published 15 September 2017,
for implementation 01 October 2017.

Ref No: TN1248 | Published On: 22-Sep-2017 | Status: Retired

Subject: Tenth Edition FAQs Part 2: Same-day endoscopy

Q:

Where an endoscopy incorporates both diagnostic and surveillance components or where a diagnostic endoscopy and a surveillance endoscopy are performed in the same episode, should the diagnostic findings be sequenced before the surveillance diagnoses?

A:

There is no hierarchy for assignment of the principal diagnosis in the above scenario. Follow the guidelines in ACS 0051 *Same-day endoscopy – diagnostic* and ACS 0052 *Same-day endoscopy – surveillance* where there are both diagnostic and surveillance endoscopies in the one episode. Then, apply the general principles in ACS 0001 *Principal diagnosis* to determine the principal diagnosis. This has always been the case in these scenarios and has not changed with Tenth Edition.

Published 22 September 2017,
for implementation 01 October 2017.

Ref No: TN1248 | Published On: 22-Sep-2017 | Status: Retired

Subject Tenth Edition FAQs Part 2: Procedural complications

Q:

Which complication code is assigned when a postoperative complication is not classified to T82-T85 *Complications of prosthetic devices, implants and grafts* but the complication is documented as due to a prosthetic device, graft or implant?

A:

Classifying of procedural complications is a complex area. Complications may be non-specific or specific to a particular procedure (eg prosthetic devices, graft or transplantation). ICD-10-AM, based on ICD-10, is not a multi-axial diagnostic classification; it is inflexible to incorporate all types of complications into the classification consistently.

Codes in the categories of T82-T85 are generally intended to be used for complications specific to prosthetic devices, grafts and implants such as mechanical complication, infection, pain, thrombosis, haemorrhage, mesh erosion and so on. Other conditions may occur when a prosthetic device, graft or implant is present but they are more general complications non-specific to the procedure itself (eg implantation of a prosthetic device). It is therefore considered more correct to classify these conditions to an appropriate body system chapter, unless documentation in the clinical record specifies that the procedural complication is 'secondary to' or 'due to' a prosthetic device, implantation or graft, for which an appropriate code from T82-T85 is assigned, followed by a code from the body system chapter.

Scenario 1:

Lymphocele following radical prostatectomy

Assign:

I97.83 *Postprocedural lymphocele, lymphoedema and chylothorax*

Scenario 2:

Lymphocele due to cannulation of the femoral vein

Assign:

T82.89 *Other specified complications of cardiac and vascular prosthetic devices, implants and grafts*

I97.83 *Postprocedural lymphocele, lymphoedema and chylothorax*

Q:

What code is assigned for peritonitis in a peritoneal dialysis patient when there is no documentation that the complication is due to the device?

A:

Peritonitis is a medical condition that may occur in the postoperative period. It may or may not be related to the procedure performed. Peritonitis is not classified as a procedural complication unless the causal relationship is clearly documented.

However, when peritonitis occurs in a peritoneal dialysis (PD) patient, clinical advice from the Australia and New Zealand Dialysis and Transplant Registry (ANZDATA) indicates that it is considered PD related peritonitis.

Therefore, for peritonitis in a peritoneal dialysis patient without further specification assign:

T85.71 *Infection and inflammatory reaction due to peritoneal dialysis catheter*

K65.- *Peritonitis*

Y84.1 *Kidney dialysis*

Y92.23 *Place of occurrence, health service area, not specified as this facility*

or

Y92.24 *Place of occurrence, health service area, this facility*

Where another cause of the peritonitis is specified, such as perforated diverticulum, assign codes following the guidelines in ACS 0001 *Principal diagnosis*/*Problems and underlying conditions,* and ACS 0002 *Additional diagnoses.*

Note: This advice defaults the classification of peritonitis in PD patients. It should not be applied to other medical conditions occurring postoperatively.

Q:

What code is assigned for postoperative pain following insertion of prosthetic devices, grafts or implants?

A:

A code for postoperative pain is only assigned when there is no underlying cause of the pain specified in the clinical record, and it meets the criteria in ACS 0001 *Principal diagnosis*/*Problems and underlying conditions* or ACS 0002 *Additional* diagnoses.

If the cause of pain is specified in the clinical record, an appropriate code for the underlying cause is assigned, not postoperative pain.

Scenario 1:

A patient readmitted with persisting pain after a recent left hip replacement. Extensive investigations, including CT of the hip were conducted, but did not reveal the cause of the pain.

Assign:

T84.83 *Pain following insertion of internal orthopaedic prosthetic devices, implants and grafts*

(external cause codes as appropriate)

Scenario 2:

A patient admitted with chronic hip pain 12 months after a left hip replacement. A radiograph showed loosening of the prosthesis at the bone–cement interface and a revision of hip replacement was carried out.

Assign:

T84.0 *Mechanical complication of internal joint prosthesis*

M25.55 *Pain in joint, pelvic region and thigh*

R52. 2 *Chronic pain*

(external cause codes as appropriate)

Q:

Could postoperative anaemia be assumed as posthaemorrhagic anaemia in the absence of any documented cause?

A:

The overall concept of procedural complications has been reviewed for ICD-10-AM Tenth Edition. This clarifies that conditions that arise during a procedure, or in the postoperative period are not considered as procedural complications unless a causal relationship is documented in the clinical record. However, for certain conditions, the causal relationship is assumed, i.e. a cause and effect relationship does not have to be documented to assign a procedural complication code. These conditions include:

- Certain conditions where the relationship is inherent in the diagnosis (eg. acute blood loss anaemia during a procedure or from a surgical wound)
- Conditions classified to T82–T85 for complications related to prosthetic devices, implants or grafts
- Conditions that are a direct consequence of a procedure, resulting in an unintended event

These conditions may or may not be documented as 'secondary to' or 'due to' the procedure performed, however they are classified as procedural complications. ICD-10-AM Tenth Edition Alphabetic Index has been updated to reflect these changes. For example:

Haemorrhage

- due to or **associated with**

- - device, implant or graft NEC *(see also Complication(s)/by site and type)* T85.83

Scenario:

A tracheoesophageal fistula formed following tracheostomy

Assign:

J95.04 *Tracheo-oesophageal fistula following tracheostomy*

Scenario:

Acute blood loss anaemia post ORIF for femoral fracture, without further specification as to cause of the anaemia.

Assign:

T84.81 *Haemorrhage and haematoma following insertion of internal orthopaedic prosthetic devices, implants and grafts*

D62 *Acute posthaemorrhagic anaemia*

(external cause codes as appropriate)

If the cause of anaemia other than acute haemorrhage is specified in the clinical record (eg pre-existing anaemia, malignancy or other chronic diseases during postoperative recovery), classify the anaemia as per the documented cause, not acute posthaemorrhagic anaemia.

Q:

What is the correct place of occurrence code to assign when the patient is registered in the hospital system, but care is delivered by a private provider on behalf of the hospital?

A:

The note at Y92.23 *Health service area, not specified* as this facility and Y92.24 *Health service area, this facility* states:

> *'This facility' includes satellite units managed and staffed by the same health care provider. These units may be located on the hospital campus or off the hospital campus and treat movements of patients between sites as ward transfers'*

Where complications occurred at a unit or centre external to the admitting facility, and the movement of patients is regarded as an internal transfer with intention of resuming care when patients return (ie continuation of the same admission), it is classified as 'this facility'. This includes transferring patients to a department or centre where the care is provided by a subcontractor.

If the movement of patients is regarded as an external transfer (ie the patient is discharged from the admitting facility and admitted to another facility under a contractual agreement), it is regarded as another facility (ie not specified as this facility).

Scenario 1:

Patient admitted for chest pain and transferred to the radiology department (privately owned, contracting to the facility) for a coronary angiogram. A haematoma at the arterial puncture site was identified the next day while the patient was still admitted at the hospital.

Assign:

Y92.24 *Place of occurrence, health service area, this facility*

Scenario 2:

Patient admitted to Hospital A for treatment of sepsis. During the admission, he slipped on the hospital floor and suffered a fracture of neck of femur (NOF). This was surgically treated and eventually he was transferred to Hospital B for rehabilitation of the fracture and deconditioning. During his stay at Hospital B he developed pneumonia and was transferred back to Hospital A where he continued physiotherapy for the fractured NOF.

Assign:

Hospital A: Y92.24 *Place of occurrence, health service area, this facility* (with COF=1)

Hospital B: Y92.23 *Place of occurrence, health service area, not specified as this facility* (with COF=2)

Hospital A: Y92.24 *Place of occurrence, health service area, this facility* (with COF=2)

Published 22 September 2017,
for implementation 01 October 2017.

Ref No: TN1248 | Published On: 22-Sep-2017 | Status: Retired

Subject Tenth Edition FAQs Part 2: Obstetrics

Q:

Should ACS 1505 *Delivery and assisted delivery codes* refer to 'ACHI code(s)'?

A:

ACS 1505 *Delivery and assisted delivery* codes states:

Where a patient delivers during an episode of care, assign:

- a code from O80–O84 Delivery **and**
- an ACHI code from **[1336]** – **[1340]** *Delivery procedures or other procedure(s) to assist delivery*

The above statement means that at least one ACHI code (delivery or other procedure to assist delivery) is assigned for every episode of care where a patient delivers. Assign multiple ACHI codes, if applicable, based on documentation in the clinical record.

Q:

Is it correct that 90467-00 **[1336]** *Spontaneous vertex delivery* is assigned once only for a twin delivery where both infants are delivered by spontaneous vertex delivery?

A:

ACS 1505 *Delivery and assisted delivery code*s states:

In a multiple delivery, if the babies are delivered by different methods, ACHI codes for all of the delivery methods must be assigned.

Therefore, if the same delivery method is used for all the infants, only one ACHI code is assigned.

That is:

- O84.0 *Multiple delivery, all spontaneous* – assign one spontaneous delivery code if all infants delivered by the same method
- O84.1 *Multiple delivery, all by forceps and vacuum extractor* – assign one forceps or vacuum code if all infants are delivered by the same method
- O84.2 *Multiple delivery, all by caesarean section* – assign one caesarean section code if all infants are delivered by the same method

Scenario: Healthy twins both delivered by spontaneous vertex delivery.

Assign:

O84.0 *Multiple delivery, all spontaneous*

O30.0 *Twin pregnancy*

Z37.2 *Twins, both liveborn*

90467-00 **[1336]** *Spontaneous vertex delivery*

(anaesthesia code if applicable)

Q:

What codes are assigned for spontaneous vertex delivery with McRoberts manoeuvre?

A:

As per the table in ACS 1505 *Delivery and assisted delivery codes*, codes for spontaneous delivery (90467-00 **[1336]** *Spontaneous vertex delivery* and 90470-00 **[1339]** *Spontaneous breech delivery*) are assigned with O80 *Single spontaneous delivery* or O84.0 *Multiple delivery, all spontaneous.*

Note that for classification purposes, once a delivery is 'assisted' it is no longer 'spontaneous'.

ICD-10-AM CODE	ACHI CODE
O80 *Single spontaneous delivery*	90467-00 **[1336]** *Spontaneous vertex delivery* 90470-00 **[1339]** *Spontaneous breech delivery*
O84.0 *Multiple delivery, all spontaneous*	90467-00 **[1336]** *Spontaneous vertex delivery* 90470-00 **[1339]** *Spontaneous breech delivery*

Scenario: Single delivery; McRoberts manoeuvre performed, followed by vertex delivery of healthy infant.

Assign:

O83 *Other assisted delivery*

Z37.0 *Single live birth*

90477-00 **[1343]** *Other procedures to assist delivery*

See also Coding Rule: *SVD in multiple delivery by combination of methods.*

Q:

What codes are assigned for fetal death in utero (FDIU)/missed abortion before fetal viability, with induction of labour?

A:

ACS 1511 *Termination of pregnancy* states:

> *For delivery episodes of care following fetal death in utero (intrauterine death) (not induced), follow the* Alphabetic Index at Death/fetus, fetal *and the guidelines in ACS 1500* Diagnosis sequencing in delivery episodes of care.
>
> …
>
> **PROCEDURES FOR TERMINATION OF PREGNANCY**
>
> - induction of labour. Assign a code from block **[1334]** *Medical or surgical induction of labour* regardless of the duration of pregnancy and outcome

Scenario: FDIU/missed abortion before fetal viability (14/40). Patient induced with prostaglandin suppository. Documentation: "IOL – Misoprostol 400mg inserted PV".

Assign:

O02.1 *Missed abortion*

O09.2 *14–19 completed weeks*

90465-01 **[1334]** *Medical induction of labour, prostaglandin*

Follow the Alphabetic Index:

Death

- fetus, fetal (cause not stated) (intrauterine)

- - before fetal viability, with retention (< 20 completed weeks (140 days) gestation and/or fetal weight < 400g) O02.1

Induction

- labour

- - medical (administration of pharmacological agent)

- - - prostaglandin 90465-01 [1334]

Note that an ACHI code for induced abortion is not assigned as the fetus is already deceased.

Q:

Is the assignment of codes from categories E09-E14 with codes from category O24 *Diabetes mellitus in pregnancy* contradictory to ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia/General classification rules/Rule 6?*

A:

ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia/Specific classification principles for DM and IH/DM and IH in pregnancy, childbirth and the puerperium* states:

> Assign codes for DM or IH (E09–E14) as per the *Instructional* notes (*code also*) at O24.-.

The above specific classification principle and the *Instructional* notes at category O24 *Diabetes mellitus in pregnancy* take precedent over the *General classification rules for DM and IH* in ACS 0401.

Scenario: Pregnant patient with type 2 diabetes mellitus; diabetes diagnosed two years ago. Patient does not have any diabetes complications; diabetes managed by diet.

Assign:

O24.14 *Pre-existing diabetes mellitus, Type 2, in pregnancy, other*

E11.9 *Type 2 diabetes mellitus without complication*

Q:

Are the guidelines in ACS 0104 *Viral hepatitis* and ACS 0505 *Mental illness in pregnancy, childbirth and the puerperium* sequencing directives?

A:

ACS 0104 *Viral hepatitis/Classification point 2. Viral hepatitis in pregnancy, childbirth and the puerperium* states:

> Where viral hepatitis is documented in pregnancy, childbirth or the puerperium, assign:
>
> - a code for the specific type of viral hepatitis (B15–B19)
> - O98.4 *Viral hepatitis in pregnancy, childbirth and the puerperium*

ACS 0505 *Mental illness in pregnancy, childbirth and the puerperium* states:

> Where a mental disorder is documented in pregnancy, childbirth or the puerperium, assign:
>
> - a code from Chapter 5 *Mental and behavioural disorders* for the specific type of mental illness
> - O99.3 *Mental disorders and diseases of the nervous system in pregnancy, childbirth and the puerperium.*

The above guidelines are not sequencing directives. Both ACS 0104 and ACS 0505 contain cross references to standards where sequencing guidelines are provided for conditions/complications in pregnancy and the puerperium:

> > See ACS 1521 *Conditions and injuries in pregnancy* and ACS 1548 *Puerperal/postpartum condition or complication.*

Note: Viral hepatitis is always coded as per the guidelines in ACS 0104, but the general classification principles in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses* apply to mental health conditions.

Q:

Does “including delivery of placenta” as a definition of delivery mean whole placenta? If there are retained portions of placenta, is the delivery considered incomplete?

A:

ACS 1548 *Puerperal/postpartum condition or complication* states:

> > The puerperium is defined as the period of 42 days following delivery (including delivery of placenta).

Delivery of placenta means expulsion of the whole placenta, excluding any retained portions that are expelled or require removal post delivery (see also ACS 1548 Example 7).

Scenario: Patient delivered (baby and placenta) at home (planned home birth). She is admitted to hospital four hours later due to postpartum haemorrhage, and is taken to theatre for removal of retained portions of placenta by dilation and curettage (D&C).

Assign:

O72.2 *Delayed and secondary postpartum haemorrhage*

Z39.02 *Postpartum care after planned, out of hospital delivery*

16564-00 **[1345]** *Postpartum evacuation of uterus by dilation and curettage*

(anaesthesia code)

Note: It is acknowledged that there are issues with the indexing and classification of postpartum haemorrhage and underlying causes (eg atonic uterus, retained portions/fragments of placenta). These issues are under review for ICD-10-AM/ACHI/ACS Eleventh Edition.

Published 22 September 2017,
for implementation 01 October 2017.

Ref No: TN1335 | Published On: 29-Sep-2017 | Status: Retired

Tenth Edition FAQs Part 3:
Obstetrics

Q:

What code is assigned for a patient admitted five months post delivery with low milk supply?

A:

Where a patient has a condition relating to lactation, assign a code from category O91 *Infections of breast associated with childbirth* or O92 *Other disorders of breast and lactation associated with childbirth*, regardless of whether the condition occurs in the delivery episode, within the puerperium or beyond the puerperium.

Scenario: Breastfeeding patient admitted 5 months post delivery with a nonobstetric condition. Patient commenced on Domperidone for low milk supply. No attachment difficulties documented. Assign:

PDx for the nonobstetric condition as per the criteria in ACS 0001 *Principal diagnosis*

O92.40 *Hypogalactia, without mention of attachment difficulty* as an additional diagnosis

This question highlighted a logic error in the guidelines in ACS 1548 *Puerperal/postpartum condition or complication/Conditions relating to lactation.* Amendments are included in Tenth Edition Addenda to Errata 2, for implementation 1 October 2017.

Published 29 September 2017,
for implementation 01 October 2017.

Ref No: TN1335 | Published On: 29-Sep-2017 | Status: Retired

Tenth Edition FAQs Part 3:
Same-day endoscopy

Q:

Why does ACS 0052 *Same-day endoscopy – surveillance* instruct that Z codes for follow-up or screening are not assigned as an additional diagnosis? Where a second endoscopic procedure is performed in the same episode for screening and nothing is found, this instruction means a diagnosis code for that particular endoscopy is unable to be assigned.

A:

This instruction was added into the standard due to the fact that there is inconsistent use of the terminology 'follow-up' and 'screening', and therefore the addition of these codes provides little value in the data. However, this has been reconsidered in the context of multiple endoscopies performed in the one operative episode, and is amended in Tenth Edition Addenda to Errata 2, for implementation 1 October 2017, to allow assignment of these codes as additional diagnoses, as appropriate.

Q:

Why is the code for liver cirrhosis sequenced as principal diagnosis in ACS 0052 *Surveillance* Example 13?

A:

Example 13 has been reviewed and is amended in Tenth Edition Addenda to Errata 2, for implementation 1 October 2017, to sequence the varices as the principal diagnosis. It's acknowledged that in that scenario there would be no surveillance of the liver cirrhosis (chronic incurable condition).

Q:

Why has a personal history code been assigned in ACS 0052 *Surveillance* Example 11?

A:

The assignment of the personal history code in this scenario was seen as relevant to the episode. However, upon review it is acknowledged that it is not consistent with the guidelines in ACS 2112 *Personal history* which states:

> These codes would only be assigned as additional diagnoses where the condition is completely resolved yet the history is directly relevant to the current episode of care.

The personal history code will be removed from example 11 in Tenth Edition Addenda to Errata 2, for implementation 1 October 2017. A task has been created to review ACS 2112 *Personal history* for a future edition.

Published 29 September 2017,
for implementation 01 October 2017.

Level 6, 1 Oxford Street
Sydney NSW 2000

Phone 02 8215 1100
Email enquiries.ihpa@ihpa.gov.au
Twitter @IHPAnews

IHPA