

The 10-AM Commandments

Adhesions

Should adhesions be coded in the following scenarios?

a. Adhesions noted at surgery but not divided as they pose a surgical risk.

Example: Dense adhesions of bowel to bladder at commencement of total abdominal hysterectomy (TAH). Adhesions not divided due to risk of bladder perforation. TAH performed.

b. Adhesions are noted at surgery and the nature of the surgery is changed or cancelled as a result of the presence of adhesions.

Example: Dense adhesions of bowel. Bowel resection is unable to be performed due to risk of perforation. Procedure abandoned.

a. Adhesions in this scenario do not appear to meet ACS 0002 *Additional diagnoses* as they do not alter therapeutic treatment, do not require any diagnostic procedure and do not require any increased clinical care or monitoring. There is a specialty standard related to adhesions. However, following the guidelines in ACS 0047 *Adhesions*, there is still no requirement to assign a code for adhesions.

b. Adhesions in this scenario do appear to meet ACS 0002, i.e. 'adjustment of therapeutic treatment'. ACS 0047 does not give further specification as to whether or not adhesions should be coded in this scenario. Therefore, assign a code for adhesions.

Anticoagulant monitoring

Could you clarify if atrial fibrillation (AF) meets ACS 0002 *Additional diagnoses* in the following scenario?

A patient taking an anticoagulant for AF is admitted one day prior to surgery for monitoring of the anticoagulant. Surgery is performed and the patient's stay is extended by a day while the anticoagulant is adjusted. AF remains stable throughout the admission. Should AF be coded given that it is the reason that the patient was receiving the anticoagulant?

When determining code assignment for a patient who is admitted pre or post surgery for monitoring of their anticoagulant, the coder should first determine the reason for the monitoring and/or adjustment of the anticoagulant.

In the scenario cited, AF does not appear to meet ACS 0002 *Additional diagnoses*. Adjustment of anticoagulant pre and post surgery is usually related to the monitoring of INR levels and ensuring they are maintained within an appropriate range.

ACS 0303 *Abnormal coagulation profile due to anticoagulants* provides classification advice when patients are admitted prior to surgery or their stay is extended post surgery for monitoring of their anticoagulant:

"Patients using anticoagulant agents often require admission to hospital (or may have their hospital stay prolonged):

- pre or postoperatively to monitor anticoagulant (warfarin, heparin, clexane or fragmin) levels
- when anticoagulant levels are not controlling a condition
- if anticoagulant levels require adjustment

In these cases, assign Z92.1 *Personal history of long term (current) use of anticoagulants* as an additional code."

Administration of Haemacel®

Should a code be assigned for infusion of Haemacel®?

Haemacel® is a plasma substitute, administered to treat or prevent hypovolaemic shock caused by plasma/blood volume deficiency due to conditions such as haemorrhage or burns. Haemacel® is a gelatin solution derived from cows, but is not a blood product.

Although the code for infusion/transfusion of Haemacel® is located in block [1893] *Administration of blood and blood products*, the guidelines in ACS 0302 *Blood transfusions* should not be followed for this procedure, as it is not a blood product.

Therefore, it is unnecessary to assign a code for administration of Haemacel® (or similar plasma volume expander) when documented in the clinical record, except for neonates where the guidelines in ACS 1615 *Specific interventions for the sick neonate* should be followed.



Admission for overnight video EEG

Should a procedure code be assigned for a patient admitted specifically for overnight video EEG when this is the reason for their admission?

The classification provides the following guidance in relation to video EEG monitoring:

ACHI Tabular List

"92011-00 [1825] *Video and radio-telemetered electroencephalographic [EEG] monitoring*

Note: Only to be assigned for monitoring ≥ 24 hours"

ACS

ACS 0042 *Procedures normally not coded*, Sixth Edition also states:

"These procedures should be coded if they are the principal reason for admission in same-day episodes of care."

While ACS 0042 *Procedures normally not coded*, Seventh Edition states:

"These procedures should be coded if they are the principal reason for admission in same-day episodes of care. This includes patients who are admitted the day before or discharged on the day after a procedure because a same-day admission is not possible or practicable for them (eg elderly patients, those who live in remote locations)."

For video EEG monitoring these statements are further qualified in point 11 of ACS 0042 in Sixth Edition and point 14 of ACS 0042 in Seventh Edition:

"...Monitoring: cardiac, electroencephalography (EEG), vascular pressure except radiographic/video EEG monitoring ≥ 24 hours"

Therefore, follow the above guidelines in the ACHI Tabular List and ACS 0042 *Procedures normally not coded* and only code video EEG if it is performed ≥ 24 hours.

Aspiration thrombectomy of the coronary artery

What is the correct code assignment for aspiration thrombectomy of the coronary artery?

Aspiration thrombectomy of the coronary artery is increasingly being used as adjunctive therapy in primary percutaneous coronary intervention (PCI) in patients with anterior ST elevation myocardial infarction (STEMI). The technique uses an aspiration catheter with two lumens, one lumen for passage of the catheter over a coronary wire and a second lumen for manual aspiration of thrombus and atheromatous debris. It has been shown to improve myocardial perfusion and improve clinical outcomes of STEMI patients undergoing PCI.

ACHI does not contain a specific code for aspiration thrombectomy of the coronary artery. Clinical advice disagreed with the assignment of 38312-01 [669] *Percutaneous transluminal coronary rotational atherectomy* for this procedure. It is also incorrect to assign a code from block [702] *Arterial embolectomy or thrombectomy* as there is an excludes note on page 106 of the ACHI Tabular List, under the heading ARTERIES which states:

"**Excludes:** coronary arteries (see blocks [667] to [681])"

The above excludes note indicates that procedures on coronary arteries are restricted to blocks [667] to [681] in Chapter 8 *Procedures on cardiovascular system*

Therefore, the NCCH advises that 38456-19 [681] *Other intrathoracic procedures on arteries of heart without cardiopulmonary bypass* should be assigned for this new procedure, following the index pathway:

Procedure

- artery NEC
- - heart (intrathoracic) (without cardiopulmonary bypass) NEC 38456-19 [681]

This new procedure has been flagged for review for a future edition of ACHI.

Bladder neck obstruction (BNO)

ACS 1420 *Bladder Neck Incision for Benign Prostatic Hypertrophy* states "Bladder neck obstruction can be assumed to be due to prostatic hypertrophy unless another condition is stated as the cause." Does this mean if coding a male with BNO without mention of benign prostatic hypertrophy (BPH), that it can be assumed that the patient has BPH? Or can BNO be assigned alone without mention of BPH?

The guidelines in ACS 1420 *Bladder Neck Incision for Benign Prostatic Hypertrophy* concerning bladder neck obstruction relates to documentation of bladder neck obstructions where there is also a diagnosis of benign prostatic hypertrophy.

The sentence which states - "Bladder neck obstruction can be assumed to be due to prostatic hypertrophy unless another condition is stated as the cause"- should be read in context with the rest of the ACS. It does NOT indicate that documentation of bladder neck obstruction alone should be assumed to be due to prostatic hypertrophy when no underlying cause is documented.

Candida urinary tract infection (UTI)

What is the correct code assignment for a UTI with a Candida positive mid stream urine (MSU)?

The finding of *Candida* in urine is mostly insignificant and occurs as a result of contamination or asymptomatic colonisation. It is often associated with the use of urinary catheters or antimicrobial therapy and many cases resolve spontaneously. If there is documentation of *Candiduria* or a *Candidal* UTI that meets the criteria for code assignment

as per ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*, the correct code to assign is B37.4 *Candidiasis of other urogenital sites* following the index pathway:

Infection

- *Candida (albicans) (tropicalis)* (see also *Candidiasis*)

Candidiasis, candidal

- urogenital site NEC B37.4

Cellulitis with superficial injuries

ACS 1210 *Cellulitis* directs coders to sequence the wound code first where there is documentation of cellulitis associated with an open wound. Does this logic apply to superficial injuries, for example, a patient admitted with an abrasion and cellulitis?

Cellulitis is diffuse inflammation of connective tissue with severe inflammation of dermal and epidermal layers of the skin. It is caused by bacteria entering the skin and may result from insect bites, blistering, animal bites, tattoos etc. ACS 1210 *Cellulitis* only applies to cellulitis with open wounds.

When coding cellulitis with superficial injuries apply the principles in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses* to determine code assignment and sequence.

This note has been flagged for review in a future edition of ICD-10-AM.

Condition onset flag for conditions occurring while patient on leave

What is the correct condition onset flag to assign for a condition that arises while the patient is on leave, that is, outside the hospital? For example, injuries due to self harm or from a car accident whilst the patient is on leave.

ACS 0048 *Condition onset flag* states:

“The condition onset flag is a means of differentiating those conditions which arise during, or arose before, an admitted patient episode of care.”

The admitted episode of care includes the period when a patient is on leave, therefore any conditions that arise during that time (even though outside the hospital) should have a condition onset flag of ‘I’ assigned.

Crush and compression fractures

Could you provide guidance for coding crush and compression fractures where there is no mention of trauma or ‘pathological’ (particularly in elderly people with osteoporosis)?

Could advice also take into consideration how this should be coded where there is an apparently minor trauma? For instance when a patient has turned over in bed and is consequently admitted with back pain. An x-ray taken on admission shows an old fracture. There is no other

diagnosis such as strain or sprain provided and the pain is likely attributable to the old fracture.

Both crush and compression fractures, without further specification, should be coded to *Fracture*, by site. At the lead term fracture in the ICD-10-AM Alphabetic Index the term ‘compression’ is a nonessential modifier while the term ‘crush’ is not listed as either an essential or nonessential modifier.

If there is no external cause of injury documented in the clinical record, and clarification is unable to be obtained from the clinician, assign X59 *Exposure to unspecified factor* as the external cause of injury code, following the pathway:

Fracture (circumstances unknown or unspecified) X59

To assign a pathological fracture code, the fracture must be either documented as ‘pathological’ or described as being ‘due to a condition.’ If in doubt, code assignment should be confirmed with the clinician.

Osteoporosis causes severe weakening of the bones and can cause fractures, particularly lumbar fractures. If a fracture is documented as being associated with osteoporosis, then assign the appropriate code from category M80 *Osteoporosis with pathological fracture*.

Paragraph 2 of this query cites a scenario where a patient is admitted with back pain following minor trauma (turning over in bed). X-ray reveals an old fracture but there is no other diagnosis of injury, can the pain be attributable to the old fracture?

This scenario highlights a documentation issue, rather than a coding query and code assignment in this instance should be verified with the clinician. A coder should not assume that pain is due to an old fracture without supporting documentation or confirmation from the clinician.

Cystic fibrosis

When a patient is admitted with cystic fibrosis (CF) and has manifestations, how should they be coded in the following scenarios?

Scenario A: Patient admitted for surgery for nasal polyps (where nasal polyps are documented as a manifestation of CF). The patient also has bronchiectasis and pancreatic insufficiency due to CF.

Do the manifestations of bronchiectasis and pancreatic insufficiency have to meet ACS 0002 *Additional diagnoses* to be coded? Which E84.- code should be assigned?

Scenario B: ACS 0402 *Cystic Fibrosis* states:

“Cystic fibrosis should be coded with the appropriate code from E84.- *Cystic fibrosis* followed by a code for any specified manifestation. Note that E84.8 *Cystic fibrosis with other manifestations* includes cases with combined manifestations.

Example 1:

Patient admitted for reduction of fractured shaft of tibia following fall from ladder. Patient also treated for bronchiectasis associated with cystic fibrosis.

Codes: S82.28 Other fracture of shaft of tibia
W11 Fall on and from ladder
An appropriate place of occurrence code (Y92.-) and activity code (U50-U73)
E84.0 Cystic fibrosis with pulmonary manifestations
J47 Bronchiectasis

If the patient mentioned in Example 1 above did not have treatment for their CF and/or the manifestation(s) then code(s) would not be assigned for CF.” Is this correct?

Scenario C: If the same patient mentioned in Example 1 above also had pancreatic insufficiency but only the bronchiectasis was treated in this episode, what codes should be assigned apart from the injury codes?

Also, do all CF manifestations have to meet ACS 0002 before they can be considered for coding and subsequent allocation of E84.-? Or should only those manifestations that meet ACS 0002 themselves be coded?

Lastly, does there have to be documentation in the clinical record linking the manifestation to the CF? Sometimes the clinical record does not document the link although medical literature refers to linkage between CF and its manifestations. Can the link be assumed in order to assign E84.-?

When determining whether cystic fibrosis or its manifestations should be coded, refer to the guidelines in ACS 0001 and ACS 0002, as well as the guidelines specified in ACS 0402 *Cystic fibrosis*.

In the first scenario nasal polyps meet the criteria for code assignment as per ACS 0001 *Principal diagnosis*, and then ACS 0402 specifically states:

“Cystic fibrosis should be coded with the appropriate code from E84.- Cystic fibrosis... followed by a code for any specified manifestation. Note that E84.8 *Cystic fibrosis with other manifestation* includes cases with combined manifestations.”

Therefore, in scenario A assign the following codes:

E84.8 Cystic fibrosis with other specified manifestations
J33.9 Nasal polyp, unspecified
J47 Bronchiectasis
K86.8 Other specified diseases of pancreas

In scenario B, if cystic fibrosis or its manifestations does not meet the criteria for code assignment as per the guidelines in ACS 0001 or ACS 0002, there is no requirement to code these conditions. ACS 0402 provides guidance on how cystic fibrosis should be coded, rather than whether or not it should be coded in the first instance.

In relation to scenario C, if cystic fibrosis meets ACS 0001 or ACS 0002, then following the guidelines in ACS 0402 (see above), the following codes should be assigned in addition to the injury codes:

E84.8 Cystic fibrosis with other specified manifestations
J47 Bronchiectasis
K86.8 Other specified diseases of pancreas

In answer to the last two questions:

When cystic fibrosis meets the criteria for code assignment as per ACS 0001 or ACS 0002 all manifestations should be coded (regardless of whether they meet ACS 0002) as per the guidelines in ACS 0402.

There must be documentation in the clinical record that states a problem is a manifestation of CF in order for it to be coded as one. If there is uncertainty as to whether a condition is a manifestation of CF, then code assignment should be verified with the clinician.

Diabetes with renal failure, unspecified

Previous advice issued by the NCCH indicated that diabetes with unspecified renal failure should be coded to diabetes with chronic renal failure:

“Coders should, where possible, confirm with the treating clinician whether the renal failure is acute or chronic. When documentation is insufficient and further clinical advice cannot be obtained, assign: E1-.23 **diabetes mellitus with advanced renal disease* and N18.90 *Unspecified chronic renal failure*.”

Given that this advice suggests unspecified chronic renal failure can be assigned to chronic renal failure can coders further specify the stage of chronic renal failure by consulting the eGFR result?

The advice quoted above is related to ICD-10-AM Fourth Edition and is no longer current given the changes made to ACS 1438 *Chronic kidney disease* in ICD-10-AM Sixth Edition.

This is a documentation issue rather than a coding issue. The coder should verify with the clinician whether the kidney failure is acute or chronic to be able to assign either E1-.29 *...diabetes mellitus with other specified kidney complication*, E1-.22 *...diabetes mellitus with established diabetic nephropathy* or E1-.21 *...diabetes mellitus with incipient diabetic nephropathy*. Once this is determined then follow the ‘use additional code’ note to identify the presence of chronic kidney disease (N18.-) as applicable.

The advice in ACS 1438 is related to the documentation of CKD (or chronic renal failure). The eGFR can then be used to determine the stage of the CKD for the assignment of the correct N18.- *Chronic kidney disease*... code. It should not be used to determine acute kidney failure versus chronic kidney failure but rather to establish the stage of CKD where CKD (or chronic renal failure) has already been documented.

Duodenal switch

What is the correct code assignment for a duodenal switch procedure?

The duodenal switch (DS) procedure is a modified biliopancreatic diversion, sometimes known as a biliopancreatic diversion with duodenal switch (BPD-DS).

Biliopancreatic diversion, or bypass procedures, are principally malabsorptive procedures, but may include an element of restrictive surgery to reduce the size of the stomach.

Both the unmodified biliopancreatic diversion and the BPD-DS include a partial gastrectomy.

In the unmodified biliopancreatic diversion, a distal gastrectomy is performed, while in the BPD-DS a 'sleeve' gastrectomy is performed along the vertical axis of the stomach, preserving the pylorus and initial segment of the duodenum, which is then anastomosed to a segment of the ileum.

The 'sleeve' gastrectomy keeps the pyloric valve intact and eliminates the possibility of dumping syndrome, marginal ulcers, stoma closures and blockages, all of which can occur with other bypass/diversion procedures.

In addition, it keeps a portion of the duodenum in the food stream. The preservation of the pylorus/duodenum pathway means that food is digested normally in the stomach before being excreted by the pylorus into the small intestine. As a result, the DS procedure enables more 'normal' absorption of many nutrients than is seen after other bypass/diversion procedures.

However, the basic principle of the DS procedure is the same as the unmodified biliopancreatic diversion i.e. producing selective malabsorption by limiting the food digestion and absorption to a short common ileal segment.

Therefore, the correct procedure code to assign for the DS procedure is 30512-02 [889] *Biliopancreatic diversion* or 30512-01 [889] *Laparoscopic biliopancreatic diversion* as appropriate, following the index pathway:

Biliopancreatic diversion (open) 30512-02 [889]
- laparoscopic 30512-01 [889]

In addition, assign 30511-01 [889] *Laparoscopic gastric reduction* or 30511-00 [889] *Gastric reduction* as appropriate, to specify the gastrectomy (restrictive component of the procedure), following the index pathway:

Reduction

- gastric (for morbid obesity) 30511-00 [889]
- - laparoscopic 30511-01 [889]

This has been flagged for review in a future edition of ACHI.

Endoluminal repair of an aortic dissection

What is the correct code for an endoluminal repair of a descending aortic dissection (type B), without mention of aneurysmal involvement?

An aortic dissection occurs when a section of the aorta weakens and tears, or is damaged. Weakening of the aorta occurs as a result of ageing, high blood pressure, or other changes. Tearing of the inner layers of the vessel walls allows blood to flow into the middle layer of the aorta, separating the inner and outer layers. This tearing is called a dissection. An aortic dissection may also involve abnormal widening or ballooning of the aorta (aneurysm).

When the dissection occurs in the part of the aorta that runs through the chest, it is called a thoracic aortic dissection.

There are two types of thoracic aortic dissection - Type A dissection and Type B dissection. Type A dissection occurs in the ascending thoracic aorta. This type of dissection often requires surgery.

Type B dissection involves the descending thoracic aorta. This type of dissection has traditionally been managed with medication and more recently by surgical intervention.

The correct code to assign for stenting of a type A or type B dissection of the aorta is 33116-00 [762] *Endovascular repair of aneurysm* following the index pathway:

Insertion

- stent
- - artery
- - - aorta (transluminal)
- - - - for endovascular repair of aneurysm (AAA stent) (endoluminal) 33116-00 [762]

In ICD-10 and ICD-10-AM aortic aneurysm and aortic dissection are classified in the same category (I71 *Aortic aneurysm and dissection*) and in ACHI the same procedure (endoluminal repair) is performed to treat these conditions. However, the ACHI Alphabetic Index and code title for this procedure inaccurately specifies only the aneurysm and not the dissection. This has been flagged for review for a future edition of ICD-10-AM.

Food poisoning

What is the correct code assignment for gastroenteritis due to food poisoning? Is a 'T' code always required?

The correct code to assign for gastroenteritis due to food poisoning is A05.9 *Bacterial food-borne intoxication, unspecified* following the index pathway:

Gastroenteritis

- due to
- - food poisoning (see also Intoxication, food-borne) A05.9

Category A05 *Other bacterial food-borne intoxications, not elsewhere classified* has an excludes note for 'toxic effect

of noxious foodstuffs (T61–T62)', which classify the toxic effect of noxious substances eaten as food. However, gastroenteritis due to food poisoning is usually the result of bacterial food-borne intoxication rather than a noxious substance eaten as food; and therefore it is unnecessary to assign a code from categories T61–T62.

A code from categories T61–T62 can be assigned for food poisoning where there is no documentation of localised effect of poisoning (eg gastroenteritis) or the bacterial agent causing the toxic effect.

Therefore, where there is documentation of food poisoning, without further specification, assign T62.9 *Noxious substance eaten as food, unspecified* by following the index pathway:

Poisoning (acute) (see also *Table of drugs and chemicals*)
- food (acute) (diseased) (infected) NEC T62.9

Hepatitis C cirrhosis

What is the correct code assignment for hepatitis C cirrhosis? ACS 0104 *Viral hepatitis* is confusing in that it refers to symptoms of hepatitis C, rather than manifestations of hepatitis C and cirrhosis is a manifestation rather than a symptom of hepatitis C.

ACS 0104 *Viral hepatitis* states:

"Chronic viral hepatitis is a variable progressive disease that ultimately results in cirrhosis and hepatic failure."

The NCCH agrees that cirrhosis of the liver is a manifestation of chronic viral hepatitis and that a patient documented as having *hepatitis C cirrhosis* should be assigned the following codes:

B18.2 *Chronic viral hepatitis C*
K74.6 *Other and unspecified cirrhosis of liver*

Improvements to ACS 0104 *Viral hepatitis* have been flagged for review for a future edition of the Australian Coding Standards.

Hypertensive kidney disease with chronic kidney disease (CKD) stage 5 and anaemia

What is the correct code assignment for hypertensive kidney disease with CKD stage 5 and anaemia?

Following the aetiology and manifestation (dagger and asterisk) convention (see ACS 0027 *Multiple coding*), codes in category D63 *Anaemia in chronic diseases classified elsewhere* can only be assigned in the sequence in which they appear in the ICD-10-AM Alphabetic Index, that is, the aetiology followed by the manifestation code.

Therefore, D63.8* *Anaemia in other chronic diseases classified elsewhere* can only be assigned in conjunction with N18.3–N18.5 as per ICD-10-AM Alphabetic Index:

Anaemia

- in
- - chronic kidney disease
- - - stage 3 N18.3† D63.8*
- - - stage 4 N18.4† D63.8*
- - - stage 5 N18.5† D63.8*
- - - unspecified N18.9† D63.8*

Following this convention, D63.8* *Anaemia in other chronic diseases classified elsewhere* cannot be assigned in conjunction with I12.0 *Hypertensive kidney disease with kidney failure*.

For the scenario cited, where a patient is admitted with hypertensive kidney disease with CKD stage 5 and anaemia, assign the following codes:

I12.0 *Hypertensive kidney disease with kidney failure*
D64.9 *Anaemia, unspecified*

This issue has been resolved in ICD-10-AM Seventh Edition with the deletion of D63.8* in category D63 *Anaemia in chronic diseases classified elsewhere*.

Intrathecal pump refill

What is the correct code assignment for intrathecal pump refill (including when the refill is for pain management)?

The correct procedure code to assign for refilling of an intrathecal pump is 96209-XX [1920] *Loading of drug delivery device...*, following the index pathway:

Loading, drug delivery device (CADD) (external infusion pump) 96209 [1920]

To assign the principal diagnosis code (including when the refill is for pain management), follow the index pathway:

Admission

- adjustment (of)
- - device (related to) NEC
- - - drug delivery or pump (CADD) (external) (implantable spinal) Z45.1

The following advice was provided in I0-AM Commandments Vol 15 No 1:

"Where patients are admitted for adjustment, management, fitting or removal of a drug delivery device, (except for loading of a drug delivery device for same-day admission of chemotherapy to treat a neoplasm...) assign:

Z45.1 *Adjustment and management of drug delivery device*"

Lexapro®

What are the correct codes to assign for poisoning or adverse effect following ingestion of Lexapro®?

Lexapro® (escitalopram oxalate) belongs to a group of medicines called selective serotonin reuptake inhibitors (SSRIs) and is used to treat depression.

The correct code to assign for poisoning following ingestion of Lexapro® is T43.2 *Other and unspecified antidepressants* or Y49.2 *Other and unspecified antidepressants for adverse effect following ingestion of this drug*, by following Antidepressant NEC in the Table of Drugs and Chemicals.

See also ACS 1901 *Poisoning* and ACS 1902 *Adverse effects*.

Multiple trauma

When a patient is admitted with multiple trauma should all of the injuries be coded or only those that meet ACS 0001 or ACS 0002 (or other specialty standards)? For example, patient admitted with fractured ankle, punctured lung and contusions to the head and arm. Contusions to the head and arm don't meet ACS 0002 i.e. no treatment, observation etc. Should they be coded?

The NCCH advises that when coding multiple trauma admissions, coders should code out all injuries, including contusions and abrasions, documented as part of the totality of multiple trauma.

Clinical advice recommended continuation of the practice to code abrasions and contusions in a multiple trauma as they are not always trivial injuries and may be significant in their own right; such as abrasions a motor cycle rider suffers in an accident when not wearing protective clothing.

This advice applies to the initial presentation for multiple trauma and not to subsequent admissions where the injuries would need to meet the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*.

The only exception to this rule is in ACS 1916 *Superficial injuries* which states:

"Superficial injuries, such as abrasions or contusions, are not coded when associated with more severe injuries of the same site."

Newborn conditions

In what circumstances should conditions noted on the examination of a newborn be coded?

ACS 0002 *Additional diagnoses* states:

"Abnormalities noted on examination of the newborn"

A code should be assigned for these conditions only when they meet the criteria outlined in this standard."

This statement is included to ensure that only significant neonatal conditions are coded.

Coders should be guided by the documentation in the clinical record to determine if a neonatal condition meets the criteria for code assignment as per ACS 0002.

If a condition is significant enough to warrant review/evaluation by a clinician or referral for an external opinion then it has met the criteria for 'increased clinical care and/or monitoring' and coders should assign a code for the condition.

The guidelines in ACS 0002 regarding 'abnormalities noted on the examination of newborns' are to steer coders away from assigning codes for conditions which are mentioned on the newborn examination only, but do not require any further treatment, diagnostic procedure or increased clinical care/monitoring.

Note 4 in the Neoplasm Table of the ICD-10-AM Alphabetic Index

Note 4 in the Neoplasm Table of the ICD-10-AM Alphabetic Index, states "Carcinomas and adenocarcinomas, of any type other than intraosseous or odontogenic, of sites marked with the sign [\leftrightarrow] (eg ischium [\leftrightarrow]) should be considered as metastatic from an unspecified primary site and coded to C79.5." There appears to be an inconsistency in some sites of the Neoplasm Table, for example:

Neoplasm, neoplastic

- bone (periosteum) \leftrightarrow (the symbol is included)

- - mandible

but at

Neoplasm, neoplastic

- mandible (there is no symbol)

and yet at

Neoplasm, neoplastic

- mastoid (air cell) (antrum) (cavity)

- - bone or process \leftrightarrow (there is an essential modifier for bone under mastoid with the symbol)

Can it be assumed that if the site is listed under Bone and also listed separately, but not flagged with the symbol, as is the case for *mandible*, that the advice in Note 4 above should not be followed?

The current index entries at 'mandible' in the Neoplasm Table are consistent with WHO ICD-10. However, the NCCH agrees that there should be an index entry under Neoplasm, mandible, bone with the following symbol \leftrightarrow , as per point 4 of the note at the Neoplasm Table of the ICD-10-AM Alphabetic Index.

This has been flagged for review in a future edition of ICD-10-AM.

Place of occurrence – highway (errata 3, March 2009)

Errata 3, March 2009 updated the ICD-10-AM Alphabetic Index for place of occurrence roadway/highway causing confusion as to the correct code assignment when an accident occurs on a roadway. Is it Y92.40 *Roadway* or Y92.49 *Unspecified public highway, street or road*?

The correct place of occurrence code to assign for an accident occurring on the roadway of a street or highway is Y92.40 *Roadway* by following the index pathway:

Place of occurrence of external cause

- street (highway)
- - roadway Y92.40

The definition of a street or highway in ICD-10-AM includes the sidewalk, cycleway and roadway itself, all of which are open to the public. So, the roadway by this definition makes up part of the street or highway. Therefore, if you know an accident has occurred on the roadway of a street or highway then Y92.40 *Roadway* is the correct place of occurrence code to assign.

However, if an accident has occurred and there is no documentation to indicate on which part of the street or highway, as per the above definition, then the correct place of occurrence code to assign is Y92.49 *Unspecified public highway, street or road*.

This ambiguity has been corrected for ICD-10-AM Seventh Edition by deleting Y92.40 *Roadway* and adding *freeway*, *motorway* and *roadway* as inclusion terms at Y92.49 *Unspecified public highway, street or road*.

Place of occurrence for intentional (prescribed) drug overdoses

What is the correct place of occurrence for intentional (prescribed) drug overdoses?

The place of occurrence code for an intentional overdose of prescribed drugs should be assigned according to where the overdose took place.

If the overdose took place at home, the correct place of occurrence code is Y92.09 *Other and unspecified place in home*.

This is different to assigning a place of occurrence code where there has been an adverse effect of a prescribed drug. The place of occurrence in these circumstances is Y92.22 *Health service area*, where the adverse effect occurs as opposed to where the manifestation of the adverse effect occurs.

Poststreptococcal glomerulonephritis

There is no specific code in ICD-10-AM to differentiate poststreptococcal glomerulonephritis (PSGN) from glomerulonephritis, unspecified. The classification split is based on acuity and the presence of morphological changes. Can B94.8 *Sequelae of other specified infectious and parasitic diseases* be assigned as an additional code to distinguish PSGN from glomerulonephritis, unspecified? Or is there another more appropriate code that could be assigned?

Poststreptococcal glomerulonephritis is a disorder of the kidneys that occurs after infection with certain strains of *Streptococcus* bacteria. It is the result of an infection, not of the kidneys, but of a completely different area, such as the skin or throat, with a specific type of Group A haemolytic *Streptococcus* bacteria. It is not sequelae of the infection but rather an immunological process triggered by the bacteria.

Poststreptococcal glomerulonephritis is uncommon because infections that lead to the disorder are commonly treated with antibiotics. The disorder may develop 1-2 weeks after an untreated throat infection, or 3-4 weeks after a skin infection. It usually resolves by itself after several weeks to months.

Therefore, for poststreptococcal glomerulonephritis assign N05.9 *Unspecified nephritic syndrome* and B95.0 *Streptococcus, group A, as the cause of diseases classified to other chapters* to specify the streptococcal component, as per the following index pathways:

Glomerulonephritis (see also Nephritis)

- poststreptococcal NEC N05.9

and

Infection, infected

- *Streptococcus*, streptococcal NEC
- - Group
- - - A, as the cause of disease classified elsewhere B95.0

B94.8 *Sequelae of other specified infectious and parasitic diseases* is inappropriate to assign as an additional code as it is not a sequela of the bacterial infection but rather an immunological process triggered by the presence of the bacteria.

The coding of poststreptococcal glomerulonephritis has been flagged for review in a future edition of ICD-10-AM.

Stable angina

Should stable angina be assigned I20.8 *Other forms of angina pectoris* or I20.9 *Angina pectoris, unspecified*? Since stable angina is precipitated by stress or exercise, is it the same as angina of effort, which is an inclusion term under I20.8?

Angina is chest pain caused by reduced blood flow to the heart muscle. The pain usually begins slowly and gets worse over a period of minutes before going away. Stable angina typically occurs on exertion, and is quickly relieved with medication or rest. It is also called chronic angina or angina of effort.

Anginal chest pain that lasts longer than a few minutes or occurs with rest is considered unstable angina.

Therefore, the correct code to assign for stable angina is I20.8 *Other forms of angina pectoris* following the index pathway:

Angina

- of effort I20.8

or

Angina

- specified NEC I20.8

Indexing improvements for this condition have been flagged for a future edition of ICD-10-AM.

Swine flu with pneumonia

What is the correct code assignment for swine flu with pneumonia?

The issue of the correct code assignment for Influenza A/H1N1 (commonly known as Swine flu) was reviewed at the Update and Revision Committee meeting of the WHO Family of International Classifications (WHO-FIC) network meeting in October 2009, where it was agreed:

- The title of J09 would be modified to 'Influenza due to certain identified influenza virus'
- The inclusion term would be modified to read 'Influenza caused by influenza virus strains of special epidemiological importance with an animal-human or inter-human transmission limited to the inclusions'. This means that only those influenza viruses listed, i.e. A/H1N1 (swine) and A/H5N1 (avian) may be assigned to this code and that additional virus strains may only be included upon recommendation from WHO
- A 'use additional code' note was added to identify pneumonia or other manifestations

These decisions and changes were too late to be included in ICD-10-AM Seventh Edition and therefore will be part of the official WHO update addenda for ICD-10-AM Eighth Edition.

Therefore, assign J09 *Influenza due to identified avian influenza virus* and J18.9 *Pneumonia, unspecified* for swine flu with pneumonia, by following the index pathway:

Pneumonia (acute) (double) (migratory) (purulent) (septic) (unresolved)

- with

- - influenza, flu or gripe (specific virus not identified)

- - - avian influenza virus identified J09

Then follow the principles in ACS 0027 *Multiple coding* and assign an additional code for pneumonia to fully translate the medical statement into code.

Changes to code J09 are being considered internationally.

Traumatic amputation

When coding traumatic amputations is it necessary to also code the individual components in addition to the amputation code? For example, fracture, nerve injury, blood vessel injury, tendon and ligament injury.

When coding traumatic amputations it is not necessary to code out the individual components of the injury in addition to the code for amputation. The amputation specifies the type of injury and that it may be either a complete or partial amputation. Complete and partial are nonessential modifiers when assigning codes for traumatic amputation.

The type of procedures performed for the amputation will also further specify the nature of the injury.

Vacuum assisted wound closure (VAC® dressings)

What is the correct code assignment for a change of VAC® dressing performed under general anaesthetic?

Vacuum assisted wound closure (VAC® dressing) is a type of wound dressing which uses negative pressure to promote wound healing. A special piece of foam is cut to fit the shape of the wound, which covers and protects the wound. It keeps the wound moist so it can heal, while soaking up the drainage. A tube is then placed into the foam and connected to a small machine which creates suction. A large bandage is then placed over the entire wound area. The suction generated by the machine pulls drainage and loose tissue out of the wound and pulls the edges of the wound closer together. The dressing is usually changed every two to three days.

The correct code to assign for a VAC® dressing is 90686-01 [I628] *Nonexcisional debridement of skin and subcutaneous tissue* or 90686-00 [I627] *Nonexcisional debridement of burn*, as appropriate.

This has been indexed for ACHI Seventh Edition as follows:

Dressing

- vacuum 90686-01 [I628]

- - for burn 90686-00 [I627]

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Classification of Hospital Acquired Diagnoses

CHADx

Data on patient safety performance is an important tool for use by hospitals and others in reducing the rate of hospital-acquired illness and injury. The costs of hospital acquired illness and injury are substantial as they add between 15 and 20 per cent to the costs of hospital care.

The Classification of Hospital Acquired Diagnoses (CHADx) (pronounced 'Chaddix') allows hospitals to track the entire spectrum of unintentional patient harms, both conventional markers of patient safety, along with more 'mundane' hospital acquired conditions that have received less attention.

In 2007, all Australian states and territories agreed to the adoption of a national condition onset flag for diagnoses on inpatient episodes of care, commencing collection in July 2008. Guidance on national condition onset flag assignment has been published in the *Australian Coding Standards* (ACS) for ICD-10-AM, Sixth Edition.

For application of a condition onset flag of '1', the coder must ascertain that there was no evidence of the condition existing prior to admission, that is, a flag of '1' is used only for a condition arising after admission. This distinguishes incident diagnoses (arising during the current episode of inpatient care) from those treated in a previous episode, or arising in the community prior to admission (a flag of '2').

The Australian Classification of Hospital Acquired Diagnoses (CHADx) uses routinely abstracted hospital data on diagnoses coded in ICD-10-AM, combined with a condition-onset flag of '1', to identify complications across the entire spectrum of illness and injury. The CHADx was designed to provide a basis for the estimation of relative per-case and total expenditure attributable to hospital-acquired complications.

It provides hospitals with a tool to group over 4000 valid diagnosis codes typically used with an inpatient condition-onset flag into a smaller set (n=144) of clinically-meaningful classes for routine monitoring of complication rates.

The CHADx overcomes many of the shortcomings of existing classifications of patient safety events because it covers a broader range of hospital-acquired conditions than other monitoring systems (for instance, variable life adjusted display (VLAD), sentinel events, patient safety indicators (PSIs)). It uses ICD-10-AM, whereas most others have been developed using ICD-9-CM, and it makes use of 'condition onset' information (present on admission versus arising after admission) not available in other routine hospital data sets.

The CHADx is primarily intended for within-hospital use rather than for public reporting, and it does not currently incorporate risk (or casemix) adjustment to allow facility-level comparisons of rates of these adverse patient outcomes. It allows hospitals to track rates of CHADx over time, with timeliness limited only by the turn-around time of patient record abstraction. It gives jurisdictions the ability to monitor CHADx trends at a systems level where patient risk factors can be assumed to be stable.

Development of the CHADx by researchers at the Australian Centre for Economic Research on Health at the University of Queensland was funded by a once-off grant from the Australian Commission on Safety and Quality in Health Care (ACSQHC). The National Centre for Classification in Health (NCCH) in conjunction with the ACSQHC has now aligned the CHADx to ICD-10-AM Seventh Edition and incorporated this vital information into the electronic version of the classification. This will enable users of the classification to identify the relevant CHADx code(s), or combination of CHADx codes, when associated with a condition onset flag of '1'.

Below is a listing of the 17 major CHADx (M CHADx) categories which include 144 CHADx classes based on ICD-10-AM Seventh Edition, with a condition onset flag of '1'. An expanded list of the CHADx can be found at the Commission's website at: http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-08_CostHAD

Summary of CHADx codes ICD-10-AM Seventh Edition

CHADx ASSIGNMENT		Included codes and code combinations
M CHADx 1	POST-PROCEDURAL COMPLICATIONS	
I.1	Complications of infusion /transfusion	T80.1–T80.9
I.2	Gas embolism	T80.0, T70.3, O88.0
I.3	Failed or difficult intubation	T88.4
I.4	Other haemorrhage and haematoma complicating a procedure	T81.0
I.5	Accidental puncture/laceration during procedure	T81.2
I.6	Foreign body or substance left following procedure	T81.5–T81.6
I.7	Other complications of surgical and medical care NEC (including shock)	T81.1, T81.7–T81.9, T88.0–T88.1, T88.8–T88.9
I.8	Disruption of wound	T81.3, O90.0–O90.1
I.9	Wound infection (excluding septicaemia)	T81.41, O86.0
I.10	Complications of cardiac and vascular implants (excluding septicaemia)	T82
I.11	Complications of genitourinary implants (excluding septicaemia)	T83
I.12	Complications of orthopaedic implants (excluding septicaemia)	T84
I.13	Complications of other implants (excluding septicaemia)	T85
I.14	Complications of transplants	T86
I.15	Complications of reattachment and amputations	T87
I.16	Post-procedural disorders: endocrine and metabolic	E89
I.17	Post-procedural disorders: nervous system	G97
I.18	Post-procedural disorders: eye and ear	H59, H95
I.19	Post-procedural disorders: circulatory system	I97
I.20	Post-procedural disorders: respiratory system	J95
I.21	Post-procedural disorders: digestive system	K91
I.22	Post-procedural disorders: musculoskeletal system	M96
I.23	Post-procedural disorders: genitourinary system	N99
M CHADx 2	ADVERSE DRUG EVENTS	
2.1	Skin Adverse effects due to systemic antibiotics	Y40, Y41 + L20–L30 (exc L22.0–L23.2, L23.4–L24.3, L24.5–L25.0, L25.2–25.9) & R20–23 (exc R22.0–R22.9)
2.2	Other adverse effects due to systemic antibiotics	Y40, Y41
2.3	Nausea & vomiting due to anti neoplastic drugs	Y43.1–Y43.3 + R11
2.4	Other adverse effects due to anti neoplastic drugs	Y43.1–Y43.3
2.5	Coagulation defect due to drugs affecting blood constituents	Y44 + D68
2.6	Other adverse effects due to drugs affecting blood constituents	Y44
2.7	Nausea and vomiting due to opioids and related analgesics	Y45.0 + R11
2.8	Alterations to mental state due to opioids and related analgesics	Y45.0 + F05.8, F05.9, R40.0–R40.2, R41.0–R41.8, or R44.0–R44.8
2.9	Other adverse effects due to opioids and related analgesics	Y45.0
2.10	Adverse effects due to anaesthesia (including misadventure)	Y48; Y60–84 + T88.2, T88.3 or T88.5
2.11	Hypotension due to anaesthesia	Y48 + I95
2.12	Alterations to mental state due to anaesthesia	Y48 + F05.8, F05.9, R40.0–R40.2, R41.0–R41.8 or R44.0–R44.8
2.13	Other adverse effects due to drugs affecting cardiovascular system	Y52
2.14	Hypotension dt drugs affecting cardiovascular system	Y52 + I95.2

CHADx ASSIGNMENT		<i>Included codes and code combinations</i>
2.15	Adverse effects due to insulin & oral hypoglycaemics	Y42.3
2.16	Adverse effects due to other drugs	Y42 (exc Y42.3), Y46–Y47, Y42 (exc Y42.3), Y43.0, Y43.4–Y43.9, Y45 (exc Y45.0), Y46–Y47, Y49–Y51, Y53–Y59, D52.1, D59.2, D61.1, E06.4, E16.0, E23.1, E24.2, E27.3, G21.1, G24.0, G25.1, G25.4, G44.4, G62.0, G72.0, I95.2, J70.4, L23.3, L24.4, L25.1, L27.0, L27.1, L43.2, L56.0, L56.1, M10.27, N14.0–N14.2
2.17	Anaphylactic shock due to correct drug properly administered	T88.6; T78.2 followed by Y40–Y59
2.18	Accidental overdose of drug or wrong drug given or taken in error	X40–X44
M CHADx 3 ACCIDENTAL INJURIES		
3.1	Falls with fractured femur	W01–W19 (exc W02.0–W02.5, W09.0–W09.9, W11–W12, W14–W16)+ S72
3.2	Falls with intracranial injury	W01–W19 (exc W02.0–W02.5, W09.0–W09.9, W11–W12, W14–W16) + S06.1–S06.9
3.3	All other falls	W01.0, W01.1, W01.2, W03, W04, W05, W06, W07, W08, W10, W13, W17, W18, W19 (exc W02.0–W02.5, W09.0–W09.9, W11–W12, W14–W16)
3.4	Injury due to assault	X85–Y09 (exc X92.1–2, Y03); Y35
3.5	Other patient accidents (exc poisoning)	W20–X59 (exc W32–W34, W39, W59, X13.0, X20.0–X20.1, most W84) & Z03.6 (w/o external cause)
M CHADx 4 SPECIFIC INFECTIONS		
4.1	Sepsis	A02.1, A32.7, A40, A41, A42.7, B37.7 + T81.42, O75.3, O85, O88.3, P36, R65.0, R65.1, R57.2
4.2	Mycoses	A31.8, A31.9, B35–B49 (exc B37.7)
4.3	MRSA	Z06.32
4.4	Other drug resistant infections	Z06 (ex Z06.32)
4.5	Other infectious agents	A06.7, A28.0, A36.3, A36.8, A42.8, A42.9, A46, A48.0, A48.3, A49.0–A49.9, A86, A87.2, A87.9, B00.0–B00.9 (exc B00.3, B00.4), B01.2, B01.9 (exc B01.0, B01.1, B01.8), (exc B02–B07), B08.4, B09, B15.9, B16.9, B17.1, B19.9, B25.0, B25.8, B25.9, B30.3, B30.9, B33.8, B34.8, B34.9, B60.8, B80, B83.9, B85.0, B85.2, B85.3, B85.4, B99 (exc, A32.7, A42.7, A31.8–A31.9, B37.7)

CHADx ASSIGNMENT		<i>Included codes and code combinations</i>
M CHADx 5 CARDIOVASCULAR COMPLICATIONS		
5.1	AMI	I21–I22.9
5.2	Pulmonary embolism (PE)	I26
5.3	Cardiac arrhythmias, conduction disturbances & abnormal heart beat	I44–I45, I47–I48, I49.1–I49.9, R00 (exc w Y40–Y59)
5.4	Ventricular fibrillation/ cardiac arrest	I46, I49.0
5.5	Heart failure	I50
5.6	Hypotension (not drug induced)	I95 (exc w Y40–59)
5.7	Cerebro-vascular disease & TIA	I60–I67 (exc I60.4, I60.6, I60.7, I65.2–I65.9, I66.0, I66.1, I66.3, I66.8, I66.9, I67.1–I67.5, I67.7–I67.9), G45, O87.3
5.8	Venous thrombosis/embolism (not progressing to PE)	I80–I82, O22.3, O87.0–O87.1, O88.2
5.9	Unstable and other angina	I20
5.10	Cardiogenic and other shock	R57.0–R57.9
5.11	Other circulatory system complications	I15.9, I23.0, I23.2, I23.3, I23.8, I24.0–I24.9, I27.2, I27.9, I28.8, I30.1–I30.9, I31.2, I31.3, I31.9, I33.0, I33.9, I34.8, I35.8, I36.1, I36.9, I37.1, I38, I40.8, I51.3, I51.4, I51.6, I51.8, I71.00, I71.01, I71.1, I72.0, I72.1, I72.2, I72.4, I72.8, I72.9, I74.0–I74.9, I77.0, I77.1, I77.2, I77.6, I77.8, I77.9, I78.8, I87.1, I87.8, I87.9, I88.0, I88.9, I89.0, I89.1, I89.8, I89.9, I99, R09.88
M CHADx 6 RESPIRATORY COMPLICATIONS		
6.1	ARDS, respiratory failure & pulmonary collapse (incl atelectasis)	J80, J96.0, J96.9, J98.1
6.2	Aspiration pneumonia	J69
6.3	Acute lower respiratory infections (incl influenza & pneumonia)	J10–J18, J20–22
6.4	Pulmonary oedema, pneumothorax & pleural effusion	J90, J93, J94.0, J94.2
6.5	Haemorrhage from respiratory passages	R04
6.6	Asphyxia & respiratory arrest	R09.0, R09.2
6.7	Breathing difficulties	R06.0–R06.5, R06.8, R09.1
6.8	Other hospital-acquired respiratory disorders	J00, J01.0, J01.4, J01.9, J02.8, J02.9, J03.9, J04.0, J04.1, J05.0, J05.1, J06.9, J30.1, J30.3, J30.4, J34.0, J34.8, J38.00–J38.04, J38.3–J38.7, J39.0, J39.2, J39.3, J39.8, J40, J82, J84.9, J85.0–J85.3, J86.0, J86.9, J94.8, J98.0, J98.4–J98.9, R09.89
M CHADx 7 GASTROINTESTINAL COMPLICATIONS		
7.1	Gastro enteritis	A02–A09 (ex A02.1, A04.7, A06.1–A06.6), K52
7.2	Paralytic ileus & intestinal obstruction (w/o hernia)*	K56
7.3	Enterocolitis dt Clostridium difficile	A04.7
7.4	Constipation	K59.0 (exc w drug effects Y40–59)
7.5	Nausea and vomiting	R11
7.6	GI bleeding not classified to a disease	K92.0–K92.2

CHADx ASSIGNMENT		<i>Included codes and code combinations</i>
7.7	Other digestive system disorders	K05.0, K05.2, K05.5, K05.6, K06.2, K06.8, K06.9, K08.1, K08.81, K08.9, K10.2, K10.3, K10.8, K11.2, K11.3, K11.4, K11.7, K11.8, K12.0–K12.2, K13.0, K13.1, K13.7, K14.0, K14.6, K14.8, K20, K22.1, K22.2, K22.3, K22.6, K22.8, K22.9, K30, K31.0, K31.5, K31.6, K31.88, K31.9, K35.2–K35.8, K36, K37, K38.8, K55.0, K55.8, K55.9, K59.1, K59.4, K59.8, K59.9, K60.0, K60.2–K60.4, K61.0–K61.3, K62.4–K62.9, K63.0–K63.9, K65.0, K65.8, K65.9, K66.1, K66.8, K72.0, K72.9, K75.0, K75.8, K75.9, K76.3, K76.6–K76.9, K81.0, K81.8, K81.9, K82.2, K82.8, K82.9, K83.0–K83.4, K83.8, K83.9, K85.0–K85.9, K86.2–K86.9, K87.1, K90.3, K90.4, K90.9, K92.8, K92.9, R19.4, R19.5, R19.8
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M CHADx 8	SKIN CONDITIONS	
8.1	Pressure ulcers	L89
8.2	Cellulitis*	L03
8.3	Dermatitis, rash & other skin effects	L20–L30 & R20–R23 (exc w Y40–Y59 or dt drugs)
8.4	Other skin disorders	L01.0, L01.1, L02.0–L02.9, L04.0–L04.3, L05.0, L05.9, L08.0, L08.8, L08.9, L10.9, L11.1, L13.8, L42, L43.9, L50.0, L50.8, L50.9, L51.1, L51.8, L51.9, L52, L53.0, L53.8, L53.9, L58.0, L58.9, L59.0, L59.8, L59.9, L60.0, L60.1, L60.3, L60.8, L60.9, L65.9, L70.0, L70.8, L70.9, L71.0, L71.9, L72.0, L72.1, L72.8, L72.9, L73.8, L73.9, L74.0, L74.1, L74.3, L88, L92.8, L92.9, L97, L98.0–L98.2, L98.5, L98.8, L98.9
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*Excludes after T code		
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M CHADx 9	GENITOURINARY COMPLICATIONS	
9.1	Acute & unspecified renal failure (exc post procedural)	N17, N19
9.2	UTIs	N10, N30.0, N39.0
9.3	Urinary retention	R33
9.4	Other complications & symptoms of the urinary system	N00–N39 (exc N02–N03, N10, N17–N19, N20.0–N21.0, N30–N30.2), R30–R39 (exc R33)
9.5	Other complications of male & female genitals	N41.0, N41.9, N42.8, N45.0, N45.9, N48.1–N48.3, N48.5, N48.8, N48.9, N49.2, N49.9, N50.1, N50.8, N50.9, N51.1, N51.2, N51.8, N61, N64.1, N64.3–N64.8, N71.0, N71.9, N73.2, N73.5, N73.9, N76.0, N76.2, N176.4–N76.8, N82.0, N82.1, N82.3, N83.6–N83.9, N85.9, N88.8, N89.8, N89.9, N90.8, N90.9, N93.8, N93.9, N94.0, N94.4, N94.6, N98.1

M CHADx 10 HOSPITAL-ACQUIRED PSYCHIATRIC STATES

10.1	Depressive episode & symptoms involving emotional state	F32, R45 (exc R45.6)
10.2	Panic and other anxiety disorders	F41
10.3	Adjustment & other psych disorders	F06.1, F06.33, F06.7–F06.9, F07.2, F07.8, F09, F23.30, F23.31, F23.90, F23.91, F29, F30.0, F30.2, F30.9, F38.8, F39, F40.8, F40.9, F43.0–F43.9, F44.5, F44.88, F44.9, F45.0, F45.31, F45.32, F45.34, F45.8, F45.9, F48.9, F51.0, F51.4, F51.5, F99, R45.6
10.4	Alterations to mental state	F05.0–F05.9, R40.0–40.2, R41.0–41.8, R44.0–44.8, R45.6
10.5	Mental & behavioural disorders due to psychoactive substance use	F10.3, F10.4, F11.3, F11.4, F12.3, F12.4 F13.30, F13.31, F13.39, F13.40, F13.41, F13.49, F14.3, F14.4, F15.30, F15.31, F15.32, F15.39, F15.40, F15.41, F15.42, F15.49, F16.30, F16.31, F16.39, F16.40, F16.41, F16.49, F17.3, F17.4, F18.3, F18.4, F19.3, F19.4
10.6	Patient self-harm (Incl intentional and undetermined intent overdose)	X60–X84 (exc X72–X75), Y10–Y34 (exc Y22–Y25)

M CHADx 11 EARLY PREGNANCY COMPLICATIONS

11.1	Complications of abortion, ectopic and molar pregnancies	O03–O08 (exc O05.0–O05.8)
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M CHADx 12 LABOUR, DELIVERY & POSTPARTUM COMPLICATIONS

12.1	Foetal heart rate anomalies	O68.0, O68.2
12.2	Foetal meconium and other distress	O68.1, O68.3–O68.9
12.3	Complications of umbilical cord	O69
12.4	Unsuccessful interventions during labour	O61, O66.5, O75.5–O75.6
12.5	Complications of maternal anaesthesia during pregnancy and puerperium	O29, O74, O89
12.6	First degree and unspecified perineal laceration	O70.0, O70.9
12.7	Second degree perineal laceration	O70.1
12.8	Third degree and fourth degree perineal laceration	O70.2–O70.3
12.9	Maternal haemorrhage	O44.1, O46, O67, O72
12.10	Other obstetric injury	O71, O90.2
12.11	Other complications intrapartum & postpartum	O75.0–O75.2, O75.4, O75.8–O75.9, O87.2, O87.8, O87.9, O90.3–O90.9, F53
12.12	Retained placenta	O73
12.13	Maternal infection (exc wound infection & septicaemia)	O86.1–O86.8, O41.1
12.14	Breast disorders associated with childbirth	O91–O92
12.15	Other disorders predominantly related to pregnancy	O20.0, O20.8, O20.9, O21.0–O21.9, O22.2, O22.5, O22.8, O22.9, O23.0–O23.9, O25, O26.4, O26.5, O26.7, O26.81–O26.88, O26.9, O31.8, O41.8, O41.9, O42.0, O42.11, O42.12, O42.2, O42.9, O45.0, O45.8, O45.9, O47.1, O47.9, O88.1

M CHADx 13 PERINATAL COMPLICATIONS

I3.1	Prenatal injuries	P03.2–P03.4, P96.50–P96.59
I3.2	Intracranial haemorrhage, hypoxia and other brain injuries	P10.0–P11.2, P20–P21, P52, P90–P91.9
I3.3	Other birth trauma	P11.3–P11.5
I3.4	Respiratory distress of newborn	P22
I3.5	Aspiration & other respiratory disorders of newborn*	P24–P26, P28 (exc P28.81, P28.83)
I3.6	Circulatory disorders of newborn	P29.0–P29.2, P29.4–P29.9, P29.3 (exc P29.82)
I3.7	Perinatal infections (exc septicaemia)	P37.5, P38, P39
I3.8	Haemorrhage and blood disorders of newborn	P50–P51 & P53–P54
I3.9	Jaundice	P58–P59
I3.10	GI and feeding disorders of newborn	P75–P78, P92, & R63.4*
I3.11	Other neonatal complications	P60, P61.0–P61.9, P70.3–P70.9, P71.0–P71.9, P72.0–P72.9, P74.0, P74.1, P74.20–P74.29, P74.30–P74.39, P74.4–P74.9, P28.81, P28.83, P80.0, P80.8, P80.9, P81.0, P81.8, P81.9, P83.0–P83.9, P96.1, P96.2, P96.81, P96.89, P96.3

* Not including Snuffles and Grunting

M CHADx 14 HAEMATOLOGICAL COMPLICATIONS

I4.1	Post haemorrhagic anaemia (not post-procedural)	D62
I4.2	Other hospital-acquired anaemia	D55.2, D59.3, D59.4, D59.6–
	D59.9, D61.9, D63, D64.1, D64.3, D64.8, D64.9	
I4.3	Coagulation defects	D65, D68.3–D68.9 (exc w Y40–Y59)
I4.4	Agranulocytosis, thrombocytopenia & other blood disorders	D69.0–D69.9, D70, D72.1–D72.9, D73.0, D73.1, D73.3, D73.5–D73.9, D75.1–D75.9, D80.1, D80.3, D84.8, D84.9, D89.0–D89.2, D89.8

M CHADx 15 METABOLIC COMPLICATIONS

I5.1	Dehydration / volume depletion	E86 (exc w Y40–Y59)
I5.2	Electrolyte disorders w/o dehydration	E87 (exc w Y40–Y59 or w E86)
I5.3	Hospital acquired nutrition deficiencies (incl nutritional anaemia)	E40–E63 & D50–D53
I5.4	Hypoglycaemia & hyperglycaemia	E16.1–E16.2, R73
I5.5	Disorders of mineral metabolism	E83 (exc w Y40–Y59)
I5.6	SIADH, hyperthyroidism & other metabolic disorders	E03.2, E05.4–E05.9, E06.0, E06.1, E06.9, E07.8, E07.9, E16.4, E20.9, E21.1–E21.4, E22.1, E22.2, E22.9, E23.3, E23.6, E26.9, E27.4, E27.8, E27.9, E29.1, E34.8, E34.9, E72.1, E73.8, E79.0, E80.1, E80.7

CHADx ASSIGNMENT		<i>Included codes and code combinations</i>
M CHADx 16 NERVOUS SYSTEM COMPLICATIONS		
16.1	Hospital-acquired paralysis	G51.0, G81–G83
16.2	Dystonia, tremors & gait disorders	G24.4–G24.9, G25.2–G25.9, R25–R27, R29.0, R29.2
16.3	Other nervous system complications	G00.2–G00.9, G03.0, G03.9, G04.8, G04.9, G06.0–G06.2, G08, G21.8, G40.00, G40.10, G40.20, G40.21, G40.30, G40.50, G40.60, G40.70, G40.80, G40.90, G40.91, G41.8, G47.0, G47.1, G47.2, G50.8, G50.9, G52.1–G52.9, G54.0, G54.1, G54.4, G54.6, G54.7–G54.9, G55.1, G55.3, G56.1–G56.3, G56.8, G56.9, G57.0–G57.3, G57.8, G57.9, G58.0, G58.8, G58.9, G61.8, G62.8, G62.9, G63.8, G70.9, G72.8, G72.9, G73.6, G90.2, G90.8, G90.9, G91.3, G91.8, G91.9, G93.1, G93.2, G93.4, G93.5, G93.6, G93.8, G93.9, G95.0, G95.1, G95.2, G95.9, G96.0, G61.0, G96.9, G98, R29.5, R29.88
M CHADx 17 OTHER COMPLICATIONS		
17.1	Major symptoms	R02, R15, R16.1, R17, R19.0, R29.1, R47.0, R47.1, R48.1, R48.2, R49.1, R58, R68.0, R96.0
17.2	Headache & migraine	R51, G43–G44
17.3	Oedema & ascites	R18, R60
17.4	Chest pain	R07.1–R07.4
17.5	Abdominal pain	R10
17.6	Fever (not classified to condition)	R50
17.7	Convulsions	R56
17.8	Dizziness, fainting & blackout	R42 & R55
17.9	Complications of the eye and ear	H00–H95 (exc H25)
17.10	Musculoskeletal complications (not associated with Falls)	M00.0–M99.9, R29.89
17.11	Dysphagia	R13
17.12	Other symptoms	R03.0, R03.1, R05, R06.6, R06.7, R07.0, R09.3, R12, R14, R19.6, R29.3, R43.1, R43.2, R43.8, R46.2, R46.4, R46.8, R47.8, R49.0, R49.2, R49.8, R52.0, R52.9, R53, R59.0, R59.1, R61.0, R61.1, R61.9, R63.0–R63.5, R63.8, R68.2, R68.8, R69
144	CHADx classes	

Outcome of the tender for the Refinement of AR-DRG classification system and NCCH

In 2009, the Department of Health and Ageing (DoHA) commissioned Price Waterhouse Coopers to review the national classification system encompassing AR-DRGs and ICD-10-AM/ACHI/ACS. One of a number of recommendations that came from the review maintained that one organisation assume responsibility for both the ICD-10-AM/ACHI/ACS and the AR-DRG refinement. Therefore, in November 2009, DoHA released an open tender for these services.

Unfortunately, the National Centre for Classification in Health (NCCH) was unsuccessful in response to the tender. This change means that NCCH will cease to be responsible for the refinement of ICD-10AM/ACHI/ACS after 30 June 2010.

Queries and public submissions will be accepted up until this date. Distribution of material including ICD-10-AM/ACHI/ACS, in hard copy and eCompress version, together with other products will cease as at 30 June 2010 in order to complete financial processes associated with contract closure.

The June edition of Coding Matters, I0-AM Commandments together with the 1st Errata will be the last produced and distributed by NCCH.

The NCCH would like to thank everyone who has been associated with the Centre since its establishment in 1992, especially for attending conferences, education workshops, your feedback and support over the years. We would like to wish everyone all the best for the future.

**coding
matters**



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CONFERENCES 2010

July 26-27	Reducing Hospital Readmissions & Discharge Planning Conference	Melbourne, VIC	www.iir.com.au/conferences/healthcare/reducing-hospital-readmissions-discharge-planning
Aug 16-17	Hospital Reform Summit 2010	Melbourne, VIC	www.informa.com.au/hospitalreform
Aug 17-19	12th National Immunisation Conference	Adelaide, SA	www.phaa.net.au/12thNationalImmunisationConference.php
Aug 24-26	HIC 2010 Informing the Business of Healthcare	Melbourne, VIC	www.hisa.org.au/hic2010
Sept 9-10	14th Annual NT Chronic Diseases Network Conference	Darwin, NT	www.cdnconference.com.au/
Sept 13	MedInfo 2010	Capetown, South Africa	www.medinfo2010.org/
Sept 14-15	The Australian Health & Medical Ethics Roadshow	Brisbane, QLD	www.qctn.com.au
Sept 17-19	Public Health Association of Australia (PHAA) 40th Annual Conference	Adelaide, SA	www.phaa.net.au/40thPHAAAnnualConference.php
Sept 22-24	HEALTHCON 2010	Adelaide, SA	www.sapmea.asn.au/conventions/ahha2010/index.html
Oct 25-27	National Forum on Safety and Quality in Health Care	Canberra, ACT	www.sapmea.asn.au/forumsqhc2010
Oct 27-29	HIMAA National Conference 2010	Sydney, NSW	www.himaa.org.au/2010/site/landing.html
Oct 28-29	HIMSS Asia'10 Health IT Leadership Summit	Daegu, South Korea	www.himssasiapac.org/summit10/index.aspx
Nov 15-19	16th Congress of International Federation of Health Records Organizations	Milan, Italy	www.iftro.org/

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

ICD-10-AM/ACHI/ACS

SEVENTH EDITION

ICD-10-AM/ACHI/ACS Seventh Edition is published and produced by the National Centre for Classification in Health (NCCH) in printed volumes and as eCompress® desktop software.

SEVENTH EDITION SOFTWARE

The popular eCompress® version of ICD-10-AM/ACHI/ACS developed by NCCH and Eurofield Information Solutions (EIS) contains all the volumes plus current I0-AM Commandments from *Coding Matters*. The update release now includes Errata 1 and the Classification of Hospital Acquired Diseases (CHADx).

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