The **10-AM** Commandments

Admission for creation of an AV fistula

ACS 1438 *Chronic kidney disease, kidney replacement therapy* provides the following classification advice:

1. Cases of chronic kidney disease with ongoing kidney replacement therapy, whether by dialysis or by transplant, which comply with ACS 0002, require a code from N18.- *Chronic kidney disease* to describe the current stage of disease, except in routine dialysis only admissions.

2. For routine dialysis only admissions it can be assumed from the assignment of Z49.1 *Extracorporeal dialysis* or Z49.2 *Other dialysis* that the patient has CKD – stage 5 (see also ACS 1404 *Admission for kidney dialysis*).

Does the same apply for patients admitted for creation of an AV fistula? Is a CKD code required, or should CKD only be assigned if it meets the criteria in ACS 0002 *Additional diagnoses?*

When a patient is admitted specifically for creation of an AV fistula assign Z49.0 *Preparatory care for dialysis* as the principal diagnosis. An additional code for CKD should be assigned if it meets the criteria in ACS 0002 *Additional diagnoses.*

Alcohol poisoning

When should the code for acute alcohol intoxication (F10.0) versus poisoning by alcohol (T51.0) be assigned?

Clinical advice indicates that alcohol poisoning is a particularly severe form of alcohol intoxication. Typically, alcohol poisoning is characterised by major disturbance of conscious level, inability to rouse the patient and resultant threat to life requiring supportive treatment.

Coders should be guided by the documentation in the clinical record. Where acute alcohol intoxication is documented, assign F10.0 *Mental and behavioural disorders due to the use of alcohol, acute intoxication* following the index pathway:

Intoxication
- alcoholic (acute) (with) F10.0

Where alcohol poisoning is documented, assign T51.0 *Toxic effect of alcohol, Ethanol* following the index pathway:

Poisoning (acute) (see also *Table of drugs and chemicals*)

Table of Drugs and Chemicals

Alcohol
- beverage T51.0

and appropriate external cause of injury codes.

See also ACS 0503 *Drug, alcohol and tobacco use disorders* and ACS 1903 *Two or more drugs taken in combination.*

Anaemia in neoplastic disease

Please clarify the following:

a. For a patient admitted with the following additional diagnoses:

   Anaemia and melaena ? cause

   Patient is transfused with 1 unit of packed red blood cells (Hb 9.2)

   Patient is also noted to have prostate cancer, not treated or investigated at this admission and therefore does not meet ACS 0002 *Additional diagnoses* for code assignment.

   Should the anaemia be coded to D63.0 *Anaemia in neoplastic disease* with additional codes for the neoplasm assigned or should the anaemia alone be coded?

The index pathway for 'Anaemia, in neoplastic disease' should not be followed in the scenario cited where the 'anaemia' and 'melaena' are clearly documented as due to an unknown cause. In this instance code the anaemia alone.

b. The following advice was issued in Coding Matters Vol 6, No 1:

   'Code D63.0* *Anaemia in neoplastic disease* should be assigned when anaemia occurs in, due to or with a neoplastic condition. The specific code for the neoplasm should be assigned when known, as indicated by the inclusion term: ▶▶▶

D63.0* *Anaemia in neoplastic disease*
Conditions in Chapter 2 (C00–D48).'

Does this advice still apply?

The NCCH acknowledges there has been difficulty in applying this advice, particularly where the anaemia is unrelated to the neoplasm. It was not intended for this code to be assigned where the anaemia has been documented as due to an unknown cause or a non-neoplastic condition.

The codes in category D63 *Anaemia in chronic diseases classified elsewhere* have been revised for ICD-10-AM Seventh Edition.

Art therapy

Should there be an allied health code in ACHI for art therapy?

ACHI contains a number of codes in block [1916] *Generalised allied health interventions* that identify specific allied health specialties. ACHI also contains an intervention code for art therapy, 96181-00 [1873] *Art therapy.*

ACS 0032 *Allied health interventions* provides the following advice for assignment of general and specific allied health intervention codes:

'… *clinical coders are encouraged to use the more specific codes for allied health interventions to better represent the interventions performed.'*

Therefore, assign specific allied health intervention codes where the documentation is available. So for documentation of art therapy in the clinical record, assign 96181-00 [1873] *Art therapy.*

Bairnsdale ulcer

What is the correct code for a Bairnsdale ulcer?

A Bairnsdale ulcer is synonymous with a Buruli ulcer, which is indexed in ICD-10-AM. Therefore, the correct code to assign for a Bairnsdale ulcer is A31.1 *Cutaneous mycobacterial infection.*

Improvements to the Alphabetic Index will be considered for a future edition of ICD-10-AM.

BK virus

What is the correct code to assign for BK virus?

The BK virus is a type of human polyomavirus that infects most people but generally causes no symptoms. The virus was first isolated in 1971 from the urine of a renal transplant patient, with initials B.K.

This virus is normally latent, however, it may be reactivated in immunocompromised or immunosuppressed patients. It is believed to be the cause of nephropathy, nephritis and haemorrhagic cystitis in organ transplant recipients.

The correct code to assign for BK virus is B97.8 *Other viral agents as the cause of diseases classified to other chapters* by following the index pathway:

Infection, infected
- virus NEC
- - specified type NEC
- - - as cause of disease classified elsewhere B97.8

Codes from category B95-B97 *Bacterial, viral and other infectious agents* are **not** intended for use as principal diagnoses. As indicated in the code titles, they are provided for use as supplementary or additional codes to identify the infectious agent(s) in diseases classified elsewhere. See 10-AM Commandments Vol. 13 No. 4.

Correction of forefoot deformity

A patient is admitted for correction of a forefoot deformity. The ACHI pathway, Correction, deformity, bony assigns 90604-00 [1578] *Correction of bony deformity* in the *Limb reconstruction* block, which does not appear correct. The body of the operation report describes the exact procedure as an arthrodesis of the 1st metatarsophalangeal (MTP) joint and four osteotomies of separate toes with internal fixation. What is the correct code assignment?

'Correction of forefoot deformity' is a general description. Coders should be guided by the details of the procedure documented in the operation report for specific code assignment.

The correct codes to assign for the scenario cited are 49845-00 [1543] *Arthrodesis of first metatarsophalangeal joint* and 48403-01 [1528] *Osteotomy of toe with internal fixation* × 4, following the pathways:

Arthrodesis (with fixation device)
- metatarsophalangeal, 1st 49845-00 [1543]

and

Osteotomy
- toe
- - with internal fixation 48403-01 [1528]

The NCCH will consider improvements to the Alphabetic Index for a future edition of ACHI.

Descmets Stripping Endothelial Keratoplasty (DSEK)

What is the correct code for Descmets Stripping Endothelial Keratoplasty (DSEK)?

DSEK is a type of partial thickness keratoplasty.

ACHI does not contain a specific code for partial thickness keratoplasty (including DSEK). The correct code to assign for this procedure is 90064-00 [173] *Other keratoplasty.*

Food challenges

What is the correct code(s) to assign for a patient admitted for a peanut challenge, who does not exhibit symptoms of allergy themselves, but is having the challenge because a sibling has a severe peanut allergy?

There are no guidelines in ICD-10-AM or the ACS for code assignment for patients admitted specifically for food challenges, and analysis of current coding practice has highlighted inconsistencies.

Patients who are admitted for a food challenge due to a **personal history** of allergy (where challenge demonstrates the allergy is no longer present) should be assigned a code from category Z03 *Medical observation and evaluation of suspected diseases and conditions* with an additional code Z88.8 *Personal history of allergy to other drugs, medicaments and biological substances*.

For the scenario cited, where there is a **family history** of food allergy, assign Z03.6 *Observation for suspected toxic effect from ingested substance* and Z84.8 *Family history of other specified conditions*, following the pathways:

Observation
- suspected (undiagnosed) (unproven)
- - toxic effects from ingested substance (drug) (poison)
  Z03.6

and

History (of) (personal)
- family, of
- - allergy NEC Z84.8

Fracture of hip prosthesis due to trauma

ACS 1309 *Dislocation of hip prosthesis* states:

'Cases where the patient sustains a traumatic dislocated hip prosthesis should be assigned code S73.0- *Dislocation of hip…*'

So an injury code is assigned. Does this ACS also apply to fractures of hip prostheses due to trauma, ie should an injury code be assigned or is T84.0 *Mechanical complication of internal joint prosthesis* the correct code?

The guidelines in ACS 1309 *Dislocation of hip prosthesis* do apply to fractures of hip prostheses due to trauma. Appropriate injury and external cause of injury codes should be assigned to reflect the trauma.

T84.0 *Mechanical complication of internal joint prosthesis* should be assigned where the conditions listed in T82.0 are specified as due to the joint prosthesis, as per the inclusion term at T84.0 and also following the criteria in ACS 1309 *Dislocation of hip prosthesis*.

Idiopathic Infantile Arterial Calcification (IIAC)

What is the correct code to assign for idiopathic infantile arterial calcification?

Idiopathic infantile arterial calcification is a rare disorder with diffuse disease of elastic and muscular arteries. It is characterised by destruction and fragmentation of the arterial internal elastic membrane, deposition of calcium along the internal elastic membrane and intimal proliferation. The coronary arteries are most commonly involved and in most cases, death is usually due to congestive heart failure and myocardial infarction.

There is no specific index entry in ICD-10-AM for idiopathic infantile arterial calcification (IIAC). The correct code to assign is Q28.8 *Other specified congenital malformations of circulatory system*.

Improvements to the Alphabetic Index will be considered for this condition for a future edition of ICD-10-AM.

Ileocolic resection

When a portion of the ileum is removed along with the caecum the procedure is called an ileocolic resection. There is no index entry for this procedure, so what code(s) should be assigned?

ACHI does not contain a specific code for ileocolic resection. Assign 30566-00 [895] *Resection of small intestine with anastomosis* and 32003-00 [913] *Limited excision of large intestine with anastamosis*, to accurately reflect the procedure performed, by following the pathways:

Excision
- intestine
- - small (with anastomosis) 30566-00 [895]

and

Colectomy
- local — see *Colectomy, limited*
…
- limited (local) (with anastomosis) 32003-00 [913]

If stoma formation is specified in the procedure, select the index entry "with formation of stoma" in the index pathways above and assign the appropriate codes.

Insertion of fiducial markers into the prostate

What is the correct code for insertion of fiducial markers into the prostate?

Fiducial markers are implantable devices used as a tool in image-guided radiotherapy (IGRT). The markers may also be called fiducial seeds or gold seed markers. Gold seeds are the most frequently used markers. The seeds are inserted into the prostate via a needle using transrectal ultrasound. Several days after insertion of the seeds treatment planning by CT simulation is commenced.

There is currently no specific code in ACHI for insertion of fiducial markers into prostate, therefore assign 90395-00 [1170] *Other procedures on prostate*.

A specific code for this procedure has been included in ACHI Seventh Edition.

Molecular Adsorbent Recirculating System (MARS) treatment

What is the correct code to assign for MARS treatment?

MARS treatment is an extracorporeal, liver support therapy. It is a mechanical detoxification system designed to selectively eliminate both water-soluble toxins (as in renal dialysis) and strongly albumin-bound toxins in the blood of patients with liver insufficiency. It supports the liver until it is capable of spontaneous recovery or it may serve as a bridge to transplantation.

ACHI does not contain a specific code for MARS treatment. Assign 13750-06 [1892] *Other therapeutic haemapheresis*.

Multiple coding of procedures

Should arterial, PICC or CVC lines, MRI and nuclear medicine scans be coded as many times as they are performed ie multiple times during an admission?

Where arterial, PICC or CVC lines, MRIs or nuclear medicine scans are inserted/performed as stand alone procedures under an anaesthetic (except local), assign a code as many times as performed, as per the principles in ACS 0042 *Procedures normally not coded*.

Where multiple arterial, PICC or CVC lines, MRIs and nuclear medicine scans are performed as stand alone procedures, but not performed under anaesthetic, or are performed under a local anaesthetic only, assign a code for the procedure once only.

Where NCCH has not published advice to exempt the coding of specific procedures/interventions multiple times, or they are not listed in ACS 0042 or ACS 0020, they should be coded as many times as they are performed. For example, thoracentesis, paracentesis or lumbar punctures should be coded each time they are performed during an episode of care.

See also, 10-AM Commandments *Central venous and arterial lines,* Vol 15, No 1, June 2008 and advice issued regarding the coding of multiple CT scans in FAQs, part 2 published in Coding Matters Vol 15, No 3, Dec 2008 and advice regarding the insertion of Hickman's line in FAQs published in this edition of Coding Matters, Vol 16, No 2.

These issues have been addressed for the Seventh Edition of ICD-10-AM/ACHI/ACS.

Osteomyelitis of knee due to *Burkholderia pseudomallei* infection

What is the correct code assignment for osteomyelitis of the knee due to *Burkholderia pseudomallei* infection?

Osteomyelitis is an unusual but well recognised manifestation of melioidosis, a disease that is endemic in South-East Asia and northern Australia. Infection is caused by *Burkholderia pseudomallei* which can be acquired by ingestion, inhalation or wound contamination. Infection more commonly occurs in people with coexistent conditions such as diabetes, renal impairment, chronic pulmonary disease and immunosuppression. Subacute presentations often mimic other disease processes and patients may not always be clinically septic.

Treatment for osteomyelitis often requires surgical drainage and multiple antibiotic therapy.

The correct codes to assign for the scenario cited above are M86.86 *Other osteomyelitis, lower leg* and B96.88 *Other and unspecified bacterial agents as the cause of diseases classified to other chapters*, following the pathways:

Osteomyelitis (infective) (septic) (suppurative)
- specified NEC M86.8-

and

Burkholderia NEC
- pseudomallei (see also Melioidosis)
- - as the cause of disease classified elsewhere B96.88

or

Infection, infected
- Burkholderia NEC
- - pseudomallei (see also Melioidosis)
- - - as the cause of disease classified elsewhere B96.88

Procedural complications

What is the correct code to assign for an intraoperative cardiac arrest with successful resuscitation – I97.8 *Other postprocedural disorders of circulatory system, not elsewhere classified* or T81.8 *Other complications of procedures, not elsewhere classified*?

For a procedural complication occurring during surgical care (as per the above scenario) refer to ACS 1904 *Procedural complications* which states:

'There are a number of terms used in ICD-10-AM to describe procedural complications and these generally relate to the timing of the complication.

Misadventure

A misadventure is defined as a complication occurring during medical or surgical care. It may be noted at the time of the procedure or after completion of the procedure.'

Then follow the guidelines for classification of procedural complications which states:

'Firstly, check the Alphabetic Index under the main term which best describes the complication, for the subterm of 'procedural' or 'postprocedural'.'

Therefore, for this scenario, follow the index pathway:

Arrest, arrested
- cardiac
- - postprocedural I97.8

and assign I97.8 *Other postprocedural disorders of circulatory system, not elsewhere classified* with I46.0 *Cardiac arrest with successful resuscitation* to provide further specification of the condition (as per ACS 1904) and the appropriate external cause of injury codes.

Do not follow the index pathway *Arrest, cardiac, complicating, surgery* and assign T81.8 as this is contrary to the guidelines in ACS 1904.

Improvements to the Alphabetic Index in relation to procedural complications will be considered for a future edition of ICD-10-AM.

Radiofrequency ablation of stellate ganglion

What is the correct code to assign for radiofrequency ablation of stellate ganglion?

The correct code to assign for radiofrequency ablation of the stellate ganglion is 39323-00 [72] *Other percutaneous neurotomy by radiofrequency* by following the pathway:

Ablation
- nerve — see *also neurotomy*

Neurotomy
- peripheral
- - percutaneous, by
- - - radiofrequency 39323-00 [72]

Improvements to the ACHI Alphabetic Index for this procedure will be considered for a future edition.

Use of abbreviations and symbols

When can coders use abbreviations and symbols documented in the clinical record to assign conditions, eg

↓Hb or Hb 98 documented and transfusion given – can anaemia be assigned?

↓K or K2.9 documented and potassium supplements commenced – can hypokalaemia be assigned?

Clinicians sometimes use abbreviations and symbols to document conditions in the clinical record. Each case should be assessed on its own merits to determine if the documentation sufficiently describes a condition that meets the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*, in order to be coded.

When ↓Hb or ↓K is documented as the indication for an intervention such as a blood transfusion or commencement of medication, a code for the condition can be assigned if the test result or clinician confirms that the patient's haemoglobin or potassium is below the normal range; as the criteria for code assignment in ACS 0001 or ACS 0002 has been met. See ACS 0010 *General abstraction guidelines*.

So, where ↓Hb is documented as the indication for a transfusion and the test results and/or clinician verifies the patient's haemoglobin is below the normal range – follow the index pathway, *Low, haemoglobin* and assign D64.9 *Anaemia, unspecified.*

Where ↓K is documented as the indication for commencement of medication and the test results and/or clinician verifies the patient's potassium is below the normal range, follow the index pathway *Deficiency, potassium (K); Depletion, potassium; Hypokalaemia; or Hypopotassaemia* and assign E87.6 *Hypokalaemia.*

However, if ICD-10-AM does not provide an index look up or there is uncertainty or ambiguity in relation to such abbreviated forms of documentation, they should be confirmed with the clinician prior to code assignment. Coders should not assign codes on the basis of test results alone.

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ICD-10-AM/ACHI/ACS

Sixth Edition education program – 2009

The NCCH conference held in March 2009 once again presented an opportunity for participants to attend an ICD-10-AM/ACHI/ACS Sixth Edition coding tutorial. As this workshop is always very popular and only caters for 100 attendees, the same workshop was then offered nationally. 29 workshops for 981 participants were presented during the months of May and June 2009.

Workshop data

State/territory	# workshops	# participants
NSW	9	260
Victoria	6	195
Queensland	6	227
South Australia	3	147
Western Australia	2	68
Tasmania	1	38
ACT	1	32
Northern Territory	1	14
TOTAL	29	981

The workshop sizes varied from 14 people (some rural centres) up to a maximum of 50 people in some of the capital cities. Graphic material to highlight clinical information was once again well received with coders indicating that these diagrams helped improve their coding knowledge. Feedback from the workshop can be seen in **Figure 1** which illustrates the total number of responses received regarding the pre-workshop material, workshop content, presentations etc.
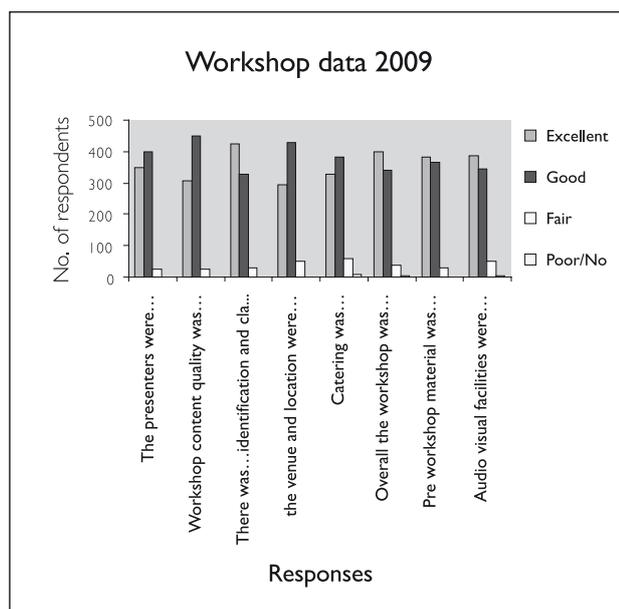

Figure 1 – Evaluation form responses.

Of the 981 attendees at the workshops, 789 evaluation forms were completed giving an 80% completion rate. From the results the majority of coders who completed the evaluation forms indicated that the pre-workshop material and workshops were either excellent or good with only a very small percentage in each category indicating fair or poor. Overall, this illustrates the benefit of the education programs for the continuing education of clinical coders on a national basis.

The main focus of this year's continuing education workshops was on coding cases related to **chronic kidney disease**. This was based on feedback received from state and territory coding authorities and from feedback received from previous workshops requesting further education in this area of the classification as well as on other topics including bilateral/multiple procedures, cardiovascular, diabetes mellitus, obstetrics, spinal injury/ surgery and ventilation.

The workshop was designed to allow participants to complete a workbook containing 12 case scenarios and 6 clinical record abstracts prior to attending. This allowed time for discussion of answers and review of the cases during the actual workshop. As with any workshop presented by the NCCH a national approach is taken, this is because the presenters are not always familiar with each state's local rules and software issues. Where possible, the presenters will try and address state issues.

Workshop comments

Feedback from participants, via the evaluation process, confirmed the benefits of this approach and also provided the following comments:

- *The workshop was very well conducted and informative. Lots of good examples were presented which I can take back for reference material when coding.*

- *Perhaps include some short films or education explaining disease process and/or procedures eg new surgical techniques or treatments that are now being used.*

- *Please continue face to face workshops, they provide a very valuable opportunity to catch up with fellow coders.*

- *Good use of diagrams throughout the presentation. Loved having the inclusion of cardiac and spinal procedures which we don't code at our hospital.*

- *Being new in the coding profession I am looking forward to expanding my knowledge and coding skills. Workshops are invaluable in achieving this.*

- *Were able to ask questions and see how other coders are dealing with issues.*

- *A break in the middle of each session would be good – the sessions were too long.*

- *Any continuing education for coders is great and a shame that all coders cannot attend.*

- *Coding queries and answers should be limited to the material being presented. Participants had general coding queries which were not related to the material and these should not have been discussed.*

- *Please include more scenarios in the workbook which are simple and straight forward to reinforce coding principles. Send education material earlier if possible as sometimes it is difficult to find time to complete the workbook due to workloads.*

- *Absolutely loved the face-to-face contact, the discussion is enlightening, the sharing of ideas and the discussion re interpretation is interesting and confirms we are going in the right direction.*

The following **Errata** were made to the Conference workshop material for the national workshops:

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Coding Workbook:

Case 4: wording change – third sentence should read as:

Following transfer he was still experiencing some dizziness and chest pain which was eventually relieved by GTN.

Case 8: wording change – first sentence should read as:

*37 y.o. primigravida, with a history of iron deficiency anaemia during pregnancy requiring iron supplements, was admitted at 39/40 with **premature** rupture of membranes at 0600hrs.*

Answers to case scenarios and clinical record abstracts:

Case 3:

add Z95.5 *Presence of coronary angioplasty implant and graft*

Clinical Record 5:

amend principal diagnosis code to:

K57.3**0** *Diverticular disease of large intestine without perforation or abscess, diverticulosis without mention of haemorrhage*

add K92.1 *Melaena*

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Frequently Asked Questions

The following FAQs were asked at the recent ICD-10-AM/ACHI/ACS Sixth Edition 2009 continuing education coding workshops. The standard abbreviation of 'ACS' has been used throughout for 'Australian Coding Standard'.

As many of the FAQs raised at the workshops were case specific, it is recommended that coders review these answers with the workbook to help understand the context of the responses.

The workshop books are still available for purchase for those who couldn't attend a workshop, please refer to our website: http://www.ncch.com.au/ and follow the link to the 2009 Coding workshops (ICD-10-AM/ACHI/ACS Sixth Edition)

Q1: In case scenario 3 the patient was admitted for insertion of a biventricular pacemaker due to CCF. Why was a code assigned for the haematoma, isn't this complication considered an expected outcome of this type of surgery?

A: In this case scenario the patient developed a wound haematoma at the pocket site where the generator for the pacemaker was inserted as indicated by the following documentation:

Haematoma noted at 1700 hours post IPPM. 10 minutes of manual pressure applied over site. Site was initially marked at 1700 hours and monitored with no increase in haematoma size since then. Seen by doctor and a pressure bandage was applied at 1800 hours. Information regarding the PPM was given to the patient and she was discharged at 1830 hours.

Where a catheter is inserted through the femoral vein, a haematoma at the puncture site is quite common. These haematomas usually resolve. However, in this case the haematoma was monitored by the nursing staff and then reviewed by the clinician to assess the size of the haematoma and apply a pressure bandage etc. Therefore, it meets the criteria in ACS 0002 and the following codes were assigned:

T82.8   *Other complications of cardiac and vascular prosthetic devices, implants and grafts*

Y83.1   *Surgical operation with implant of artificial internal device*

Y92.22 *Place of occurrence, health service area*

Q2: If a patient is admitted for insertion of a biventricular pacemaker and following the procedure develops a wound haematoma, can an additional code be assigned for contusion of thorax?

A: Yes, S20.2 *Contusion of thorax* can be assigned as an additional code to further specify the type of complication as per ACS 1904, *'An additional code from Chapters 1 to 19 may be assigned to provide further specification of the condition.'*

Q3: If an intraoperative haemorrhage occurs during, for example the insertion of a pacemaker as seen in case scenario 3, which is the correct code to assign T81.0 *Haemorrhage and haematoma complicating a procedure, not elsewhere classified* or T82.8 *Other complications of cardiac and vascular prosthetic devices, implants and grafts?*

A: Follow the excludes note at T81.0 *Haemorrhage and haematoma complicating a procedure, not elsewhere classified* and assign the most appropriate code:

T81.0 Haemorrhage and haematoma complicating a procedure, not elsewhere classified

Haemorrhage at any site resulting from a procedure

Excludes: haematoma of obstetric wound (O90.2) haemorrhage due to or associated with prosthetic devices, implants and grafts (T82.8, T83.8, T84.8, T85.8)

'associated with' was added to the excludes note in Sixth Edition at T81.0 as there doesn't need to be a cause and effect relationship between the device, implant or graft and the haemorrhage for T82.8 to be assigned.

Q4: Why was I25.2 *Old myocardial infarction* and Z95.5 *Presence of coronary angioplasty implant and graft* assigned in case scenario 3?

A: In this case scenario there is documentation that the patient was admitted for insertion of a biventricular pacemaker due to CCF *'on a history of recurrent MI, … history of stenting of RCA and LAD four years previously'*. Codes have been assigned for these conditions, as per ACS 0940 *Ischaemic heart disease - Old myocardial infarct* (I25.2) and *Chronic ischaemic heart disease* (I25.9) and ACS 2112 *Personal history*, because the history of old myocardial infarct and coronary implant status is documented as being directly relevant to the current episode of care (or is linked to the condition currently being treated).

Q5: In case scenario 4:

Principal diagnosis Bradycardia

History ESRD secondary to CKD
Hypertension
Mitral regurgitation
Gout

Patient was transferred from another hospital dialysis centre on 11/8 for investigation and management of chest pain and bradycardia. He

was noted to have chest pain while receiving dialysis and his heart rate was 40bpm. Following transfer he was still experiencing some dizziness and chest pain which was eventually relieved by GTN…

Why was chest pain coded and should it have been the principal diagnosis?

A: R07.4 *Chest pain, unspecified* was coded as an additional diagnosis as it met the criteria in ACS 0002 *Additional diagnoses* - the condition was a problem on admission and it was treated with GTN.

In selecting a condition as the principal diagnosis ACS 0001 *Principal diagnosis* should be followed. Within this ACS guidelines are provided for when 'two or more conditions, each potentially meeting the definition for principal diagnosis' occurs and the clinician should be asked to indicate which diagnosis best meets the principal diagnosis definition. In this scenario the bradycardia and chest pain both could have equally met the definition of principal diagnosis however the clinician has then indicated that the principal diagnosis was bradycardia.

Q6: In case scenario 4 an ECG was performed which 'showed no acute changes, however, ventricular bigeminy was noted'. Should a code for ventricular bigeminy be assigned?

A: '**Ventricular bigeminy** refers to alternating normal sinus and premature ventricular complexes. Three or more successive premature ventricular complexes are arbitrarily defined as ventricular tachycardia. Premature ventricular complexes become more prevalent with increasing age and occur in association with a variety of stimuli. It is important to determine whether underlying structural heart disease is present and left ventricular function is impaired. Other common causes include electrolyte abnormalities, stimulants, and some medications.' (http://www.aafp.org/afp/20020615/2491.html - Journal of the American Academy of Family Physicians)

Ventricular bigeminy noted on the ECG is not coded as per ACS 0010 *General abstraction guidelines – Test results*. The clinician has not indicated a relationship between this finding and a condition OR indicated its significance.

Q7: Why was fluid overload coded in case scenario 5 when it is a symptom of chronic kidney disease?

A: In this scenario the patient was initially admitted for investigation of acute on chronic renal failure however the focus of the admission was the management of fluid overload. As per ACS 0002 *Additional diagnoses* – Problems and underlying conditions:

'If a problem with a known underlying cause is being treated, then both conditions should be coded (see also ACS 0001 *Principal diagnosis, Problems and underlying conditions*).'

Therefore in this case scenario a code has been assigned for fluid overload (E87.7) as it was documented that the condition did not improve after 10 days treatment.

Q8: If a patient with acute on chronic kidney disease is transferred to another hospital within 24–48 hrs of admission what code is assigned for the chronic component of the disease?

A: As per Coding Matters (FAQs) Vol 15, No 2, September 2008:

'In this scenario assign N18.9 *Chronic kidney disease, unspecified* for the chronic component of the disease as the eGFR will not be a true indicator of the underlying level of kidney function. However if 'end-stage' is documented or the patient is on ongoing haemodialysis or peritoneal dialysis then N18.5 *Chronic kidney disease, stage 5* would be assigned.'

Q9: When should Z91.1 *Personal history of noncompliance with medical treatment* be assigned?

A: ACS 0517 *Noncompliance with treatment* provides the following guidelines:

'Z91.1 *Personal history of noncompliance with medical treatment and regimen* should be used where noncompliance is a precipitating factor in an admission. It should not be used as a principal diagnosis.'

These guidelines were developed specifically for the coding of mental health episodes of care where noncompliance with medication commonly exacerbates the patient's condition, resulting in their admission to hospital. This code may also be assigned in other circumstances if it meets the criteria in ACS 0002 *Additional diagnoses*. ACS 0517 will be reviewed for a future edition.

Q10: Why wasn't the Hickman's line insertion coded in case scenario 6?

A: Insertion of the Hickman's catheter was not assigned in this case scenario as it was the route of administration for the haemodialysis. As per ACS 0042 *Procedures normally not coded*:

'These procedures are normally not coded because they are usually routine in nature, performed for most patients and/or can occur multiple times during an episode. Most importantly, the resources used to perform these procedures are often reflected in the diagnosis or in an associated procedure. That is, for a particular diagnosis or procedure there is a standard treatment which is unnecessary to code.'

Changes are being made to this area of the classification for Seventh Edition to provide specific guidance on the coding of IV lines and catheters.

See also advice in 10-AM Commandments – *Multiple coding of procedures*, published in Coding Matters Vol 16, No 2, September 2009.

Q11: What is the principal diagnosis if a patient is admitted with multiple microvascular complications of their diabetes?

A: Refer to ACS 0401 *Diabetes mellitus and impaired glucose regulation - Diabetes with multiple microvascular and other specified nonvascular complications.* The following coding principles can assist in code assignment:

- Only assign E1-.71 as the principal diagnosis when no one microvascular complication is the focus of the admission

- If, for example, the nephropathy complication is the focus of the admission assign as the principal diagnosis E1-.2- followed by the chapter specific code as appropriate. E1-.71 is then assigned as an additional diagnosis together with any other specific complication codes as appropriate to indicate the patient has multiple microvascular complications.

Q12: Could you please clarify the coding of excision of skin lesions in point 5 of ACS 0020 *Bilateral/multiple procedures?*

For example, if a patient is admitted for excision of a BCC on the forearm and a compound naevus on the breast and both are excised during the same visit to theatre, what code(s) would be assigned?

A: ACS 0020 *Bilateral/multiple procedures* has the following sections:

Bilateral procedures

1. Procedures with a bilateral code

2. Inherently bilateral procedures

3. Procedures with no code option for bilateral

Multiple procedures

1. The SAME PROCEDURE repeated during the episode of care at different visits to theatre

2. The SAME PROCEDURE repeated during a visit to theatre involving ONE ENTRY POINT/ APPROACH and similar/same lesions

3. The SAME PROCEDURE repeated during a visit to theatre involving ONE ENTRY POINT/ APPROACH and different lesions

4. The SAME PROCEDURE repeated during a visit to theatre involving MORE THAN ONE ENTRY POINT/APPROACH and more than one non-bilateral site

5. Skin or subcutaneous lesion removal

Point 5 - Skin or subcutaneous lesion removal - Assign the relevant code for excision of multiple lesions. In the scenario cited, two lesions have been removed from different sites, ACHI assigns the same code for these two sites therefore assign 31205-00 [1620] *Excision of lesion(s) of skin and subcutaneous tissue of other site* once only, as per the following index pathway:

Excision — see also *Removal*
- lesion(s) — see also *Excision, tumour* and *Excision, cyst* and *Excision, polyp*
- - skin and subcutaneous tissue
- - - specified site NEC 31205-00 [1620]
- - - - ankle 31235-04 [1620]
- - - - calf 31235-03 [1620]
- - - - cheek 31235-00 [1620]
- - - - ear 31230-02 [1620]
- - - - - wedge 45665-02 [1663]
- - - - eyelid 31230-00 [1620]
- - - - - wedge 45665-01 [1662]
- - - - finger 31230-04 [1620]
- - - foot 31235-04 [1620]
- - - - forehead 31235-00 [1620]
- - - - genitals 31230-05 [1620]
- - - - hand 31235-02 [1620]
- - - - head NEC 31235-00 [1620]
- - - - hip 31235-03 [1620]
- - - - knee 31235-03 [1620]
- - - - leg 31235-03 [1620]
- - - - lip (see also Excision, lesion(s), lip) 31230-03 [1620]
- - - - - wedge 45665-00 [1664]
- - - - neck 31235-01 [1620]
- - - - nose 31230-01 [1620]
- - - - penis 31230-05 [1620]
- - - - pre and postauricular region 31235-00 [1620]
- - - - scrotum 31230-05 [1620]
- - - - thigh 31235-03 [1620]
- - - - thumb 31230-04 [1620]
- - - - toe 31235-04 [1620]
- - - - vulva 31230-05 [1620]
- - - - wrist 31235-02 [1620]

The following examples can assist in code assignment:

- single or multiple forehead skin sites eg assign 31235-00 [1620] once only

- lesion(s) removed from hip, thigh and knee assign 31235-03 [1620] once only as ACHI provides the same code for these sites

- lesion(s) removed from hand and foot assign 31235-02 [1620] and 31235-04 [1620] as ACHI provides a separate code for each site.

Q13: In case scenario 7 why was the revision of the burns scar coded 8 times when the procedure was only performed on both the left and right leg, therefore shouldn't this procedure have only been coded twice?

A: As per ACS 0020 *Bilateral/multiple procedures* – Multiple procedures point 4 - the same procedure repeated during a visit to theatre involving more than one entry point/approach and more than one non-bilateral site.

'Assign a code for each procedure as there is a separate entry point/approach for each one.'

In this case a total of 8 revisions of the burn scars were performed, 6 on the right leg and 2 on the left with separate entry points for each, therefore a total of 8 procedures were performed. Laterality doesn't apply to skin as the skin is considered one organ therefore the reference to left and right leg is irrelevant and point 4 is followed.

Q14: What is the difference between:
O72.0 *Third-stage haemorrhage*
O72.2 *Delayed and secondary postpartum haemorrhage* and
O73.0 *Retained placenta without haemorrhage*
O73.1 *Retained portions of placenta and membranes, without haemorrhage?*

A: The difference between these two groups of codes is that the term 'without haemorrhage' has to be documented before assigning O73.0 or O73.1 as per the following index pathway where 'without haemorrhage' is an essential modifier:

Retention, retained
- placenta (total) (with haemorrhage) O72.0
- - without haemorrhage O73.0
- - portions or fragments (with haemorrhage) O72.2
- - - without haemorrhage O73.1

ICD-10-AM defaults to 'with haemorrhage' unless 'without' is clearly documented.

Q15: The term 'pre-existing' is used in the code titles for O99.02 *Anaemia complicating pregnancy, with mention of pre-existing anaemia* and O99.04 *Anaemia complicating childbirth and the puerperium, with mention of pre-existing anaemia*, what does the term 'pre-existing' mean?

A: In ICD-10-AM 'pre-existing anaemia' refers to an anaemia which exists prior to the current pregnancy. A note defining 'pre-existing anaemia' will be included in the Tabular List in a future edition.

Q16: Can Z35.51 *Supervision of primigravida with advanced maternal age* be assigned as an additional code in case scenario 8 where 'a 37 y.o. primigravida' was documented?

A: No, this code should not be assigned based on documentation of age alone. When only the age of the patient is documented (≥35 years) without any qualifying statements to indicate that the age of the patient has had an impact on the patient's care this code should not be assigned as per ACS 0002 *Additional diagnoses* and ACS 1524 *Advanced maternal age*.

Q17: Can a code from category O42 *Premature rupture of membranes* be assigned from the times documented on the partogram for when labour was established?

A: No, a code from this category should not be assigned based on documentation of the times for the establishment of labour alone. Therefore 'premature rupture of membranes' must be documented and must meet the criteria in either ACS 0001 *Principal diagnosis*, ACS 0002 *Additional diagnoses* or ACS 1531 *Premature rupture of membranes* before it can be coded.

Q18: In case scenario 9 a patient was admitted following a multi vehicle collision with suspected C6/7 paraplegia, test results revealed:

MRI – central cord contusion and defect at C6/7 CT (with contrast) – diffuse lesion at C6/7, no displacement of cord.

As central cord syndrome has not been documented should S14.10 *Injury of cervical spinal cord, unspecified* be assigned instead of S14.12 *Central cord syndrome (incomplete cord injury) of cervical spinal cord*?

A: Central cord syndrome (CCS) is an acute incomplete cervical spinal cord injury (SCI). This syndrome, usually the result of trauma, is associated with damage to the large nerve fibres that carry information directly from the cerebral cortex to the spinal cord. The segment of spinal cord affected by central cord syndrome is the cervical segment, the part of the spinal cord that is encased within the first seven vertebrae, running from the base of the brain and into the neck. The cord syndromes describe the area (almost cross sectionally) of the spinal cord that has been affected by the lesion (ie contusion/haemorrhage etc). A common cause of this type of injury includes trauma.

Any injury or condition that preferentially damages the central, grey matter of the cervical spinal cord can lead to central cord syndrome. The most common causes include complications of the progressive, degenerative spinal disease called spondylosis, as well as traumatic injury to the cervical spine, such as fractures or dislocations. The diagram below illustrates the location of the injury to the spinal cord.

Incomplete lesions of the spinal cord

Central Cord Syndrome

Anterior Cord Syndrome

Brown Séquard Syndrome

Central cord lesion/contusion/injury are all synonymous terms that describe a central cord syndrome and an MRI can show direct evidence of spinal cord impingement from bone, disc, or haematoma – therefore S14.12 is the most appropriate code to assign in this case. A central cord contusion can be assumed to be central cord syndrome as any injury of the central cord is effectively a central cord syndrome. The indexing of this condition will be reviewed for a future edition.

http://www.answers.com/topic/central-cord-syndrome
http://www.ninds.nih.gov/disorders/central_cord/central_cord.htm

http://www.healthline.com/galecontent/central-cord-syndrome

http://www.neurosurgerytoday.org/what/patient_e/central_cord_syndrome_06.asp

Q19: Does there need to be a causal link between jaundice and prematurity for P59.0 *Neonatal jaundice associated with preterm delivery* to be assigned?

A: No, the index indicates that the jaundice can be 'due to or associated with' preterm delivery.

Q20: Does sedation need to be coded with ventilation when it is administered?

A: As per ACS 0031 *Anaesthesia*, a code is assigned for any form of anaesthetic except local anaesthesia and oral sedation, when administered for anaesthetic purposes to perform a procedure ie for intubation/ventilation.

Q21: In clinical record 2 the acute renal failure was documented as being due to dehydration and medications. Should N17.8 *Other acute kidney failure* be assigned?

A: There is a 'specified NEC' pathway in the index under *Failure, kidney, acute*. However, when checking the Tabular List we can see that the axis at the fourth character level specifies the type and site of necrosis rather than specifying the cause of the renal failure. The appropriate code to assign in this case is, therefore, N17.9 *Acute kidney failure, unspecified*.

Q22: Should patient controlled analgesia (PCAs) be coded as per the hierarchy in ACS 0031 *Anaesthesia – Classification point 5*?

A: Codes for PCAs in Fifth Edition were only assigned if 'data was required at the local hospital level'. This entry was removed from ACS 0031 in Sixth Edition to reinforce coding consistency at a national level. However no changes were made to the hierarchy of codes in the ACS:

[1912] *Postprocedural analgesia*

i.   Management of neuraxial block (92516-00)

ii. Management of regional block (codes 92517-00, 92517-01, 92517-02, 92517-03)

iii. Subcutaneous postprocedural analgesic infusion (90030-00)

iv. Intravenous postprocedural infusion, patient controlled analgesia (PCA) (92518-00)

v.   Intravenous postprocedural analgesic infusion (92518-01)

Subcutaneous and intravenous postprocedural analgesic infusions should not be coded and ACS 0031 will be amended in Seventh Edition to reflect this advice with points iii–v being deleted in the above hierarchy of codes.

Q23: Why was bradycardia in clinical record 5 coded as a procedural complication and assigned a misadventure code for the external cause?

A: In this record bradycardia was coded as a procedural complication following clinical advice which indicated that bradycardia was related to the procedure being performed:

'During an endoscopy a patient can become "vagal" due to the stimulation of the bowel, this produces bradycardia which sometimes may need to be treated with a vagal blocker like atropine. This is considered an effect of having the procedure and therefore can be caused by the endoscopy.'

Therefore, as per ACS 1904 *Procedural complications*, bradycardia meets the definition of a procedural complication:

A condition or injury which is directly related to a surgical/procedural intervention.

Although the bradycardia is not documented as being 'due to' the procedure it was 'related' to the procedure as per the definition above. There is documentation on the discharge summary that the patient developed bradycardia intraoperatively and the operation report indicated that the procedure was 'limited' because of this condition.

Once this definition is met follow the classification guidelines for the coding of a symptom:

Symptoms which meet the criteria of procedural complications
When a procedural complication is a symptom classifiable to Chapter 18 *Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified*, assign an appropriate chapter specific 'postprocedural disorder' code, followed by the code for the symptom and the appropriate external cause codes.

and assign:

I97.8   *Other postprocedural disorders of the circulatory system, not elsewhere classified*

R00.1   *Bradycardia, unspecified*

As bradycardia occurred intraoperatively it meets the criteria for a misadventure as per the following definition in ACS 1904:

'Misadventure

A misadventure is defined as a complication occurring during medical or surgical care. It may be noted at the time of the procedure or after completion of the procedure.

From the documentation we know the complication occurred intraoperatively and the external cause code then identifies the timing of the complication. Assign Y65.8 *Other specified misadventures during surgical and medical care* as per the following classification guidelines:

Misadventure

A code from block Y60–Y69 *Misadventures to patients during surgical and medical care* should be assigned when the complication occurs during a procedure.

Refer to the main term of 'Misadventure' in the ICD-10-AM Index to External Causes of Injury, and then by the type of misadventure.'

Improvements to the Alphabetic Index are being considered for a future edition.

Q24: In clinical record 5 why was diverticulosis assigned as the principal diagnosis given the patient was being admitted for investigation of anaemia and melaena as per ACS 0046 *Diagnosis selection for same-day endoscopy*?

A: In this case a discharge summary was completed by the clinician which indicated the principal diagnosis was sigmoid diverticulosis. The intent of ACS 0046 is to provide guidelines to coders for the coding of same-day cases where a number of conditions may meet the definition of principal diagnosis and no guidance is provided by the clinician. However, this case provides a discharge summary which clearly indicates the principal diagnosis.

Additional codes were assigned for the anaemia and melaena (refer to ACS 1102 *Gastrointestinal (GI) haemorrhage*) and as the contact bleeding (transverse colon) occurred at a different site to the diverticulosis (sigmoid colon) no link has been made between these two conditions.

**Q25:** Why was a short colonoscopy coded in clinical record 5?

A: The operation report in this record indicated that the colonoscopy was only able to be passed to the transverse colon, therefore 32084-00 [905] *Fibreoptic colonoscopy to hepatic flexure* is the correct code to assign. A long colonoscopy goes beyond the hepatic flexure as per the index pathway in ACHI:

Colonoscopy (beyond hepatic flexure) (fibreoptic) (long) (to caecum) 32090-00 [905]

…

\- to hepatic flexure (short) 32084-00 [905]

The following diagram illustrates the anatomy of the colon and where a short and long colonoscopy passes to:

Anatomy of the colon
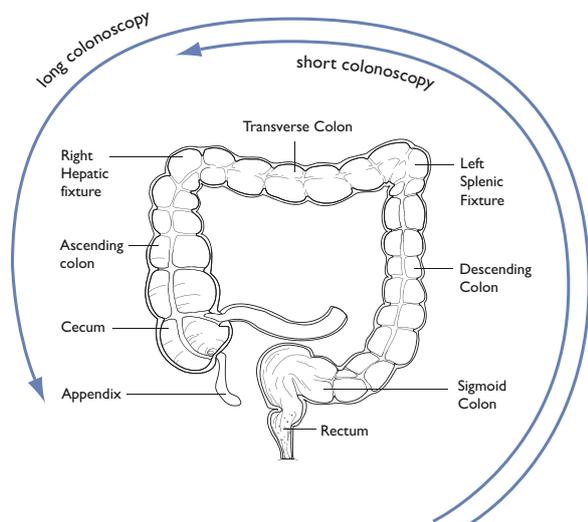
Q26: Why was Z06.99 *Agent resistant to other single specified antibiotic* assigned in clinical record 6?

A: There was documentation on the discharge summary and in the progress notes that the *E. coli* (found on MSU) was resistant to Keflex. ACS 0112 *Infection with drug resistant microorganisms* indicates that:

'If the clinician has documented in the record that the organism causing the infection is resistant to an antibiotic, then the appropriate code from Z06.- *Bacterial agents resistant to antibiotics* must also be assigned.

A code from category Z06.- *Bacterial agents resistant to antibiotics* is assigned as an additional code to identify the antibiotic to which a bacterial agent is resistant.'

It should be noted that a code from this category should not be assigned based on microbiology sensitivity results alone.

Q27: Why was I25.9 *Chronic ischaemic heart disease, unspecified* assigned in clinical record 6, wouldn't I25.2 *Old myocardial infarction* be more specific?

A: In this record IHD was noted on the discharge summary as one of the associated conditions for the episode of care. During the admission an echocardiogram was performed and the indication for this intervention was IHD, therefore this condition meets ACS 0002 for code assignment.

ACS 0940 *Ischaemic heart disease* provides guidelines on the assignment of I25.9. As this record does not provide any additional information in the current episode of care and there is no access to previous admission notes which could indicate the specificity of the IHD (ie coronary atherosclerosis I25.1-), I25.9 is assigned.

I25.2 *Old myocardial infarction* would not be assigned as the condition does not meet the classification guidelines in ACS 0940:

I25.2 *Old myocardial infarction* is essentially a 'history of' code, even though it is not included in the Z code chapter. It should be assigned as an additional code only if all of the following criteria apply:

- the 'old' myocardial infarction occurred more than four weeks (28 days) ago;

- the patient is currently not receiving care (observation, evaluation or treatment) for their 'old' myocardial infarction; and

- the 'old' myocardial infarction meets the criteria in ACS 2112 *Personal history*.

CONFERENCES 2009/10

Oct 1-4	GP'09 — The conference for general practice	Perth, WA	www.gpconference.com.au/
Oct 7-9	AHHA 2009, AHHA and Australian Institute of Health Policy Studies	Hobart, TAS	http://healthpolicystudies.org.au/
Oct 11-13	Australian Private Hospitals Association (APHA) National Congress	Melbourne, VIC	www.apha.org.au/media_files/2378040505.html
Oct 12	2nd IFHRO SEAR Conference	Perth, WA	www.himaa.org.au/
Oct 14-16	HIMAA National Conference	Perth, WA	www.himaa.org.au/
Oct 20-23	Australian Association of Practice Managers (AAPM) National Conference The edge of practice management.	Melbourne, VIC	www.cdesign.com.au/aapm2009/
Oct 28-29	Software and Systems Quality Conference	Melbourne, VIC	www.sqs-conferences.com/au/index.htm
Oct 30	4th Annual NSW Health Expo	Sydney, NSW	www.awards-expo.health.nsw.gov.au/expo
Nov 2-3	1st Australian Rural & Remote Mental Health Symposium	Canberra	www.anzmh.asn.au/rmha9/
Nov 4-7	AGPN Forum, General Practice Network	Sydney. NSW	www.gpnetworkforum.com.au/site/index.cfm
Nov 10-12	Australian Health Insurance Association (AHIA) National Conference	Melbourne, VIC	www.ahia.org.au/events.php
Nov 14-18	American Medical Informatics Association (AMIA) Annual Symposium	San Francisco, USA	http://symposium2009.amia.org/
Nov 16-17	Australia's welfare 2009 conference	Canberra, ACT	www.aihw.gov.au/
Nov 25-27	2009 Health Services and Policy Research Conference	Brisbane, QLD	www.healthservicesconference.com.au/
Dec 2-3	Australasian Mortality Data Interest Group (AMDIG) 6th Understanding Mortality Data Workshop	Wellington, NZ	http://nis-web.fhs.usyd.edu.au/ncch_new/ AMDIG2009.aspx
2010			
Jan 18-21	Australasian Workshop on Health Informatics and Knowledge Management	Brisbane, QLD	www.himaa.org.au/Pubs/HIKM_2010_CFP.pdf
Jan 25-28	Arab Health 2010	Dubai	www.arabhealthonline.com
May 26-28	HIMSS AsiaPac10 Exposition	Beijing	www.himssasiapac.org/expo10/

Conference information is also published at the NCCH website www.fhs.usyd.edu.au/ncch

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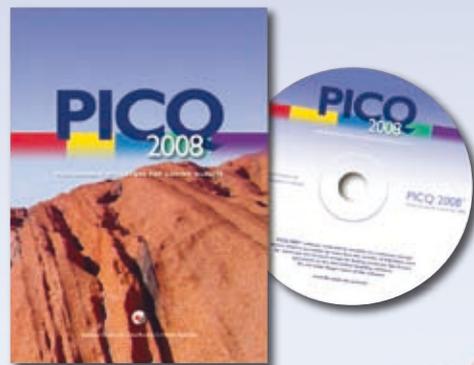
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