ICD-10-AM, ACHI and ACS Seventh Edition Forecast

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We are now entering the final stages of preparation for the publication of ICD-10-AM/ACHI/ACS Seventh Edition. The Seventh Edition includes extensive input from interested parties and stakeholders. It also includes changes derived from the foundation classifications: WHO ICD-10 and the Medicare Benefits Schedule (MBS). Public submissions for changes to ICD-10-AM/ACHI/ACS are accepted all year round, via the public submissions link on the NCCH website. All classification users, for example: clinical coders, clinicians, epidemiologists and researchers who identify a need for improvement to the classification content (codes in the tabular, changes to the index, or perhaps clarification of a coding standard) are invited to submit their suggestion(s) through the NCCH Public Submission process. Public submissions are prioritised, with regard to the timing of the current updating work. NCCH staff constantly monitor the submissions and assess each proposal as it is received.

The NCCH acknowledges input from members of the Clinical Casemix Committee (CCC), Clinical Classification and Coding Groups (CCCGs) and particularly from the NCCH's

Coding Standards Advisory Committee (CSAC). The CSAC has representation from Australian state and territory jurisdictions, New Zealand, the Health Information Management Association of Australia (HIMAA), the Australian Institute of Health and Welfare (AIHW), the Clinical Coders Society of Australia (CCSA), the private sector, CCC, the Commonwealth Department of Health and Ageing and the National Health Information Standards and Statistics Committee (NHISSC).

One of the primary aims of the work undertaken for Seventh Edition has been to review individual ACS to align them with the primacy of ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnosis*. The content of a number of ACS has been incorporated into either ICD-10-AM or ACHI. This work minimises the number of standards required, allowing for ICD-10-AM and ACHI to stand alone where possible in the coding process.

The depth and scope of the scrutiny of changes emanating from both inside and outside the NCCH, should guarantee the relevance of the classification as the Australian Standard for the two years following 1 July 2010.

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Following are the summary statistics regarding the number of new and deleted codes and a summary of the major changes in Seventh Edition.

Summary statistics - ICD-10-AM/ACHI/ACS Seventh Edition

ICD-10-AM Seventh Edition

Total number of new disease codes	552
Total number of deleted disease codes	61

Australian Classification of Health Interventions (ACHI) Seventh Edition

Total number of new procedure codes	73
Total number of deleted procedure codes	72
Total number of new blocks	0
Total number of deleted blocks	5

Australian Coding Standards (ACS) Seventh Edition

Approximate number of new Australian Coding Standards	0
Approximate number of deleted Australian Coding Standards	42
Approximate number of modified Australian Coding Standards	51

WHO ICD-10 Updates

Proposals considered	331
Proposals included in ICD-10-AM Seventh Edition	222
Australian proposals accepted as part of ICD-10	20

Summary of Major Changes Expected in ICD-10-AM/ACHI/ACS Seventh Edition

1.   ICD-10-AM Seventh Edition

The modifications to the disease classification include a number of important improvements to ICD-10-AM

1.1   Major Changes

Include, but are not limited to:

- Addition of definitions to conventions
- Anaemia in chronic diseases
- Congenital malformations, deformations and chromosomal abnormalities
- Diabetes mellitus
- Healthcare associated bacteraemia
- Obstetric principal diagnosis
- Obstructive sleep apnoea in newborns
- Pharmacotherapy amendments
- Pregnancy complicated by conditions in...
- Premature rupture of membranes
- Sepsis, severe sepsis and septic shock

1.2   WHO ICD-10 updates

Recommendations for change to ICD-10 are made by the Update Reference Committee and the WHO Family of International Classifications (WHO-FIC) meeting. ICD-10-AM Seventh Edition contains those recommendations ratified at the Trieste (October 2007) and Delhi (October 2008) meetings of the Update and Revision Committee (URC) of WHO-FIC.

The main changes include new codes for:

- Acute bronchiolitis due to human metapneumovirus
- Aneurysm and dissection of other precerebral arteries
- Dysplasia of prostate
- HELLP syndrome
- HIV complicating pregnancy, childbirth and the puerperium
- Human metapneumovirus pneumonia
- Immune reconstitution syndrome
- Leukaemia and lymphoma, with changes to existing code titles in line with current terminology
- Malignant neoplasm, primary site unknown
- Malignant neoplasm, unspecified
- Oral mucositis
- Osteomyelofibrosis
- Postpolio syndrome
- Refractory anaemia with multilineage dysplasia
- Secondary malignant neoplasm of unspecified site
- Tumour lysis syndrome
- Vibrio vulnificus

Expansion of categories:

- Deaths from obstetric causes and sequelae of obstetric causes
- Victim of earthquake, to uniquely identify victims of tsunami

New terminology in the area of:

- Aneurysms, to include the concept of dissection
- Maltreatment
- Subsequent myocardial infarction

Change of classification for:

- Acute appendicitis

Improved indexing for:

- Collagenous colitis
- Lymphocytic colitis
- Microscopic colitis
- Neonatal abstinence syndrome

- Nonalcoholic fatty liver disease (NAFLD)
- Nonalcoholic steatohepatitis (NASH)
- Tertiary hyperparathyroidism

1.3 External cause of injury codes

A submission was received by the Monash University Accident Research Centre (MUARC) and the Research Centre for Injury Studies (RCIS). Changes made as a result of this submission include the following areas:

- Contact with sharp glass
- Exposure to other specified electric current.

Other changes made to the external cause of injury section as a result of other public submissions included:

- Place of occurrence codes for street and highway
- Place of occurrence codes for tennis court
- Reaction to food

2. Australian Classification of Health Interventions (ACHI) Seventh Edition

The major modifications to the interventions classification include both changes made through public submissions as well as amendments based on MBS changes from May, July, November 2008 and January, February 2009). The major changes include, but are not limited to:

- Admission for removal of contraceptive device
- Bladder neck vaporisation
- Composite grafts with CABG
- Flaps
- Laminectomy with rhizolysis
- Leech and maggot therapy
- Posterior juxtascleral depot injection
- Procedures normally not coded
- Reduction of proximal fibula fracture
- Suture of current obstetric laceration
- Thymectomy
- Thyroidectomy

3. Australian Coding Standards (ACS)

3.1 Major amendments

There have been 51 ACS amended for ACS Seventh Edition. Significant changes include:

ACS 0001 *Principal diagnosis*

ACS 0016 *General procedure guidelines*

ACS 0027 *Multiple coding*

ACS 0031 *Anaesthesia*

ACS 0042 *Procedures normally not coded*

ACS 0110 *Sepsis, severe sepsis and septic shock*

ACS 0111 *Healthcare associated Staphylococcus aureus bacteraemia*

ACS 0401 *Diabetes mellitus and impaired glucose regulation*

ACS 0909 *Coronary artery bypass grafts*

ACS 0940 *Ischaemic heart disease*

ACS 1309 *Dislocation or complication of hip prosthesis*

ACS 1438 *Chronic kidney disease*

ACS 1506 *Malpresentation, disproportion and abnormality of maternal pelvic organs*

ACS 1513 *Induction and augmentation*

ACS 1530 *Premature labour and delivery*

ACS 1614 *Respiratory Distress Syndrome/Hyaline Membrane Disease/Surfactant Deficiency*

ACS 1911 *Burns*

ACS 1915 *Spinal (cord) injury*

ACS 2113 *Follow-up examinations for specific disorders*

3.2 Major deletions

A total of 42 standards have been deleted. The content of a number of standards incorporated into either ICD-10-AM or ACHI therefore rendering the ACS obsolete.

Publication information

ICD-10-AM Seventh Edition will be published in March 2010, for implementation from July 2010. ICD-10-AM will be available as:

- Five volumes in hard copy, with optional slipcases
- An eCompress interactive electronic version, which can be networked for designated numbers of users, or as stand alone options. The eBook's features include split screen (can view up to four components of the eBook at any one time), global notes, which allows an administrator to create or edit notes that can be seen by all users, and a personal notes field. Links make looking up Australian Coding Standards and the latest published information from 10-AM Commandments easy and fast
- electronic code list – an ASCII comma delimited file

Ordering information will be posted on the website and in the March issue of Coding Matters when the classification is available for distribution.
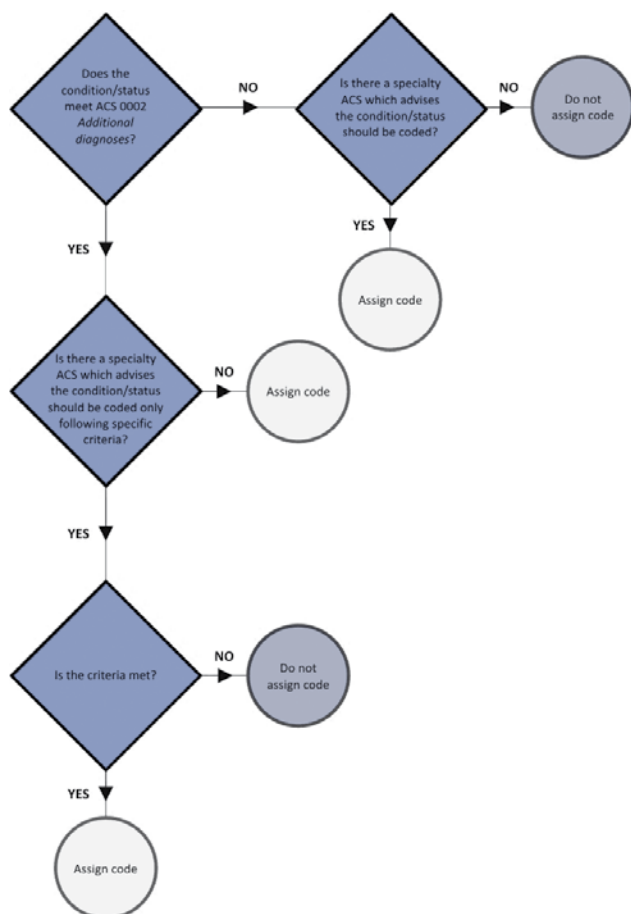
Seventh Edition Education

The model for delivery for Seventh Edition education will be similar to that used for Sixth Edition education. This will include on-line education via the web, CD-ROM for those without access to the Internet and optional face-to-face workshops. Details will be available early in 2010. See page 11 for further details.

10-AM Commandments

ACS 0002 Additional diagnoses and specialty standards

Do specialty standards override the guidelines in ACS 0002 *Additional diagnoses?*

A. To determine if a condition or status should be coded as an additional diagnosis follow the flow chart below:

Example 1 – A patient recovering from a stroke is diagnosed with dysphagia, reviewed by the clinician and commenced on enteral feeding, which continues for six days and is then ceased. The patient is then placed on a modified diet until they are discharged from hospital.

Following the flowchart above dysphagia meets the criteria for code assignment as per the guidelines in ACS 0002 and ACS 0604 *Stroke*, states:

> 'Dysphagia – should be assigned only when requiring nasogastric tube/enteral feeding, or when the dysphagia is present at discharge or still requiring treatment more than 7 days after the stroke occurred.'

Therefore, dysphagia also meets the criteria for code assignment as per the guidelines in ACS 0604 *Stroke* and should be coded.

Example 2 – A patient recovering from a stroke is diagnosed with dysphagia, reviewed by the Speech Pathologist and placed on a modified diet. The dysphagia resolves rapidly and the patient is discharged on Day 6 on a full diet.

Following the flowchart above dysphagia meets the criteria for code assignment as per the guidelines in ACS 0002, but ACS 0604 *Stroke* states:

> 'Dysphagia – should be assigned only when requiring nasogastric tube/enteral feeding, or when the dysphagia is present at discharge or still requiring treatment more than 7 days after the stroke occurred.'

Therefore, dysphagia does not meet the criteria for code assignment as per ACS 0604 and should not be coded.

Example 3 – Patient is admitted to hospital for resection of ingrown toe nail and is noted to be a current smoker. Smoking does not meet the criteria for code assignment as per the guidelines in ACS 0002, but ACS 0503 *Drug, alcohol and tobacco use disorders* states:

> '**Z72.0 Tobacco use, current**
> Assign this code if the documentation indicates that:
>
> 1. The patient has smoked tobacco (any amount) within the last month.'

Therefore, 'Current use of tobacco' meets the guidelines for code assignment as per ACS 0503 and should be coded.

Example 4 – Patient is admitted for inguinal hernia repair and is noted to be a 'hepatitis B carrier.' Hepatitis B carrier status does not meet the criteria for code assignment as per ACS 0002, but ACS 0104 *Viral hepatitis* states:

> 'Documentation of 'hepatitis B carrier' without any indication of an infectious process should be coded to Z22.51.'

Therefore, Z22.51 *Carrier of viral hepatitis B* should be assigned as per the guidelines in ACS 0104.

A comprehensive review of all Australian Coding Standards is being undertaken in light of the Sixth Edition changes made to ACS 0002 Additional diagnoses.

Anaemia in myelodysplastic syndromes

Should D63.0* *Anaemia in neoplastic disease* **be assigned with codes from category D46** *Myelodysplastic syndromes?*

Refractory anaemia is symptomatic of myelodysplastic syndrome and therefore it is unnecessary to assign D63.0*

Anaemia in neoplastic disease where refractory anaemia in myelodysplasia is assigned to D46.- *Myelodysplastic syndromes.*

This is confirmed by guidelines for the assignment of dagger and asterisk codes in ACS 0027 *Multiple coding,* which states:

> 'Codes for aetiology (underlying cause) are annotated by a dagger symbol (†) and manifestation codes by an asterisk (*) symbol. Assign both codes in the same sequence in which they appear in the Alphabetic Index, that is, the aetiology followed by the manifestation code.'

The following index entry for *Anaemia, myelodysplastic* does not provide a dagger and asterisk combination, so it is incorrect to assign D63.0* *Anaemia in neoplastic disease* with D46.9 *Myelodysplastic syndrome, unspecified:*

Anaemia
- myelodysplastic (M9989/3) (see also Anaemia, refractory) D46.9

In contrast, the index entry for *Anaemia, myelofibrosis,* assigns D47.1† *Chronic myeloproliferative disease* and D63.0* *Anaemia in neoplastic disease:*

Anaemia
- myelofibrosis (M9961/3) D47.1† D63.0*

AV nodal reentrant tachycardia (AVNRT)

Should AVNRT be coded to I47.0 *Re-entry ventricular arrhythmia* or I47.1 *Supraventricular tachycardia?*

AVNRT is the most common type of reentrant supraventricular tachycardia (SVT). Because of the abrupt onset and termination of the reentrant SVT, the nonspecific term *paroxysmal supraventricular tachycardia* has been used to refer to these tachyarrhythmias.

Treatment for AVNRT can be curative or palliative. Palliative measures include physical manoeuvres, such as carotid sinus massage, or medication. Patients unresponsive to palliative measures may require ablation, often by radiofrequency, in which the abnormally conducting tissue in the heart is destroyed.

The correct code assignment for AVNRT is I47.1 *Supraventricular tachycardia,* following the index pathway:

Tachycardia
- nodal I47.1

The NCCH will consider improvements to the Alphabetic Index for this condition for a future edition of ICD-10-AM.

Bipolar affective disorder

The ICD-10-AM Alphabetic Index contains index entries under *Disorder, bipolar, affective* for 'current episode' and 'most recent episode'. What do these

terms mean when assigning a code for bipolar affective disorder?

Category F31 *Bipolar affective disorder* in ICD-10-AM allows coders to specify the nature of the current (or most recent) episode in patients who have recurrent mood episodes. The terms 'current' and 'most recent' in this context are interchangeable and selection of either one allocates the same code.

There should be documentation in the current episode of care of the 'current' or 'most recent' affective episode before selecting either of these terms from the index pathway *Disorder, bipolar, affective.* If the 'episode' is not documented, and cannot be verified with the clinician, assign the default code F31.9 *Bipolar affective disorder, unspecified.* Coders should not assume that outpatient notes or other admission notes are indicative of the most recent affective state.

Carpal tunnel syndrome in pregnancy

What is the correct code assignment for carpal tunnel syndrome in pregnancy?

Carpal tunnel syndrome is a painful disorder of the hand caused by pressure on the median nerve, the main nerve that runs through the wrist. Symptoms include numbness, pins and needles, and pain (particularly at night). Anything that causes swelling inside the wrist can cause carpal tunnel syndrome, including repetitive hand movements, pregnancy and arthritis. Treatment options include rest, splinting, cortisone injections and surgery.

The hormones associated with pregnancy cause general fluid retention, which can compress the median nerve. Carpal tunnel syndrome in pregnancy usually occurs towards the end of the pregnancy and is likely to recur in a subsequent pregnancy. It can also continue, or sometimes develop, in the days following delivery. However, it is not normally a serious condition and usually eases off within a week or two of delivery, when hormone and fluid levels return to normal. Occasionally it does not resolve and may continue for months after delivery. In this instance surgery may be recommended.

The correct code to assign for carpal tunnel syndrome in pregnancy is O26.82 *Carpal tunnel syndrome in pregnancy* following the index pathway:

Syndrome
- carpal tunnel
- - in pregnancy O26.82

The NCCH will consider improvements to the Alphabetic Index for carpal tunnel syndrome in pregnancy for a future edition of ICD-10-AM.

Coding of findings on pathology results

The following queries highlight an issue as to whether findings on pathology results (often received after patient separation) should be coded.

A patient is admitted with menorrhagia for vaginal hysterectomy, pathology results show leiomyoma of the uterus, with no documented connection on the report or in the record between the menorrhagia and the leiomyoma. Would you code the leiomyoma?

Clinical advice confirms that leiomyomas/fibroids may or may not be an incidental finding:

> 'Fibroids can be incidental within the uterus and may not be the reason for the uterus being removed. Such fibroids are often small and in the subserous or intramural position in the uterus.
>
> If, however, the uterus is massively enlarged, it can certainly cause menorrhagia and would be the reason for the hysterectomy. Small fibroids in the submucous position can cause severe menorrhagia and could be a reason for hysterectomy.
>
> For the above reasons, unless the fibroids are indicated to be the reason for the hysterectomy by the operating surgeon, the surgeon should be asked to advise whether the fibroids were the reason for the surgery, and if the answer was YES, code accordingly.' Pepperell, Roger, O&G Clinician/O&G CCCG (personal communication).

Therefore, coders should follow the guidelines in ACS 0010 *General abstraction guidelines, Findings with an unclear, or no associated condition documented* which states:

> 'Unless a clinician can indicate that a test result is significant and/or indicates the relationship between an unclear test result and a condition, such test results should not be coded.'

Where there is uncertainty, such as when histopathology indicates a subserous leiomyoma, which are known to cause menorrhagia, coders should verify with the clinician whether the leiomyoma is significant to determine whether it should be coded.

A patient is admitted with haematuria secondary to benign prostatic hypertrophy (BPH). A TRUS biopsy was performed and pathology reveals adenocarcinoma, but the documented principal diagnosis is BPH. Would you code the adenocarcinoma?

This scenario is an example of poor documentation and so the guidelines below from ACS 0010 *General abstraction guidelines* should be followed in this instance:

'It is important to seek clinical advice where necessary for:

- verification of diagnoses recorded on the front sheet which are not supported in the clinical record, **and**
- clarification of discrepancies between investigation results and clinical documentation.'

The following is advice received by the NCCH from the Nephrology CCCG:

> 'The only reason to perform a TRUS and biopsy is to diagnose a cancer. No one biopsies a prostate because they suspect BPH. A finding of cancer is significant but may still result in no change to a treatment plan.' Travis, Douglas, Urologist/Nephrology CCCG (personal communication).

Therefore, when presented with poor documentation as indicated in the scenario above, coders should seek advice from the treating clinician to determine the correct principal diagnosis.

A patient is admitted with chronic ongoing pelvic pain for abdominal hysterectomy. Pathology results show CIN III, would you code CIN III as an additional diagnosis?

Clinical advice confirms that CIN III in the scenario cited is an unexpected finding:

> 'CIN III usually does not produce any symptoms at all, and certainly not pelvic pain. It results in an abnormal smear test, which then requires assessment by colposcopy and biopsy. It is usually treated by laser or cone biopsy, rarely by hysterectomy. In this instance it was likely to be an unexpected finding on histologic examination of the excised uterus, where the uterus was removed for pain not the CIN III.' Pepperell, Roger, O&G Clinician/O&G CCCG (personal communication).

Therefore, in the scenario cited CIN III should not be coded as per the guidelines in ACS 0010 *General abstraction guidelines.*

A patient is admitted with breast hypertrophy for reduction mammoplasty. After discharge pathology of the breast reveals ductal carcinoma in situ (DCIS). Would you code the DCIS?

In the scenario cited the finding of DCIS on pathology is an unexpected finding and should not be coded, as per the guidelines in ACS 0010 *General abstraction guidelines.*

The above scenarios have also highlighted an issue where coders may consider it necessary to assign a cancer code to generate a cancer notification for the cancer registry. Coders should be aware that the pathology department will do this automatically, irrespective of whether the condition is coded in the inpatient episode of care.

De Morsier's syndrome

What is the correct code assignment for De Morsier's syndrome?

De Morsier's syndrome, also known as septo-optic dysplasia (SOD), is a rare disorder characterised by abnormal development of the optic disc, pituitary deficiencies, and often agenesis (absence) of the septum pellucidum (the part of the brain that separates the anterior horns or the lateral ventricles of the brain).

Symptoms may include blindness in one or both eyes, pupil dilation in response to light, nystagmus, inward and outward deviation of the eyes, hypotonia, and hormonal problems. Seizures may also occur. In a few cases, jaundice may occur at birth. Intellectual problems vary in severity among individuals. While some children with SOD have normal intelligence, others have learning disabilities and mental retardation. Most, however, are developmentally delayed due to vision impairment or neurological problems.

The correct code to assign for De Morsier's syndrome is Q04.4 *Septo-optic dysplasia* following the index pathway:

Dysplasia
- septo-optic Q04.4

Manifestations of the syndrome should be coded if they meet the criteria for code assignment as per ACS 0002 *Additional diagnoses* and ACS 0005 *Syndromes.*

Improvements to the Alphabetic Index will be considered for De Morsier's syndrome for a future edition of ICD-10-AM.

Drug induced diarrhoea

What is the correct code to assign for drug induced diarrhoea?

There is no specific code in ICD-10-AM for drug induced diarrhoea/gastroenteritis and ICD-10 defaults gastroenteritis to A09.9 *Gastroenteritis and colitis of unspecified origin* in category A09 *Other gastroenteritis and colitis of infectious and unspecified origin*. Due to the absence of a specific code and because the default code assigns a code from Chapter 1 *Certain infectious and parasitic diseases* there has been variation in code assignment for this condition. Some coders have elected not to assign the default code in the absence of documentation of the condition being linked to an infectious agent. This has resulted in other code assignment, by selection of other essential modifiers in the index pathway, such as toxic or noninfectious.

Clinical advice was sought, both internationally and nationally, to ascertain correct code assignment for this condition, which indicates:

> 'different drugs can cause diarrhoea via different mechanisms and there may be either an infectious or toxic component involved, depending on the action of the drug. For example, if the drug modifies the intestinal flora it may result in a 'pathogen' taking over which then induces diarrhoea. Alternatively the drug may have a direct affect on the intestinal tissue (mucosa, muscles, nerves etc.). The resultant affects being either increased intestinal motor activity causing diarrhoea or the excretion of fluid by the mucosal cells due to the toxic effect, which increases the volume of stools.' Olafr Steinum, WHO-FIC Morbidity Reference Group (MbRG), Senior Consultant, Department of

Infectious Diseases, NU-Sjukvården, Sweden (personal communication).

Given the above advice, selecting 'noninfectious' from the index pathway or assigning A09.9 despite it being the default code is not correct. The preferred option of the Gastroenterology CCCG is K52.1 *Toxic gastroenteritis and colitis*, with an appropriate external cause code to specify the type of drug, if documented.

There is precedence in the classification to select 'toxic' for drug induced conditions, such as chronic liver disease due to drugs, which is assigned to K71.9 *Toxic liver disease, unspecified*. There are also other instances where the NCCH has given advice to use a more accurate code rather than the default code provided by ICD-10. However, coders should not make such decisions without advice from the NCCH. Furthermore coders shouldn't assume that all cases of drug induced conditions should be assigned to a toxic code because of the advice provided here. This advice is only provided after lengthy consideration and extensive clinical consultation.

A review of the classification of drug induced diarrhoea/ gastroenteritis is being considered for a future edition of ICD-10-AM, as a public submission concerning this issue has already been received.

Family history of hereditary non-polyposis colon cancer (HNPCC)

A patient undergoes colonoscopic surveillance due to a family history of HNPCC. At colonoscopy polypectomies are performed and histology reveals tubular adenoma with high grade dysplasia and hyperplastic polyps. The patient is given the option of close colonoscopic surveillance or total colectomy.

Should C18.- *Malignant neoplasm of colon* be coded as the principal diagnosis as per the guidelines in ACS 0247 *Hereditary non-polyposis colon cancer?*

The guidelines in ACS 0247 *Hereditary non-polyposis colon cancer* state:

'If hereditary non-polyposis colon cancer (HNPCC) is documented assign the following codes:

C18.- *Malignant neoplasm of colon*

Z80.0 *Family history of malignant neoplasm of digestive organs*'

Therefore, C18.- should only be assigned if there is documented evidence of HNPCC. In the scenario cited there is **NO** documented evidence of the patient having HNPCC, only a family history of HNPCC. The patient is undergoing colonoscopic surveillance due to the family history and current histology reports tubular adenoma with high grade dysplasia and hyperplastic polyps. For code assignment follow the guidelines in ACS 2111 *Screening for specific disorders* and ACS 0010 *General abstraction* guidelines.

What is the correct principal diagnosis code to assign in an admission where a total colectomy is performed as per the above scenario?

For the second scenario cited, where the patient with a family history of HNPCC elects to have a colectomy without documented evidence of HNPCC, it is reasonable to assume that the procedure, though extreme, is being performed prophylactically. In this instance assign Z40.08 Other in category Z40.0 *Prophylactic surgery for risk-factors related to malignant neoplasms* and Z80.0 *Family history of malignant neoplasm of digestive organs*, following the index pathways:

Prophylactic
- surgery
- - for risk factors related to malignant neoplasm
- - - specified NEC Z40.08

and

History
- family, of
- - malignant neoplasm (of) NEC
- - - digestive organ Z80.0

If there is any doubt, the coder should verify code assignment with the clinician.

Incorrect drug given in hospital

When assigning a code for a prescribed drug taken/ given in error, following the index pathway, 'Wrong drug (given in error)', assigns a poisoning code for the specified drug and an 'accidental poisoning' external cause code. When poisoning is coded why does the classification assign an 'accidental' external cause code rather than one for misadventure?

Also, the definition of poisoning in ACS 1901 *Poisoning* does not include 'drugs given or taken in error'.

See ACS 2005 *Poisonings and Injuries – Indication of Intent* which states:

> 'X40–X49 Accidental poisoning by and exposure to noxious substances
> The 'includes' note at the beginning of this block in the Tabular List of Diseases specifies:
>
> • accidental overdose of drug
>
> • wrong drug given or taken in error
>
> • drug taken inadvertently
>
> • accidents in the use of drugs, medicaments and biological substances in medical and surgical procedures.'

This is consistent with ICD-10, which classifies a wrong drug given or taken in error, as an accidental poisoning.

The NCCH will consider amending the definition of poisoning at ACS 1901 *Poisoning* to include 'drugs given/ taken in error,' for a future edition of the ACS.

Methicillin resistant or multi-resistant Staphylococcus aureus (MRSA) or Vancomycin resistant Enterococcus (VRE) carriers

When is it appropriate to assign a code for a carrier or suspected carrier of MRSA or VRE?

Where documentation indicates that a patient is a carrier or suspected carrier of MRSA or VRE, assign Z22.3 *Carrier of other specified bacterial diseases,* if it meets the criteria for code assignment as per ACS 0002 *Additional diagnoses.*

For a carrier of MRSA follow the index pathway:

Carrier (suspected)
- staphylococci Z22.3

For a carrier of VRE follow the index pathway:

Carrier (suspected)
- streptococci Z22.3

See also ACS 0112 *Infection with drug resistant microorganisms.*

Should Z29.2 *Other prophylactic pharmacotherapy* be assigned if pharmacotherapy is commenced for a carrier or suspected carrier of MRSA or VRE?

There are no guidelines requiring the assignment of Z29.2 *Other prophylactic pharmacotherapy* where pharmacotherapy is commenced for carriers or suspected carriers of MRSA or VRE, so this code should not be assigned in a multi day admission.

Neonatal jaundice

ACS 1615 *Specific interventions for the sick neonate* states:

'A diagnosis code for jaundice of the newborn should only be assigned when > 12 hours of phototherapy is provided.'

Can jaundice be coded if it is documented as contributing to feeding difficulty but phototherapy is given for less than 12 hours or where other measures such as sunlight treatment or increased feeds are undertaken?

The current guidelines in ACS 1615 Specific interventions for the sick neonate state that:

> 'A diagnosis code for jaundice of the newborn **should only be assigned when > 12 hours of phototherapy is provided.**'

The exception to this guideline (previously published in Coding Matters Vol 5 No 1) is where a neonate is admitted specifically for jaundice. In this instance jaundice may be coded even if the phototherapy is given for less than 12 hours.

See also 'Additional diagnoses and specialty standards' Commandment in this edition.

Replacement of pacemaker/automatic implantable cardiac defibrillator (AICD) due to end of battery life

When a patient is admitted for replacement of pacemaker/AICD, is it necessary to code the underlying condition, such as arrhythmia, which necessitated the pacemaker insertion?

For replacement of pacemaker/AICD due to end of battery life, follow the guidelines in ACS 0936 *Cardiac pacemakers and implanted defibrillators* which states:

> 'End-of-(battery) life is an indication for elective replacement of the pacemaker or defibrillator generator (device)...

Admission for elective replacement of pacemaker or defibrillator is assigned code:

Z45.0 *Adjustment and management of cardiac device* together with the appropriate procedure code(s).'

A code for the underlying condition should only be assigned if it meets the criteria in ACS 0002 *Additional diagnoses*.

Sequestration of intervertebral disc

What is the correct code assignment for sequestration of intervertebral disc?

Disc sequestration is synonymous with a ruptured or displaced disc. It is incorrect to select M86.6- *Other chronic osteomyelitis*... by following the pathway, *Sequestrum, bone (see also Osteomyelitis)*, as a sequestered disc is not sequestered bone.

The three classifications of herniated/displaced disc are disc protrusion, disc extrusion, and disc sequestration. Disc sequestration is where the nucleus pulposis has leaked out of the disc entirely and has separated with the disc due to a breach of the posterior longitudinal ligament (PLL). Disc sequestration is often severely painful, exhibiting sciatica, or pain down the back and leg. Disc sequestration usually requires decompressive surgery.

Clinical advice confirms that the correct code assignment for disc sequestration is determined by selecting the appropriate code from the index pathway, *Displacement, displaced, intervertebral disc.*

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

Sliding Scale Insulin

When a patient is commenced on 'sliding scale insulin,' does diabetes meet the criteria for code assignment as per ACS 0002 *Additional diagnoses*?

Sliding scale insulin is used to prospectively manage blood sugar levels (BSLs) in diabetic patients. It means that a scale has been set for a particular dose of short acting insulin to vary, depending on the blood glucose level at the time it is to be given. It is a more formal method of guiding an insulin dose, both the short acting and 'fix up' doses. Most diabetics do their 'fix up' doses without having a set scale written, but some diabetics and their doctors and educators prefer a written scale.

So a clinician may require, that when a diabetic patient is admitted for surgery, they be placed on a sliding scale insulin regime. It doesn't mean their medication is being altered but rather their regime is being formalised.

If a diabetic patient is admitted with poorly controlled diabetes and placed on a sliding scale insulin regime, the issue is that the diabetes is poorly controlled, not whether a sliding scale insulin regime is being used to stabilise the diabetes.

Therefore, when determining whether diabetes should be coded, coders should look for the reasons why the patient was commenced on a sliding scale insulin regime rather than basing the decision on the treatment alone.

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ICD-10-AM/ACHI/ACS

Seventh Edition education program

From 1 July 2010 ICD-10-AM/ACHI/ACS Seventh Edition will be implemented nationally. In order to familiarise clinical coders and other users with the changes that have been made to the classification an education program will be offered for Australian coders only from May to June 2010.

Education program

Education material containing all the changes that have been made to ICD-10-AM Sixth Edition to create the Seventh Edition will be provided via:

- a downloadable PDF file via the web – the pre-education material can be worked through at your own pace and includes all major and minor changes that have been made to ICD-10-AM/ACHI/ACS with exercises to help reinforce some of these changes. (This document is > 400 pages in length and will therefore take considerable time to work through in detail.)
- optional (recommended) one day face-to-face workshops that will be conducted in all capital cities and many regional centres.
- a workbook with a number of case scenarios and clinical record abstracts, to help illustrate the changes, will be distributed to participants for completion prior to attending the workshop. At each workshop there will be opportunity to discuss the answers with information also being provided on the main areas of change.

How to access the pre-education program material

The pre-education material can be accessed by:

- NCCH website via a PDF file
- order a CD-ROM
- order a hard copy of the PDF file

Access to the pre-education PDF file via the NCCH website will be made using a secure user name and password which will be issued once you have registered for the education program. Access to the pre-education PDF file will be made available from February 2010.

To complete the exercises in the pre-education and workshop material access to ICD-10-AM/ACHI/ACS Seventh Edition is recommended however the pre-education exercises can be completed by accessing the pre-education material alone.

ICD-10-AM/ACHI/ACS Seventh Edition workshops

Optional (but recommended) one day face-to-face workshops will be offered to Australian coders between May and June 2010 in all state and territory capital cities, as well as major regional areas. Attendance at workshops is optional, but provides an opportunity for coders to consolidate their learning and to also network with other ICD-10-AM/ACHI/ACS users. A fee will be charged for attending the workshops. **Completion of the pre-education material and coding workbook is mandatory for coders attending the workshops.**

All registrants for the workshops will receive a workbook containing a number of case scenarios and clinical records to help illustrate the changes which are to be completed prior to attending. The workbook will be sent to participants, at least two weeks prior to the nominated workshop date, for completion. An answer book will be provided on the day plus morning tea, lunch, and tea/coffee being available throughout the day.

Participants will need their own copies of ICD-10-AM/ACHI/ACS Seventh Edition in hard copy or the eBook on laptop at the workshops plus your completed workbook. Educators will reinforce some of the main changes to the classification outlined in the pre-education material as well as providing answers to the case scenarios and clinical record abstracts. These workshops provide valuable opportunities for users of the classification to learn and discuss aspects of coding with Seventh Edition.

The workshops will commence at 9.00am and conclude at approximately 4.00pm and often fill very quickly so book early to secure your place. It is important that registrations are forwarded to the NCCH well in advance of a selected workshop in order that room bookings and catering arrangements can be made.

Maximum places offered for a workshop is fifty with the minimum being fifteen. If the minimum quota for registrations is not reached (exception being the Northern Territory and some regional areas) the workshop may be cancelled.

The workshop will focus on the following main areas of change which have been made to the classification:

- diabetes mellitus
- lymphoma/leukaemia
- obstetrics
- procedures not normally coded
- sepsis

What you'll need to bring to the workshop

- a set of ICD-10-AM/ACHI/ACS Seventh Edition books or
- eBook installed on your own laptop computer and
- completed coding workbook
- writing equipment

Workshops are operated on the assumption that all participants have completed the pre-education material and coding workbook before attending. Educators are unable to retrospectively review information covered in the education material at workshops.

Cost

Users must register to access the Seventh Edition education program material. Costs are:

Downloadable PDF file via web	Free
CD-ROM	$55*
Hardcopy	$110*
Workshop	$198*

*All costs include GST

You must register and complete the education material to be eligible to attend workshops.

Workshop registrations will be taken from 1st February 2010 onwards to secure a place, visit http//www.ncch.com.au

Workshop places are limited. To avoid disappointment you must register as soon as possible from this date to secure a place and so that venues can be booked.

Cancellations received with more than 10 working days notice before a workshop will be refunded, less an administration fee of $50.00. No refunds are available for cancellations received within 10 working days of a workshop.

Workshop schedule

Please note: The NCCH reserves the right to cancel, reschedule or relocate workshops if target numbers are not reached

The 2010 proposed workshop dates and locations* are:

NEW SOUTH WALES

4 May	Bankstown
5 May	Bankstown
6 May	North Ryde 1
7 May	North Ryde 2
5 May	Newcastle 1
6 May	Newcastle 2
8 June	Penrith
8 June	Dubbo
9 June	Wollongong
10 June	Tamworth
16 June	Albury
24 June	Lismore
29 June	Coffs Harbour

WESTERN AUSTRALIA

12 May	Perth 1
13 May	Perth 2
14 May	Perth 3

NORTHERN TERRITORY

1 June	Darwin

QUEENSLAND

1 June	Brisbane 1
2 June	Brisbane 2
3 June	Brisbane 3
3 June	Cairns
4 June	Toowoomba
13 May	Rockhampton
23 June	Maroochydore

TASMANIA

11 May	Hobart

SOUTH AUSTRALIA

25 May	Adelaide 1
26 May	Adelaide 2
27 May	Adelaide 3

AUSTRALIAN CAPTIAL TERRITORY

22 June	Canberra

VICTORIA

18 May	Bendigo
19 May	Melbourne 1
20 May	Melbourne 2
16 June	Melbourne 3
17 June	Melbourne 4
18 June	Geelong

*subject to change

NB: the minimum number of participants required for a workshop to be held is 15 participants (excluding NT) otherwise the workshop will be cancelled.

More information…

will also be published at www.ncch.com.au and in the March 2010 edition of *Coding Matters*. Previous workshop registrants will be provided with more information by direct mail.

Win a free ICD-10-AM/ACHI/ACS Seventh Edition eBook….

By registering on-line to attend the education workshops, participants will be entered into a competition to win a Seventh Edition eBook.

WHOFIC – Seoul, Korea

The annual meeting of the World Health Organization Family of International Classifications (WHOFIC) Network was held from 10-16 October 2009 in Seoul, Korea. The meeting was hosted by the Korean WHO Collaborating Centre and was attended by approximately 150 participants from 12 WHO Collaborating Centres and representatives from Ministries of Health or National Statistics Bureaux. Representing Australia were Penny Albon and Gordon Tomes, Australian Institute of Health and Welfare (AIHW), Richard Madden, Julie Rust, Megan Cumerlato and Young Tjoa from the NCCH, and Ros Madden (ICF expert).

This report will concentrate on the areas of development of the International Classification of Diseases (ICD), both for the current classification, ICD-10, and the revision process towards ICD-11, as well as the development of an International Classification of Health Interventions (ICHI) and an update on ICF activities.

The final meeting report, containing detailed summaries of the meetings of the various committees and groups of the Network, will be available at: http://www.who.int/classifications/network/meetings/en/index.html

Update and Revision Committee (URC) for ICD-10

A total of 81 proposals were reviewed by the URC in 2009, with 61 proposals being accepted as official updates to ICD-10 during the WHOFIC meeting with 6 proposals being referred to the ICD-11 Topic Advisory Groups (TAGs) for further discussion.

Of the proposals accepted a number of these were public submissions received by the NCCH during the past two years which required ratification by WHO before inclusion into the classification, these included:

- Changes to code titles for pre-eclampsia and hypertension in pregnancy with the deletion of the term 'moderate' pre-eclampsia
- Changed default code for anaesthetic death in pregnancy
- Improved index entries for peritoneal eosinophilia
- Addition of inclusion terms and improved indexing for primary sleep apnoea of newborn

A brief report was provided to the group by those members who participated in the ICD-11 writing camp (iCamp) in Geneva during September 2009. The URC will continue to work on ICD-10 proposals to support both ICD-10 and ICD-11 development. The revised terms of reference of the URC were accepted during the Network meeting and they now incorporate the process for updating the International Classification of Functioning, Disability and Health (ICF).

Morbidity Reference Group (MbRG)

The Morbidity Reference Group (MbRG) met twice during the Network meeting and work continues on a number of key areas:

- ICD-11 Revision process and the Topic Advisory Groups (TAGs) for this development work
- Discussion of main condition definition for ICD-11
- Instruction manual (volume 2) development for ICD-10 – it is envisaged that this work will also inform development of volume 2 for ICD-11
- Presenting problem and underlying condition

The terms of reference and work plan for 2009-2010 were reviewed and updated accordingly to reflect the activities of the group. The midyear meeting of the MbRG will be held in Cologne, Germany, 1-3 March 2010.

WHOFIC attendees 2009

Family Development Committee (FDC)

The Family Development Committee met twice during the Network meeting and the following are the main items of work which progressed during these meetings:

- International Classification on Health Interventions (ICHI) development - work continues on the development of an interventions classification which can be used and adapted internationally with a broad scope and a framework which can be adapted for individual country or specialised requirements.
- There was discussion on the revision of the International Classification for Primary Care (ICPC) and the relationship with other WHOFIC classifications.
- Revision process for the System of Health Accounts was discussed.
- Update provided on work to date on the International Classification for Patient Safety (ICPS).
- Plans were further outlined on the development of an International Classification of Traditional Medicine (ICTM).

The work plan for 2009-2010 was reviewed and updated to reflect the ongoing work of the FDC. The mid-year meeting of the FDC will be held in Cologne, Germany, 4– 5 March 2010.

Functioning and Disability Reference Group (FDRG)

The Functioning and Disability Reference Group had three days of meetings, discussing its work plan on topics such as:

- International Classification of Functioning, Disability and Health (ICF) updates
- Education in ICF
- Ethical use of ICF
- ICF and terminologies.

One of the lively discussions included ICF implications for the ICD revision; among other work already done, the FDRG has identified key terms from the ICF which should be used consistently in the ICD - terms such as 'functioning', 'activity limitation', 'participation restriction' and 'disability'

CONFERENCES 2010

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

Australian Refined Diagnosis Related Groups (AR-DRG)

Version 6.0

AR-DRG is a classification scheme based on ICD-10-AM/ACHI/ACS codes. It provides a way of grouping episodes of care in a hospital according to clinical characteristics and resource use.

AR-DRG Version 6.0 incorporates ICD-10-AM/ACHI/ACS Sixth Edition codes.

AR-DRG definition manuals are published by the Australian Government Department of Health and Ageing and distributed by the NCCH.

For further information and to order:

NCCH Sydney
Telephone: +61 2 9351 9461
E-mail: fhsNCCHsales@usyd.edu.au

Attention!

Health Information Managers and Clinical Coders

The NCCH needs case scenarios or clinical record abstracts for possible use in future education workshops!

If you have a case that can be used, please either send a de-identified copy to the NCCH or summarise the case and email it to...

E-mail:
m.cumerlato@usyd.edu.au

Address:
NCCH
The University of Sydney
PO Box 170 Lidcombe NSW 1825

The Director and staff of the NCCH wish you a

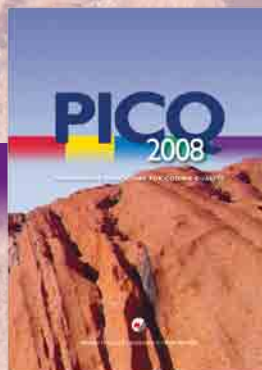*Merry Christmas*

and a prosperous New Year

PICQ 2008

Performance Indicators for Coding Quality (PICQ)
is a set of pre-determined indicators which identifies records
in data sets that may be incorrectly coded based on Australian
Coding standards (ACS) and coding conventions.

PICQ 2008 makes it easy to measure ICD-10-AM/ACHI coded
patient morbidity data using a series of indicators based on
Australian Coding Standards (ACS) and coding conventions.

PICQ can identify data problem areas, suggest possible causes
and provide corrections. PICQ will measure data accuracy
against specific indicators and data quality over time. PICQ
can assist coder education and provide feedback to individual
coders.

PICQ 2008 is now available, incorporating 245 indicators for
ICD-10-AM/ACHI/ACS Fifth Edition and 302 indicators for
ICD-10-AM/ACHI/ACS Sixth Edition.

PICQ 2008 is now available.
For further information on
how to order:
NCCH Sydney
Phone: +61 2 9351 9461
E-mail: fhsNCCHsales@usyd.edu.au