IHACPA

Retired National Coding Advice

Effective 1 January 2023

Version 1.2

Retired National Coding Advice

Version History:

- Version 1.2 published 15 December 2022. Clinical updates have been removed and are located on the IHACPA website.
- Version 1.1 published 15 September 2022. Amended incorrect ‘retired on’ date for Q3503 Eleventh Edition ACS 1904 *Procedural complications* – due to/related to prosthetic devices, implants or grafts.
- Version 1.0 published 1 July 2022.

Contents

Coding Rules

Retired/Superseded for Twelfth Edition

Ref No: Q3742 | Published On: 15-Sep-2021 | Status: Retired | Retired On: 1-Jul-2022

Current COVID-19 diagnosis after a previous diagnosis of COVID-19

Q:

Can a code for personal history of coronavirus disease 2019 (COVID-19) be assigned in the same episode as a code for a current diagnosis of COVID-19?

A:

When a patient is diagnosed with COVID-19 after having previously recovered from COVID-19, assign an appropriate emergency use code for COVID-19 and a code for personal history of COVID-19 to identify the previous recovery from COVID-19.

Assign U07.1 *Emergency use of U07.1 [COVID-19, virus identified]* or U07.2 *Emergency use of U07.2 [COVID-19, virus not identified]* in accordance with the guidelines in Coding Rule *Coronavirus disease 2019 (COVID-19).*

Assign U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* in accordance with the guidelines in Coding Rule *Classification of post COVID-19 conditions*.

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Ref No: Q3499 | Published On: 15-Sep-2021 | Status: Retired | Retired On: 1-Jul-2022

Epileptic psychosis with delirium

Q:

What codes are assigned where delirium occurs in a patient with psychosis of epilepsy?

A:

Where clinical documentation indicates delirium in a patient with psychosis of epilepsy, assign F05.8 *Other delirium*.

Follow the ICD-10-AM Alphabetic Index:

Epilepsy, epileptic, epilepsia

- psychosis

- - with delirium F05.8

or

Psychosis

- epileptic

- - with delirium F05.8

Assign an additional code from category G40 *Epilepsy* in accordance with the *Instructional* note at category F05 *Delirium, not induced by alcohol and other psychoactive substances*:

> *Use additional code to identify underlying disease.*

Amendments will be considered for a future edition.

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Ref No: Q3718 | Published On: 15-Sep-2021 | Status: Retired | Retired On: 1-Jul-2022

Fever as an adverse effect of COVID-19 vaccination

Q:

What code is assigned for fever due to an adverse effect of COVID-19 vaccination?

A:

For classification purposes, ICD-10-AM classifies a vaccine as a drug.

Where there is documentation of fever due to an adverse effect of COVID-19 vaccination, assign R50.2 *Drug-induced fever*.

Follow the ICD-10-AM Alphabetic Index:

Fever

- drug-induced R50.2

Improvements to ICD-10-AM are proposed for Twelfth Edition.

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Ref No: Q3726 | Published On: 15-Sep-2021 | Status: Retired | Retired On: 1-Jul-2022

Monoclonal macroglobulinaemia

Q:

What morphology code is assigned for monoclonal macroglobulinaemia?

A:

Monoclonal macroglobulinaemia is also known as monoclonal gammopathy of undetermined significance.

The following ICD-10-AM Alphabetic Index subterm is missing a morphology code:

Macroglobulinaemia (idiopathic) (primary)

- monoclonal (essential) D47.2

Assign the following topography and morphology codes for monoclonal macroglobulinaemia:

D47.2 *Monoclonal gammopathy of undetermined significance (MGUS)*

M9765/1 *Monoclonal gammopathy of undetermined significance*

This has been corrected for Twelfth Edition.

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for implementation 01 October 2021.

Ref No: Q3638 | Published On: 15-Jun-2021 | Status: Retired | Retired On: 1-Jul-2022

Telangiectasia of the intestine and rectum

Q:

What is the correct code assignment for telangiectasia of intestine and rectum?

A:

Gastrointestinal telangiectasia is synonymous with gastrointestinal angiodysplasia, a term used to describe non-specific vascular malformation originating from the gastrointestinal mucosa and/or submucosa (WHO 2020). Research into the nature of gastrointestinal angiodysplasia has resulted in the development of a multitude of synonymous terms including arteriovenous malformation, telangiectasia, angiectasia, or vascular ectasia (Al-Hamid & Gamarra 2011).

As gastrointestinal telangiectasia is synonymous with gastrointestinal angiodysplasia, assign an appropriate code for gastrointestinal telangiectasia by the following the lead term **Angiodysplasia**.

Assign K55.2- *Angiodysplasia of colon* for telangiectasia of intestine or rectum.

Follow the ICD-10-AM Alphabetic Index:

Angiodysplasia (caecum) (colon) (intestine) K55.21

- with haemorrhage K55.22

Amendments to the classification of gastrointestinal telangiectasia are being considered for ICD-10-AM Twelfth Edition.

References and Bibliographies

Al-Hamid, H. and Gamarra, M.R. (2019), 'Angiodysplasia of the Colon', *Medscape*, viewed 12 January 2021, <http://emedicine.medscape.com/article/170719-overview>.

Jaramillo, E. (2002), 'Multiple rectal telangiectasias', *Medscape*, viewed 29 March 2021, <https://www.medscape.com/viewarticle/418937_2>.

Li, J. A., Zhong, L. L., Li, B., Jiang, D. Q., & Zhao, Y. L. (2020), 'Diffuse telangiectasia of the colon: A case report', *Medicine*, vol. 99, no. 34, e21106., viewed 29 March 2021, <https://doi.org/10.1097/MD.0000000000021106>

World Health Organization (2020), International classification of diseases for mortality and morbidity statistics (11th Revision) (ICD-11), viewed 11 March 2021, <https://icd.who.int/ct11/icd11_mms/en/release>.

Published 15 June 2021,
for implementation 01 July 2021.

Ref No: TN1551 | Published On: 16-Mar-2021 | Status: Retired | Retired On: 1-Jul-2022

COVID-19 vaccines causing adverse effects in therapeutic use

Effective from 1 January 2021

To identify adverse effects of COVID-19 vaccines in therapeutic use, the World Health Organization has activated an additional emergency use code.

In Australia, this emergency use code will be implemented as U07.7 *Emergency use of U07.7 [COVID-19 vaccines causing adverse effects in therapeutic use]*.

Assign U07.7 in addition to external cause codes where clinical documentation indicates that a patient has experienced an adverse effect due to a COVID-19 vaccination.

The COVID-19 vaccines currently approved for use in Australia are not serum based, therefore codes from T80 *Complications following infusion, transfusion and therapeutic injection* are not appropriate.

Example 1: A patient is admitted with allergic urticaria due to a COVID-19 vaccination. Assign codes for the adverse effect followed by emergency use code U07.7:

Codes: T88.1 *Other complications following immunisation, not elsewhere classified*

L50.0 *Allergic urticaria*

Y59.0 *Viral vaccines [causing adverse effects in therapeutic use]*

Y92.23 *Health service area, not specified as this facility*

U07.7 *Emergency use of U07.7 [COVID-19 vaccines causing adverse effects in therapeutic use]*

Example 2: A patient presents with wheezing, itchy skin and difficulty swallowing and is diagnosed with anaphylaxis due to COVID-19 vaccination. Assign a code for the anaphylaxis followed by emergency use code U07.7:

Codes: T88.6 *Anaphylaxis and anaphylactic shock due to adverse effect of correct drug or medicament properly administered*

Y59.0 *Viral vaccines [causing adverse effects in therapeutic use]*

Y92.23 *Health service area, not specified as this facility*

U07.7 *Emergency use of U07.7 [COVID-19 vaccines causing adverse effects in therapeutic use]*

See also Coding Rule *Allergens and anaphylaxis.*

Reference:

World Health Organization 2020, *Serology and early investigation protocols*, viewed 2 September 2020, https://www.who.int/emergencies/diseases/novel-coronavirus-2019/serology-in-the-context-of-covid-19.

Australian Government Department of Health 2021, *Are COVID-19 vaccines safe?,* viewed 21 January 2021, https://www.health.gov.au/initiatives-and-programs/covid-19-vaccines/about-covid-19-vaccines/are-covid-19-vaccines-safe.

Centres for Disease Control and Prevention 2021, *Allergic reactions*, United States Department of Health & Human Services, viewed 21 January 2021, https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/allergic-reaction.html.

Published 16 March 2021,
for implementation 01 January 2021.

Ref No: Q3498 | Published On: 18-Dec-2020 | Status: Retired | Retired On: 1-Jul-2022

Clarification of ACS 0236 *Neoplasm coding and sequencing*

Q:

Can the primary neoplasm be coded when a patient is admitted for a late complication of the neoplasm treatment, or subsequently develops a complication of neoplasm treatment during an episode of care for treatment of a nonmalignant condition?

A:

ACS 0236 *Neoplasm coding and sequencing/Primary neoplasm* as a current condition states:

> *A primary neoplasm is classified as a current condition if the episode of care is for:*
> - *diagnosis or treatment of the primary neoplasm, in any of the following circumstances:*
>   - *initial diagnosis of the primary neoplasm*
>   - *treatment of complications of the primary neoplasm or neoplasm treatment*
>   - *operative intervention to remove the primary neoplasm*
>   - *medical care related to the primary neoplasm, including palliative care (see also ACS 2116 Palliative care)*
>   - *recurrence of the primary neoplasm previously eradicated from the same organ or tissue (see also ACS 0237 Recurrence of malignancy)*
>
> …
>
> *If the episode of care is for treatment of another nonmalignant condition, the malignancy may be classified as a current condition only if it meets the criteria for code assignment as per ACS 0002 Additional diagnoses.*

The term ‘neoplasm treatment’ in ACS 0236 (above) relates to interventions specifically targeting the neoplasm, such as pharmacotherapy or radiotherapy. Complications of surgical interventions performed for treatment of a neoplasm are assigned in accordance with the guidelines in ACS 1904 *Procedural complications.*

Therefore, a primary neoplasm code is assigned in an episode of care when there is treatment of a primary neoplasm, neoplasm related condition, or a pharmacotherapy or radiotherapy related complication.

When a nonmalignant condition is the principal diagnosis in an episode of care, a primary neoplasm code is assigned as an additional diagnosis when:

- it meets the criteria in ACS 0002 *Additional diagnoses*; or
- a neoplasm related condition, or pharmacotherapy or radiotherapy related complication, meets the criteria in ACS 0002 *Additional diagnoses.*

Where documentation confirms a neoplasm is completely resolved and none of the above points applies, and the history is relevant to the current episode of care, assign a code from category Z85 *Personal history of malignant neoplasm.*

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B95–B97 *Bacterial, viral and other infectious agents*

Q:

Can a code from block B95–B97 be assigned with another code from Chapter 1 to add specificity?

A:

Codes in block B95–B97 *Bacterial, viral and other infectious agents* are assigned to identify certain organisms as the cause of diseases classified to other chapters. Therefore, they are never assigned with another code from Chapter 1 *Certain infectious and parasitic diseases* to classify a single clinical concept (ie a single infection).

For example:

- Sepsis due to *Klebsiella pneumoniae* is a single clinical concept. Assign A41.58 *Sepsis due to other Gram-negative organisms*.

  Follow the ICD-10-AM Alphabetic Index:

  Sepsis (generalised)

  - Gram-negative (organism)

  - - specified NEC A41.58

- Bacteraemia due to Klebsiella pneumoniae is a single clinical concept. Assign A49.*8 Other bacterial infections of unspecified site.*

  Follow the ICD-10-AM Alphabetic Index:

  Bacteraemia *(see also Infection/by type)*

  Infection, infected (opportunistic)

  - Klebsiella (K.) pneumoniae NEC A49.8

Note also that the Conventions used in the ICD-10-AM Tabular List state:

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

For guidelines regarding multiple clinical concepts (ie multiple infections) see Coding Rule Q3332 *E. coli* UTI and *E. coli* bacteraemia.

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Multisystem inflammatory syndrome associated with COVID-19

The COVID-19 pandemic has resulted in reports describing patients with COVID-19-associated multisystem inflammatory conditions that appear to develop after the infection rather than during the acute stage of COVID-19. This condition may be synonymously referred to as:

- paediatric inflammatory multisystem syndrome temporally associated with SARS-CoV-2 (PIMS-TS)
- multisystem inflammatory syndrome in children (MIS-C) associated with COVID-19
- multisystem inflammatory syndrome in adults (MIS-A).

While the clinical presentation may vary, signs and symptoms generally include persistent fever, abdominal pain, vomiting, diarrhoea, skin rash, mucocutaneous lesions and, in severe cases, hypotension and shock. Some patients may develop myocarditis, cardiac dysfunction or acute kidney injury (Centres for Disease Control and Prevention 2020a; World Health Organization 2020).

To identify this condition, the World Health Organization has activated an emergency use code that will be implemented in Australia as U07.5 *Emergency use code U07.5 [Multisystem inflammatory syndrome associated with COVID-19].*

U07.5 *Multisystem inflammatory syndrome associated with COVID-19* is assigned in accordance with ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*.

Example 1: A patient is diagnosed with multisystem inflammatory syndrome after recovering from COVID-19. Assign emergency use code U07.5 *Emergency use code U07.5 [Multisystem inflammatory syndrome associated with COVID-19]* in accordance with the guidelines in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*.

Codes: U07.5 *Emergency use code U07.5 [Multisystem inflammatory syndrome associated with COVID-19]*

Example 2: A paediatric patient is diagnosed with Kawasaki-like syndrome. Symptoms include fever, odynophagia, two days of diarrhoea and vomiting, and abdominal pain. Laboratory tests reveal residual antibodies from a previous SARS-CoV-2 infection. Assign emergency use code U07.5 *Emergency use code U07.5 [Multisystem inflammatory syndrome associated with COVID-19]* as principal diagnosis. Do not assign additional diagnosis codes for the symptoms or M30.3 *Mucocutaneous lymph node syndrome [Kawasaki]* in addition to U07.5.

Codes: U07.5 *Emergency use code U07.5 [Multisystem inflammatory syndrome associated with COVID-19]*

References:

Centres for Disease Control and Prevention 2020a, Information for healthcare providers about Multisystem Inflammatory Syndrome in Children (MIS-C), United States Department of Health Human Services, viewed 2 September 2020, https://www.cdc.gov/mis-c/hcp.

Centres for Disease Control and Prevention 2020b, Multisystem Inflammatory Syndrome in Adults (MIS-A), United States Department of Health Human Services, viewed 2 December 2020, https://www.cdc.gov/mis-c/mis-a.html.

Jiang, L., Tang, K., Levin, M., Irfan, O., Morris, S.K., Wilson, K., Klein, J.D., Bhutta, Z.A. 2020, 'COVID-19 and multisystem inflammatory syndrome in children and adolescents', Lancet Infectious Diseases: Online first, viewed 2 September 2020, https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(20)30651-4/fulltext#:~:text=This%20COVID%2D19%2Dassociated%20multisystem,19%2C%20and%20herein%20is%20referred.

World Health Organization 2020, Multisystem inflammatory syndrome in children and adolescents temporally related to COVID-19: Scientific brief, viewed 2 September 2020, https://www.who.int/news-room/commentaries/detail/multisystem-inflammatory-syndrome-in-children-and-adolescents-with-covid-19.

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Classification of post COVID-19 conditions

The long term health outcomes of the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection and coronavirus disease 2019 (COVID-19) are uncertain and unfolding.

The World Health Organization has activated two additional emergency use codes to identify episodes of care where documentation indicates a post COVID-19 condition, resulting from either a previous COVID-19 diagnosis or SARS-CoV-2 infection.

These emergency use codes are not for the classification of current infections of SARS-CoV-2 and are never assigned as a principal diagnosis.

In Australia, the post COVID-19 emergency use codes will be implemented as follows:

- assign U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* as an additional diagnosis where clinical documentation indicates that the patient has previously confirmed COVID-19 that is no longer current.
- assign U07.4 *Emergency use of U07.4 [Post COVID-19 condition]* as an additional diagnosis where clinical documentation indicates a current condition is causally related to previous COVID-19.

Do not assign B94.8 *Sequelae of other specified and infectious and parasitic diseases* as this concept is identified by the assignment of U07.4.

Where clinical documentation indicates previous COVID-19 but it is not clearly linked to a current condition, seek clarification from the treating clinician before assigning U07.4. Where a causal relationship is not established, assign U07.3 *Emergency use of U07.3 [Personal history of COVID-19].*

U07.3 and U07.4 are only assigned when COVID-19 is documented as no longer current. This includes where clinical documentation indicates that a patient does not have COVID-19, despite a positive laboratory test result for SARS-CoV-2. This scenario may occur where antibodies remain in the system even though an acute infection is no longer present (World Health Organization 2020). See also Coding Rule *Coronavirus disease 2019 (COVID-19)* when COVID-19 is documented as current.

Example 1: A patient is diagnosed with interstitial lung disease associated with previous COVID-19. As the clinical documentation states a causal relationship between the interstitial lung disease and previous history of COVID-19, assign emergency use code U07.4 *Emergency use of U07.4 [Post COVID-19 condition]* as an additional diagnosis.

Codes: J84.9 *Interstitial pulmonary disease, unspecified*

U07.4 *Emergency use of U07.4 [Post COVID-19 condition]*

Example 2: Following a full recovery from viral pneumonia with a SARS-CoV-2 (COVID-19) infection a patient is statistically discharged from an acute admitted episode of care and transferred to rehabilitation. The SARS-CoV-2 infection is no longer active in the rehabilitation episode of care.

In the rehabilitation episode of care, assign U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* as an additional diagnosis NOT U07.1 *Emergency use of U07.1 [COVID-19, virus identified]* as the SARS-CoV-2 infection is no longer current.

Codes: J12.8 *Other viral pneumonia*

Z50.9 *Rehabilitation*

U07.3 *Emergency use of U07.3 [Personal history of COVID-19]*

Example 3: Patient admitted with community acquired pneumonia. Laboratory test identifies SARS-CoV-2 positive, but a review by the infectious diseases team states 'old viral RNA that is not infectious'. As there is clinical documentation of a previous SARS-CoV-2 infection but no causal relationship with a current condition, assign emergency use code U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* as an additional diagnosis.

Codes: J18.9 *Pneumonia, unspecified*

U07.3 *Emergency use of U07.3 [Personal history of COVID-19]*

Example 4: Patient presents with gastro-oesophageal reflux disease. Clinical documentation in the current episode of care notes a recent history of COVID-19. As there is no causal relationship documented between COVID-19 and the current condition, assign emergency use code U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* as an additional diagnosis.

Codes: K21.9 *Gastro-oesophageal reflux disease without oesophagitis*

U07.3 *Emergency use of U07.3 [Personal history of COVID-19]*

Reference:

World Health Organization 2020, Serology and early investigation protocols, viewed 2 September 2020,https://www.who.int/emergencies/diseases/novel-coronavirus-2019/serology-in-the-context-of-covid-19.

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Insertion of minimally invasive glaucoma surgery (MIGS) device without concurrent cataract extraction

Q:

What code is assigned for insertion of a minimally invasive glaucoma surgery (MIGS) device without concurrent cataract extraction?

A:

Minimally invasive glaucoma surgery (MIGS) is an alternative surgical method that provides a medication-sparing approach to reduce intra-ocular pressure for patients with mild to moderate glaucoma (Richter Coleman 2016). A number of MIGS devices such as iStent®, XEN® gel stent or CyPass have been developed for micro-bypass stenting for open angle glaucoma to drain fluid from the anterior chamber (Glaucoma Australia n.d.).

Assign 90075-00 **[191]** *Other procedures for glaucoma* when a MIGS device is inserted as a standalone procedure (ie without concurrent cataract extraction).

Follow the ACHI Alphabetic Index:

Procedure

- glaucoma NEC 90075-00 **[191]**

An update is being progressed for Twelfth Edition to incorporate a new dedicated MBS item number now available for MIGS.

References:

Richter, G.M. Coleman, A.L. 2016, 'Minimally invasive glaucoma surgery: current status and future prospects', *Clinical Ophthalmology*, vol. 10, pp. 189–206, viewed 24 February 2020,https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4734795/pdf/opth-10-189.pdf.

Glaucoma Australia n.d., *Minimally invasive glaucoma surgery fact sheet*, viewed 24 February 2020, https://www.glaucoma.org.au/media/1179/minimally-invasive-glaucoma-surgery-mw-1114144.pdf.

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Ref No: Q3476 | Published On: 18-Dec-2020 | Status: Retired | Retired On: 1-Jul-2022

Oral pharmacotherapy for neoplasm and neoplasm (treatment) related conditions

Q:

Can all oral pharmacotherapy be coded for the treatment of neoplasm and neoplasm (treatment) related conditions?

A:

The instruction in previous versions of ACS 0044 *Pharmacotherapy* to not code oral chemotherapy in admitted episodes of care was deleted in Eleventh Edition to allow the assignment of 96203-00 **[1920]** *Oral administration of pharmacological agent, antineoplastic agent* for the treatment of neoplasms, neoplasm related conditions and neoplasm treatment related conditions. It was never intended that this code be assigned for agents that are not chemotherapeutic (eg oral hydration, paracetamol, steroids, antihistamines, antiemetics).

Therefore, assign 96203-00 **[1920]** *Oral administration of pharmacological agent, antineoplastic agent* for oral chemotherapy only.

Follow the ACHI Alphabetic Index:

Pharmacotherapy (systemic effect)

- oral 96203 **[1920]**

Note that this guideline relates to both same-day and multi-day episodes of care.

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Terms synonymous with adhesiolysis

Q:

When adhesions are referred to as being dissected or taken down are these terms synonymous with adhesiolysis?

A:

The Australian Classification of Health Interventions (ACHI) Alphabetic Index includes a number of lead terms that are synonymous with adhesiolysis. There are also cross references directing users to alternate indexed lead terms or subterms.

Adhesiolysis — *see also Division/adhesions*

Division (freeing)

- adhesions

Freeing

- adhesions — *see Division/adhesions*

Lysis — *see also Division*

- adhesions — see Division/adhesions

Release

- adhesions

Dissection is the technique used for adhesiolysis. Although neither *dissection* or *taken down* are indexed terms for adhesiolysis both are synonymous with adhesiolysis, with *taken down* used colloquially.

In circumstances where the documented terms are not indexed it may be necessary to identify the clinical concept or procedures performed from the clinical documentation and then select the most appropriate index terms to locate the correct codes.

Amendments will be considered for a future edition.

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Catamenial anaphylaxis

Q:

What code is assigned for catamenial anaphylaxis?

A:

Catamenial symptoms are symptoms that occur around the beginning of the menstrual cycle. These symptoms may include cramping, headaches, acne, anxiety or anaphylaxis and may be related to endogenous changes in hormone (eg progesterone) levels (Parker Jones 2016; Mustafa 2018).

Catamenial or cyclic/cyclical anaphylaxis (CA) is an extremely rare condition where the exact cause is complex and unclear, but occurs in the setting of menses. CA results in an allergic reaction with manifestations such as skin rash, abdominal cramping or angioedema (Lin et al. 2018).

Where CA is documented and the cause is not specified, assign N94.8 *Other specified conditions associated with female genital organs and menstrual cycle*.

Follow the ICD-10-AM Alphabetic Index:

Disease, diseased

- pelvis, pelvic

- - female

- - - specified N94.8

Where CA is documented as due to exogenous hormone exposure (eg due to administration of the oral contraceptive pill), assign T88.6 *Anaphylaxis and anaphylactic shock due to adverse effect of correct drug or medicament properly administered*.

Follow the ICD-10-AM Alphabetic Index:

Anaphylaxis

- due to

- - drug or medicament (adverse effect) T88.6

Also assign external cause and place of occurrence codes.

See also Q3496 Eleventh Edition FAQs Part 1: Allergens and anaphylaxis.

Amendments will be considered for a future edition.

References:

Lin, K., Rasheed, A., Lin, S. Gerolemou, L. 2018, 'Catamenial anaphylaxis: a woman under monthly progesterone curse', *Case Reports*, vol. 2018, viewed 4 November 2019, http://dx.doi.org/10.1136/bcr-2017-222047.

Mustafa, S. 2018, *What is catamenial anaphylaxis?*, viewed 4 November 2019, https://www.medscape.com/answers/135065-52896/what-is-catamenial-anaphylaxis .

Parker Jones, K. 2016, *Catamenial catastrophes: the worst things that can happen at the start of your period*, University of Utah Health, viewed 4 November 2019, https://healthcare.utah.edu/the-scope/shows.php?shows=0_30l8vgme .

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Transoral endoscopic (hemi) thyroidectomy vestibular approach

Q:

What is the correct code assignment for transoral endoscopic (hemi) thyroidectomy vestibular approach?

A:

Transoral endoscopic thyroidectomy is an emerging technique that uses natural orifice transluminal endoscopic surgery to access the thyroid gland via the mouth. In transoral endoscopic thyroidectomy vestibular approach (TOEVA), incisions are made in the region between the lips and cheek mucosa and the teeth (the oral vestibule) to allow placement of three endoscopic ports and to create space below the platysma, using carbon dioxide insufflation. This technique offers a scarless operation while retaining the advantages of minimally invasive surgery (Camenzuli et al. 2018).

As ACHI does not include a code for transoral endoscopy using vestibular approach, assign an ACHI code according to the type of thyroidectomy performed using this technique, for example:

- 30306-01 **[114]** *Total thyroid lobectomy*, unilateral alone for transoral endoscopic hemithyroidectomy vestibular approach
- 30296-01 **[114]** *Total thyroidectomy* alone for transoral endoscopic thyroidectomy vestibular approach.

Follow the ACHI Alphabetic Index:

Hemithyroidectomy (complete or total excision of 1 lobe) 30306-01 **[114]**

Thyroidectomy

- bilateral (complete or total excision of both lobes) 30296-01 **[114]**

Amendments will be considered in a future edition.

References:

Camenzuli, C., Schembri Wismayer, P. Calleja Agius, J. 2018, 'Transoral endoscopic thyroidectomy: a systematic review of the practice so far', *Journal of the Society of Laparoendoscopic Surgeons*, vol. 22, no. 3, viewed 9 January 2020, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6158973/.

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Spinal cord compression secondary to neoplasm

Q:

What codes are assigned for spinal cord compression secondary to a neoplasm?

A:

Spinal cord compression is a type of myelopathy, that is, functional disturbance or pathological change in the spinal cord. Myelopathy is an injury to the spinal cord due to compression that may result from trauma, stenosis or degenerative disease (Johns Hopkins Medicine n.d.). Neoplastic myelopathy is commonly caused by direct intraparenchymal involvement or external compression on the spinal cord (Nagpal Clarke 2012).

Where spinal cord compression is documented as due to a neoplasm, assign:

A code for the neoplasm from Chapter 2 *Neoplasms* (C00–D48) with appropriate morphology code

G99.2* *Myelopathy in diseases classified elsewhere*

G95.2 *Cord compression, unspecified*

Sequence codes in accordance with the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*.

Follow the ICD-10-AM Alphabetic Index:

Myelopathy

- in (due to)

- - neoplastic disease NEC (M8000/1) *(see also Neoplasm)* D48.9† G99.2*

Compression

- spinal (cord) G95.2

References:

Johns Hopkins Medicine n.d., *Spinal cord compression*, Johns Hopkins Medicine, viewed 12 March 2020, https://www.hopkinsmedicine.org/health/conditions-and-diseases/spinal-cord-compression.

Nagpal, S. Clarke, J.L. 2012, 'Neoplastic myelopathy', *Seminars in Neurology*, vol. 32, no. 2, pp. 137–145, viewed 12 March 2020, https://www.ncbi.nlm.nih.gov/pubmed/22961188.

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COPD exacerbation and influenza

Q:

What codes are assigned for an exacerbation of chronic obstructive pulmonary disease and influenza?

A:

The Conventions used in the ICD-10-AM Tabular List state:

> *In Australia, multiple condition coding (meaning that multiple conditions may be assigned in an episode of care) is used to provide the necessary specificity to fully describe the episode of care. This does not mean multiple codes are assigned to describe a single condition.*

Chronic obstructive pulmonary disease (COPD) with an (infective) exacerbation is a separate clinical entity to influenza although the two conditions may be related.

ACS 0015 *Combination codes* states:

> *Assign only the combination code when that code fully identifies the diagnostic conditions involved and when the Alphabetic Index so directs.*

For COPD exacerbated by influenza assign codes for both conditions to classify both diagnostic conditions. Assign J44.0 *Chronic obstructive pulmonary disease with acute lower respiratory infection* and an appropriate code for influenza (J09–J11), and sequence in accordance with the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*.

Follow the ICD-10-AM Alphabetic Index:

Disease, diseased

- lung
- - obstructive (chronic)
- - - with (acute)
- - - - exacerbation NEC
- - - - - infective J44.0

Influenza

- virus
- - identified (respiratory manifestations) (seasonal) NEC *(see also Influenza/A/H5N1)* J10.1
- - not identified (respiratory manifestations) NEC J11.1

See also Coding Rules Q3479 *Lower respiratory tract infection (LRTI) with presence of chronic obstructive pulmonary disease (COPD)* and Q3504 *Influenza with lower respiratory infection*.

Amendments will be considered for a future edition.

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Ref No: Q3547 | Published On: 21-Sep-2020 | Status: Retired | Retired On: 1-Jul-2022

Newborn of a diabetic mother

Q:

Is P70.0 *Syndrome of infant of mother with gestational diabetes* or P70.1 *Syndrome of infant of a diabetic mother* assigned for a newborn of a diabetic mother, where the infant has blood glucose monitoring but does not have hypoglycaemia documented in the clinical record?

A:

Syndrome of infant of a diabetic mother describes a range of effects on an infant born to a mother with diabetes mellitus (eg type I, type II or gestational). Hypoglycaemia is a common manifestation of the syndrome (WHO 2019a; WHO 2019b).

In the absence of documentation specifying 'syndrome of infant of a diabetic mother':

- Where a newborn has a mother with diabetes mellitus, assign P70.0 *Syndrome of infant of mother with gestational diabetes* or P70.1 *Syndrome of infant of a diabetic mother* only if the infant is documented with a manifestation (ie effect) of the syndrome (eg hypoglycaemia) in accordance with ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*.

  Follow the ICD-10-AM Alphabetic Index:

  Diabetes, diabetic (controlled) (mellitus) (without complication)

  - in pregnancy, childbirth or puerperium

  - - affecting fetus or newborn P70.1

  - - arising in pregnancy

  - - - affecting fetus or newborn P70.0

  - - gestational

  - - - affecting fetus or newborn P70.0

- Where a newborn with a diabetic mother is suspected and observed but does not manifest any signs of the syndrome (ie there is no effect on the infant), assign Z03.79 *Observation of newborn for other suspected condition*.

  Follow the ICD-10-AM Alphabetic Index:

  Observation (for)

  - newborn

  - - for suspected condition

  - - - specified condition NEC Z03.79

See also ACS 0010 *Clinical documentation and general abstraction guidelines/Test results and medication charts* and Coding Rule Q3146 *Neonatal hypoglycaemia in infant of diabetic mother*.

Amendments will be considered for a future edition.

References:

World Health Organization (WHO) 2019a, *ICD-11 Mortality and Morbidity Statistics (MMS) April 2019*, United Nations, viewed 20 April 2020, Foundation Id: http://id.who.int/icd/entity/1010481205.

World Health Organization (WHO) 2019b, *ICD-11 Mortality and Morbidity Statistics (MMS) April 2019*, United Nations, viewed 20 April 2020, Foundation Id: http://id.who.int/icd/entity/1500607905.

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Ref No: Q3528 | Published On: 21-Sep-2020 | Status: Retired | Retired On: 1-Jul-2022

Subcapital neck of femur fracture (NOF) with total hip joint replacement (THJR)

Q:

What intervention code is assigned for a subcapital NOF fracture with THJR?

A:

The Conventions used in the Alphabetic Index of Interventions state:

> *Wherever a preposition from the list below immediately follows a lead term or subterm, it takes precedence over symbols, numbers and the alphabetic sequence of subterms:*
>
> • *as*
>
> • *by*
>
> • *for*
>
> • *with*
>
> • *without*

Where there is documentation of total hip joint replacement (THJR), the ACHI Alphabetic Index at *Replacement/joint/hip/with/fracture of subcapital femur* is misleading if the convention regarding prepositional terms is applied strictly and in isolation.

Replacement
- joint (total) 50127-00 [1571]
- - hip
- - - with
- - - - fracture of subcapital femur (hemiarthroplasty) 47522-00 [1489]
- - - - insertion of cement spacer 49312-00 [1489]
- - - - removal of prosthesis 49312-00 [1489]
- - - excision 49312-00 [1489]
- - - partial 49315-00 [1489]
- - - revision — see Revision/joint replacement/hip
- - - total (unilateral) (with bone graft) 49318-00 [1489]
- - - - bilateral 49319-00 [1489]
- - - - Birmingham (metal) (unilateral) (with bone graft) 90607-00 [1489]
- - - - - bilateral 90607-01 **[1489]**

For documentation of THJR for unilateral fractured subcapital neck of femur, assign 49318-00 **[1489]** *Total arthroplasty of hip, unilateral*.

Follow the ACHI Alphabetic Index:

Replacement

- joint (total) 50127-00 **[1571]**
- - hip
- - - total (unilateral) (with bone graft) 49318-00 **[1489]**

Amendments will be considered for a future edition.

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Ref No: Q3615 | Published On: 21-Sep-2020 | Status: Retired | Retired On: 1-Jul-2022

Tight perineum as indication for episiotomy

Q:

What code is assigned for tight perineum, when documented as the indication for episiotomy?

A:

The perineum stretches during vaginal delivery to accommodate passage of the fetus. A perineum that is rigid (tight) does not stretch easily (Thomas 2019) and an episiotomy may be performed to facilitate delivery (Kilgore 2015).

Where tight perineum is documented as an indication for episiotomy, assign O65.5 *Labour and delivery affected by abnormality of maternal pelvic* organs.

Follow the ICD-10-AM Alphabetic Index:

Rigid, rigidity

- perineum or vulva

- - affecting

- - - labour or delivery O65.5

Amendments will be considered for a future edition.

References:

Kilgore, R. 2015 *To episiotomy or not to episiotomy?*, blog, Herman Wallace Pelvic Rehabilitation Institute, viewed 21 July 2020, https://hermanwallace.com/blog/to-episiotomy-or-not-to-episiotomy.

Thomas, L. 2019, *Perineal tear*, News-Medical.Net, viewed 21 July 2020, https://www.news-medical.net/health/Perineal-Tear.aspx.

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for implementation 01 October 2020.

Ref No: Q3614 | Published On: 21-Sep-2020 | Status: Retired | Retired On: 1-Jul-2022

Venous hypertension

Q:

What code is assigned for peripheral venous hypertension?

A:

Peripheral venous hypertension is described as increased pressure in the veins of the lower legs, caused by venous reflux due to dysfunction of venous valves or venous obstruction (eg deep vein thrombosis, thrombophlebitis), or a combination of both. Chronic peripheral venous hypertension may lead to redirection of blood flow from deep to superficial vessels, producing local tissue inflammation, fibrosis or ulceration (Alguire et al. 2019; Goldman 2015; Raju et al. 2019).

Assign I87.8 *Other specified disorders of veins* for peripheral venous hypertension.

Follow the ICD-10-AM Alphabetic Index:

Increase, increased

- venous pressure I87.8

Amendments will be considered for a future edition.

References:

Alguire, P. Mathes, B.M. 2019, *Pathophysiology of chronic venous disease*, UpToDate, viewed 20 July 2020, https://www.uptodate.com/contents/pathophysiology-of-chronic-venous-disease.

Goldman, M. 2015 'Adverse sequelae and complications of venous hypertension', *Sclerotherapy*, viewed 20 July 2020, DOI:10.1016/B978-0-323-37726-3.00002-2.

Raju, S., Knight, A., Lamanilao, L., Pace, N. Jones, T. 2019, 'Peripheral venous hypertension in chronic venous disease', *Journal of Vascular Surgery: Venous and Lymphatic Disorders*, vol. 7, issue 5, pp 706–714, viewed 20 July 2020, https://doi.org/10.1016/j.jvsv.2019.03.006.

Published 21 September 2020,
for implementation 01 October 2020.

Ref No: Q3566 | Published On: 21-Sep-2020 | Status: Retired | Retired On: 1-Jul-2022

Phantom limb pain

Q:

What code is assigned for phantom limb pain?

A:

Phantom limb syndrome is described as the perception of sensations in a limb that has been amputated or a body part that has been removed (Healthdirect n.d.; Woodhouse 2005). These sensations may include a specific position, shape, or movement of the phantom, feelings of warmth or cold, itching, tingling, or electric sensations, and other paraesthesias (WHO 2019).

Phantom limb pain (phantom pain following amputation of a limb) is synonymous with phantom limb syndrome with (perception of) pain; assign G54.6 *Phantom limb syndrome with pain*.

Follow the ICD-10-AM Alphabetic Index:

Phantom limb syndrome (without pain) G54.7

- with pain G54.6

Amendments will be considered for a future edition.

References:

Healthdirect n.d., *Amputation*, Healthdirect, viewed 29 July 2020, https://www.healthdirect.gov.au/amputation.

Woodhouse, A. 2005, 'Phantom limb sensation', *Clinical and Experimental Pharmacology and Physiology*, vol. 32, issue 1–2, pp. 132–34, viewed 29 July 2020, https://doi.org/10.1111/j.1440-1681.2005.04142.x.

World Health Organization (WHO) 2019, *8E43.00 Phantom limb syndrome*, ICD-11 Mortality and Morbidity Statistics (MMS) April 2019, viewed 22 June 2020, https://icd.who.int/ct11/icd11_mms/en/release.

Published 21 September 2020,
for implementation 01 October 2020.

Ref No: Q3558 | Published On: 21-Sep-2020 | Status: Retired | Retired On: 1-Jul-2022

Haemorrhoid procedure using LigaSure™ device

Q:

What code is assigned for haemorrhoid procedure using LigaSure™ device?

A:

The LigaSure™ device is a bipolar electrothermal sealing device that uses a combination of pressure and energy (ie radiofrequency ablation) to permanently fuse (seal) blood vessels (Medtronic 2020; Nienhuijs et al. 2010).

Where the LigaSure™ device is used for haemorrhoids, assign 32135-01 **[941]** *Destruction of haemorrhoids*.

Follow the ACHI Alphabetic Index:

Destruction (ablation) (cauterisation) (coagulation) (cryotherapy) (diathermy) (HIFUS) (irreversible electroporation) (laser) (microwave) (radiofrequency) (thermotherapy)

- haemorrhoids (cauterisation) (cryotherapy) (infrared therapy) 32135-01 **[941]**

Amendments will be considered for a future edition.

References:

Medtronic 2020, *LigaSure™ technology*, viewed 22 June 2020, https://www.medtronic.com/covidien/en-us/products/vessel-sealing/ligasure-technology.html.

Nienhuijs, S.W. de Hingh, I.H.J.T. 2010, 'Pain after conventional versus Ligasure haemorrhoidectomy. A meta-analysis', *International Journal of Surgery*, vol. 8, issue 4, pp. 269–273, viewed 22 June 2020, https://doi.org/10.1016/j.ijsu.2010.04.001.

Published 21 September 2020,
for implementation 01 October 2020.

Ref No: Q3553 | Published On: 21-Sep-2020 | Status: Retired | Retired On: 1-Jul-2022

Admission for correction of stretched earlobe(s)

Q:

What code is assigned for admission for correction of stretched earlobe(s)?

A:

The stretching of an earlobe due to body piercing (plugs) is an acquired deformity (ie a change in normal size or shape of the body part). Where stretched earlobe is documented as the indication for surgical repair, assign:

H61.1 *Noninfective disorders of pinna*

W45.0 *Body piercing*

Place of occurrence and activity codes

Follow the ICD-10-AM Alphabetic Index Section I:

Deformity
- ear (acquired) H61.1

Follow the ICD-10-AM Alphabetic Index Section II *External causes of injury*:

Piercing
- body (rings) (studs) (voluntary) W45.0

Amendments will be considered for a future edition.

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Ref No: Q3473 | Published On: 22-Jun-2020 | Status: Retired | Retired On: 1-Jul-2022

Covered endovascular reconstruction of the aortic bifurcation (CERAB)

Q:

What code is assigned for covered endovascular reconstruction of the aortic bifurcation (CERAB)?

A:

The covered endovascular reconstruction of the aortic bifurcation (CERAB) technique uses covered stents to reconstruct the aortic bifurcation in patients with aortoiliac occlusive disease by preserving its normal anatomical structure (Grimme et al. 2015).

CERAB uses a balloon expandable covered stent that is expanded in the distal aorta above the aortic bifurcation. The proximal two-thirds of the stent is flared to create a funnel shaped covered stent within the aorta. Two covered stents are then placed proximally into the distal third of the aortic stent and distally into the common iliac arteries and simultaneously inflated (Grimme et al. 2015).

The CERAB technique is similar to endovascular stent repair performed for aortic aneurysm and dissection.

Assign 33116-00 **[762]** *Endovascular repair of aneurysm* as a best fit for CERAB.

Follow the ACHI Alphabetic Index:

Insertion

- stent

- - artery

- - - aorta (transluminal)

- - - - endovascular repair (AAA stent) (aneurysm) (dissection) (endoluminal) 33116-00 **[762]**

Amendments will be considered for a future edition.

References:

Grimme, F.A.B., Goverde, P.C.J.M., Verbruggen, P.J.E.M., Zeebregts, C.J. & Reignen, M.M.P.J. 2015, 'Editor's choice – first results of the covered endovascular reconstruction of the aortic bifurcation (CERAB) technique for aortoiliac occlusive disease', *European Journal of Vascular and Endovascular Surgery*, vol. 50, issue 5, pp. 638–647, viewed 17 April 2020, https://www.ejves.com/article/S1078-5884(15)00540-7/pdf.

Published 22 June 2020,
for implementation 01 July 2020.

Ref No: Q3447 | Published On: 22-Jun-2020 | Status: Retired | Retired On: 1-Jul-2022

Debulking of free flap

Q:

What code is assigned for a debulking procedure for a free flap?

A:

Debulking or redraping of a free flap for functional or cosmetic reasons is a type of elective flap revision (Garg et al. 2015) and can be achieved in several ways, including direct excision, liposuction, tissue shaving or skin grafting (Kim & Choi 2018).

As a best fit, assign an appropriate code from block **[1686]** *Revision of free flap and associated procedures* where debulking of free flap procedure is documented.

Follow the ACHI Alphabetic Index:

Revision

- flap

- - free

- - - tissue (by liposuction) (microvascular techniques)

- - - - 1st stage 45498-00 **[1686]**

- - - - 2nd stage 45499-00 **[1686]**

- - - - complete revision 45497-00 **[1686]**

- - - - open 45496-00 **[1686]**

Amendments will be considered for a future edition.

References:

Garg, R.K., Poore, S.O., Wieland, A.M., Mcculloch, T.M. & Hartig, G.K. 2015, 'Elective free flap revision in the head and neck cancer patient: indications and outcomes', *Microsurgery*, vol. 35, no. 8, pp. 591–595, viewed 23 January 2020, https://www.ncbi.nlm.nih.gov/pubmed/26419863.

Kim, T.G. & Choi, M.K. 2018, 'Secondary contouring of flaps', *Archives of Plastic Surgery*, vol. 54, no. 4, pp. 319–324, viewed 23 January 2020, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6062696/.

Published 22 June 2020,
for implementation 01 July 2020.

Ref No: Q3518 | Published On: 22-Jun-2020 | Status: Retired | Retired On: 1-Jul-2022

Fetal intracardiac injection for termination of pregnancy

Q:

What code is assigned for fetal intracardiac injection for termination of pregnancy (abortion)?

A:

Fetal intracardiac injection of a pharmacological agent (eg potassium chloride) is performed to achieve asystole (Sfakianaki et al. 2019). Fetal demise may be induced prior to another abortion procedure, or for fetal reduction in a multiple pregnancy (Kaur et al. 2018).

Where fetal intracardiac injection is performed for termination of pregnancy (abortion), assign 90462-01 **[1330]** *Termination of pregnancy [abortion procedure], not elsewhere classified*.

Follow the ACHI Alphabetic Index:

Termination of pregnancy (administration of pharmacological agent) (medical) NEC
90462-01 **[1330]**

Amendments will be considered for a future edition.

References:

Kaur, R., Goel, B., Sehgal, A., Goyal, P. & Mehra, R. 2018, 'Feticide with intracardiac potassium chloride to reduce risk of haemorrhage in medical termination of pregnancy', *Journal of Gynecology and Women Healthcare*, vol. 1, issue 1, viewed 3 April 2020, http://article.scholarena.co/Feticide-with-Intracardiac-Potassium-Chlorid-to-Reduce-Risk-of-Hemorrhage-in-Medical-Termination-of-Pregnancy.pdf.

Sfakianaki, A., Copel, J. & Stanwood, N. 2019, *Induced fetal demise*, UpToDate, viewed 3 April 2020, https://www.uptodate.com/contents/induced-fetal-demise.

Published 22 June 2020,
for implementation 01 July 2020.

Ref No: Q3531 | Published On: 22-Jun-2020 | Status: Retired | Retired On: 1-Jul-2022

Hypotension due to anaesthesia

Q:

What codes are assigned for hypotension due to anaesthesia?

A:

ICD-10-AM classifies complications of anaesthesia and anaesthetics (that were properly administered) to code range T88.2–T88.59 and is reflected in the ICD-10-AM Alphabetic Index:

Anaesthesia, anaesthetic

- complication or reaction NEC (*see also Complication(s)/anaesthesia*) T88.59

Complication(s)

- anaesthesia, anaesthetic NEC T88.59
- - awareness (during) T88.53
- - due to
- - - correct substance properly administered T88.59

…

- - failed T88.53
- - headache T88.52
- - hyperthermia, malignant T88.3
- - hypothermia NEC T88.51
- - intubation (endotracheal)
- - - difficult T88.42
- - - failed T88.41
- - malignant hyperthermia T88.3
- - shock T88.2

While an anaesthetic is a type of drug, it is used to induce anaesthesia. Therefore, where there is documentation of hypotension due to general anaesthesia, assign T88.59 *Complications of anaesthesia, not elsewhere classified*.

Follow the ICD-10-AM Alphabetic Index:

Complication(s)

- anaesthesia, anaesthetic NEC T88.59
- - due to
- - - correct substance properly administered T88.59

Assign I95.9 *Hypotension, unspecified* to add specificity. Also assign external cause and place of occurrence codes.

See also ACS 0002 *Additional diagnoses* and ACS 1904 *Procedural complications*.

Amendments will be made for a future edition.

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Ref No: Q3459 | Published On: 22-Jun-2020 | Status: Retired | Retired On: 1-Jul-2022

Lipoedema

Q:

What code is assigned for lipoedema?

A:

Lipoedema is characterised by chronic abnormal fat deposition, typically localised to the thighs, buttocks and lower legs, resulting in large legs that are out of proportion to overall body size. It may also occur in the arms or other body sites.

Lipoedema may be painful, hence the synonymous term ‘painful fat syndrome’. It is a rare clinical entity in its own right, but is often misdiagnosed as obesity or lymphoedema, although there is often an association with these conditions (Crescenzi et al. 2017; Lipoedema Australia 2020; Oakley 2016; Reich-Schupke et al. 2012).

Assign R60.0 *Localised oedema*.

Follow the ICD-10-AM Alphabetic Index:

Lipoedema — *see Oedema*

Oedema, oedematous
- localised R60.0

Amendments will be considered for a future edition.

References:

Crescenzi, R., Marton, A., Donahue, P., Mahany, H., Lants, S., Wang, P., Beckman, J., Donahue, M. & Titze, J. 2017, ‘Tissue sodium content is elevated in the skin and subcutaneous adipose tissue in women with lipedema’, *Obesity: A Research Journal*, viewed 5 February 2020, https://onlinelibrary.wiley.com/doi/full/10.1002/oby.22090.

Lipoedema Australia 2020, *Lipoedema*, viewed 5 February 2020, https://www.lipoedemaaustralia.com.au/.

Oakley, A. 2016, *Lipoedema*, DermNet NZ, viewed 5 February 2020, https://dermnetnz.org/topics/lipoedema/.

Reich-Schupke, S., Altmeyer, P. & Stücker, M. 2012, ‘Thick legs – not always lipedema’, *Journal of the German Society of Dermatology*, viewed 5 February 2020, https://onlinelibrary.wiley.com/doi/full/10.1111/ddg.12024.

Published 22 June 2020,
for implementation 01 July 2020.

Ref No: Q3480 | Published On: 22-Jun-2020 | Status: Retired | Retired On: 1-Jul-2022

Median arcuate ligament syndrome

Q:

What code is assigned for median arcuate ligament syndrome?

A:

Median arcuate ligament syndrome (MALS) is a rare disorder characterised by chronic, recurrent abdominal pain related to compression of the coeliac artery (which supplies blood to the upper abdominal organs) by the median arcuate ligament (a muscular fibrous band of the diaphragm) (National Institutes of Health 2016).

MALS is also known as coeliac artery compression syndrome (CACS) (National Institutes of Health 2016).

Assign I77.4 *Coeliac artery compression syndrome* where median arcuate ligament syndrome is documented.

Follow the ICD-10-AM Alphabetic Index:

Syndrome

- coeliac artery compression I77.4

Amendments will be considered for a future edition.

References:

National Institutes of Health 2016, Median arcuate ligament syndrome, US Department of Health & Human Services, viewed 28 February 2020, https://rarediseases.info.nih.gov/diseases/12308/median-arcuate-ligament-syndrome.

Published 22 June 2020,
for implementation 01 July 2020.

Ref No: Q3468 | Published On: 22-Jun-2020 | Status: Retired | Retired On: 1-Jul-2022

Removal of adnexa with vaginal hysterectomy

Q:

What codes are assigned for transvaginal removal of adnexa (ie salpingectomy, oophorectomy or salpingo-oophorectomy) with vaginal hysterectomy?

A:

One or both ovaries and fallopian tubes may be removed during vaginal hysterectomy. If the ovaries require removal, the fallopian tubes will be removed as well (Foust-Wright et al. 2019).

Prior to ACHI Eleventh Edition, removal of adnexa was classified with vaginal hysterectomy (ie vaginal hysterectomy with removal of adnexa). The decision to assign additional codes for salpingectomy, oophorectomy and salpingo-oophorectomy was made to identify the specific adnexa removed, and the laterality (which could not be previously identified).

Codes for open and laparoscopic salpingectomy, oophorectomy and salpingo-oophorectomy were listed in ACHI prior to Eleventh Edition and the expectation was that these codes would be assigned with amended Eleventh Edition hysterectomy codes. Codes for transvaginal removal of adnexa were not considered and therefore not created for Eleventh Edition.

Where transvaginal removal of adnexa is performed with vaginal hysterectomy, assign 35657-00 **[1269]** *Vaginal hysterectomy* with one of the following codes as a best fit:

35713-07 **[1243]** *Oophorectomy, unilateral*

35717-01 **[1243]** *Oophorectomy, bilateral*

35713-11 **[1252]** *Salpingo-oophorectomy, unilateral*

35717-04 **[1252]** *Salpingo-oophorectomy, bilateral*

35713-09 **[1251]** *Salpingectomy, unilateral*

35717-03 **[1251]** *Salpingectomy, bilateral*

Amendments will be considered for a future edition.

References:

Foust-Wright, C. & Berkowitz, L. 2019, *Patient education: vaginal hysterectomy (beyond the basics)*, UpToDate, viewed 2 April 2020, https://www.uptodate.com/contents/vaginal-hysterectomy-beyond-the-basics.

Published 22 June 2020,
for implementation 01 July 2020.

Ref No: Q3464 | Published On: 20-Mar-2020 | Status: Retired | Retired On: 1-Jul-2022

Periodic limb movement disorder

Q:

What code is assigned for periodic limb movement disorder?

A:

Periodic limb movement disorder (PLMD) is a sleep disorder characterised by repetitive cramping or jerking of the limbs (most commonly the legs) during sleep (Ondo 2019; WebMD n.d.). PLMD is related to, but not the same as, restless leg syndrome (Anderson 2019).

Historically, PLMD was called nocturnal myoclonus. This name is no longer used as PLMD movements are not myoclonic (ie rapid, rhythmic contraction of a group of muscles similar to that seen in seizures) (WebMD n.d.).

Assign G47.8 *Other sleep disorders* for periodic limb movement disorder.

Follow the ICD 10 AM Alphabetic Index:

Disorder (of)

…

- sleep

…

- - specified NEC G47.8

or

Parasomnia G47.8

Amendments will be considered for a future edition.

References:

Anderson, W. 2019, *Periodic limb movement disorder*, Medscape, viewed 9 January 2020, https://emedicine.medscape.com/article/1188558-overview.

Ondo, W. 2020, *Clinical features and diagnosis of restless legs syndrome and periodic limb movement disorder in adults*, UpToDate, viewed 9 January 2020, https://www.uptodate.com/contents/clinical-features-and-diagnosis-of-restless-legs-syndrome-and-periodic-limb-movement-disorder-in-adults.

WebMD n.d., *Periodic limb movement disorder*, WebMD, viewed 19 December 2019, https://www.webmd.com/sleep-disorders/periodic-limb-movement-disorder#1.

Published 20 March 2020,
for implementation 01 April 2020.

Ref No: Q3486 | Published On: 20-Mar-2020 | Status: Retired | Retired On: 1-Jul-2022

Insertion of Fetal Pillow®

Q:

What code is assigned for insertion of Fetal Pillow®?

A:

Fetal Pillow® is a balloon device used to assist with disimpacting an engaged fetal head at full dilation immediately prior to caesarean section.

The balloon device is inserted vaginally and placed beneath the fetal head. Inflation of the balloon with saline lifts and dislodges the fetal head from the maternal pelvis (Bisht 2019; Safe Obstetric Systems n.d.).

Where insertion of a Fetal Pillow® is documented with an emergency caesarean section, assign a code for the emergency caesarean section from block **[1340]** *Caesarean section*. Insertion of the Fetal Pillow® is a procedure component and therefore is not coded as per the guidelines in ACS 0016 *General procedure guidelines/Procedure components*. This is consistent with the *Includes* note at block **[1340]**, which identifies other procedures inherent in caesarean section (ie forceps, manual removal of placenta, suture of uterine lacerations/tears).

Amendments will be considered for a future edition.

References:

Bisht, S. 2019, *Fetal Pillow – Guidelines to use (GL1046)*, Royal Berkshire NHS Foundation Trust, viewed 11 November 2019, https://www.royalberkshire.nhs.uk/Downloads/GPs/GP%20protocols%20and%20guidelines/Maternity%20Guidelines%20and%20Policies/Intrapartum/Fetal%20pillow_V2.0_GL1046_APR19.pdf.

Safe Obstetric Systems Limited n.d., *Fetal Pillow*, Safe Obstetrics Systems Limited, viewed 11 November 2019, https://www.safeob.com/fetalpillow.html.

Published 20 March 2020,
for implementation 01 April 2020.

Ref No: Q3437 | Published On: 20-Mar-2020 | Status: Retired | Retired On: 1-Jul-2022

Aspiration pneumonia or ventilation associated pneumonia (VAP) with a specified infectious agent

Q:

What codes are assigned for aspiration pneumonia or VAP with a specified infectious organism?

A:

Codes from category B95–B97 *Bacterial, viral and other infectious agents* are assigned as additional diagnosis codes to identify the infectious agent(s) in diseases classified elsewhere.

The *Note* at B95–B97 states:

> *A code from these categories must be assigned if it provides more specificity about the infectious agent. Do not assign a code from these categories if the same agent has been identified in the infection code (eg streptococcal sepsis in A40.-).*

Therefore, where there is documentation of either *aspiration* pneumonia or *ventilation associated* pneumonia and cytology confirms an organism as an infectious agent, assign J69.0 *Pneumonitis due to food or vomit* or J95.82 *Ventilation associated pneumonia* with an additional code (B95–B97) to identify the infectious agent.

For example, for aspiration pneumonia with *Pseudomonas* documented as the infectious agent, assign:

J69.0 *Pneumonitis due to food or vomit*

B96.5 *Pseudomonas (aeruginosa) as the cause of diseases classified to other chapters*

Follow the ICD-10-AM Alphabetic Index:

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

- aspiration J69.0

Infection, infected (opportunistic)

- Pseudomonas, pseudomonad NEC

- - as cause of disease classified elsewhere B96.5

Amendments will be considered for a future edition.

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Ref No: Q3426 | Published On: 20-Mar-2020 | Status: Retired | Retired On: 1-Jul-2022

Large or grade 3 tonsils

Q:

Are ‘large’ or ‘grade 3’ tonsils synonymous terms for enlarged or hypertrophied?

A:

Tonsillar enlargement may be documented using a grading classification (eg Brodsky grading scale, Friedman grading scale, Modified 3-grade scale or Modified 5 grade scale). These size grading systems categorise the size of the tonsils based on the percentage/area of the oropharyngeal airway that is occupied by the two tonsils. Large tonsils may require surgical removal if they have an impact on health (eg swallowing difficulties, airflow limitation or obstructive sleep apnoea) (Jara & Weaver 2018; Kumar et al. 2014).

Where ‘large’ or ‘grade 3’ tonsils are documented and meet the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses* (eg as the indication for tonsillectomy), assign J35.1 *Hypertrophy of tonsils* or J35.3 *Hypertrophy of tonsils with hypertrophy of adenoids*.

Follow the ICD-10-AM Alphabetic Index:

Enlargement, enlarged — *see also Hypertrophy*

- tonsils J35.1

- - with adenoids J35.3

or

Hypertrophy

- tonsils (faucial) (infective) (lingual) (lymphoid)

- - with adenoids J35.3

Amendments may be considered for a future edition.

References:

Jara, S.M. & Weaver, E.M. 2018, ‘Association of palatine tonsil size and obstructive sleep apnea in adults’, *The Laryngoscope*, vol. 128, no. 4, viewed 30 October 2019, https://onlinelibrary.wiley.com/doi/abs/10.1002/lary.26928.

Kumar, D.S., Valenzuela, D., Kozak, F.K., Ludemann, J.P., Lea, J. & Chadha, N.K. 2014, ‘The reliability of clinical tonsil size grading in children’, *JAMA Otolaryngology-Head & Neck Surgery*, vol. 140, no. 11, viewed 30 October 2019, https://www.ncbi.nlm.nih.gov/pubmed/25317509.

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Assignment of F17.3 with Z72.0

Q:

Can Z72.0 *Tobacco use, current* be assigned with F17.3 *Mental and behavioural disorders due to use of tobacco, withdrawal state* in the same episode of care?

A:

While there is nothing in the ICD-10-AM Tabular List or Alphabetic Index, or the guidelines in ACS 0503 *Drug, alcohol and tobacco use disorders* to specify that F17.3 *Mental and behavioural disorders due to use of tobacco, withdrawal state* is not assigned concurrently with Z72.0 *Tobacco use, current*, withdrawal from tobacco (ie nicotine) is not clinically possible unless the patient is a current (chronic) user.

Therefore, as current tobacco (nicotine) use is inherent in F17.3, do not assign both of these codes in the same episode of care.

Where there is documentation that a patient is a current user and withdrawing from tobacco (nicotine), and meets the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*, assign F17.3 *Mental and behavioural disorders due to use of tobacco, withdrawal state*.

Follow the ICD-10-AM Alphabetic Index:

Tobacco (nicotine)

- withdrawal state F17.3

Amendments will be considered for a future edition.

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Detorsion of ovary

Q:

What code is assigned for detorsion of the ovary?

A:

Ovarian detorsion is a surgical intervention performed to treat torsion (ie twisting) of the ovary. Detorsion may be performed with or without fixation (ie transposition/oophoropexy) of the ovary.

Assign a code for repair of the ovary:

35729-00 **[1245]** *Laparoscopic transposition of ovary*

35729-01 **[1245]** *Transposition of ovary*

90430-00 **[1246]** *Other laparoscopic repair of ovary*

90430-01 **[1246]** *Other repair of ovary*

Follow the ACHI Alphabetic Index:

Repair

- ovary
- - laparoscopic NEC 90430-00 **[1246]**
- - - by transposition 35729-00 **[1245]**
- - via laparotomy NEC 90430-01 **[1246]**
- - - by transposition 35729-01 **[1245]**

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Body lift procedure

Q:

What code is assigned for body lift procedure?

A:

A body lift is a form of body contouring surgery that involves removing loose skin folds and extra fat, which results in improved shape and tone of the underlying tissue (Better Health Channel 2019). This procedure is also known as a lipectomy (Merriam Webster n.d.).

Assign multiple ACHI codes when body lift procedures are performed on multiple body regions. Follow the ACHI Alphabetic Index at *Lipectomy/by site*.

For example, brachioplasty is classified in ACHI to *Lipectomy/arm*.

Follow the ACHI Alphabetic Index:

Brachioplasty — *see Lipectomy/arm*

Lipectomy

- arm (circumferential) (wedge)
- - 1 excision 30168-00 **[1666]**
- - 2 excisions 30171-00 **[1666]**
- - suction 45584-00 **[1666]**

Where there is no documentation of the number of excisions performed, follow the guidelines in ACS 0038 *Procedures distinguished on the basis of size, time, number of lesions or sites*; default to *Lipectomy/arm/1 excision*:

> *Where there is no documentation in the clinical record, no further information can be obtained from the clinician and there is no default in the index, assign the code for the smallest size, the least duration, the least number of lesions or sites, as appropriate.*

Amendments will be considered for a future edition.

References:

Better Health Channel 2019, *Body contouring surgery*, Department of Health and Human Services, Victoria, viewed 10 December 2019, https://www.betterhealth.vic.gov.au/health/ConditionsAndTreatments/body contouring surgery.

Merriam-Webster n.d., *Lipectomy*, Merriam-Webster, viewed 3 January 2020, https://www.merriam webster.com/medical/lipectomy.

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Ref No: P462 | Published On: 20-Mar-2020 | Status: Retired | Retired On: 1-Jul-2022

Clarification of code assignment for procedures assisting delivery

Amendments were made to procedures assisting delivery for ACHI and the ACS for Eleventh Edition. The guidelines in ACS 1505 *Delivery and assisted delivery codes* and the advice below will assist clinical coders in assigning codes for these episodes.

- As per the table in ACS 1505, when O83 *Other assisted single delivery* or O84.81 *Multiple delivery, all assisted, not elsewhere classified* are assigned, one of the following ACHI codes must be assigned:

  90470-01 **[1339]** *Assisted breech delivery* OR

  90470-03 **[1339]** *Breech extraction* OR

  90477-01 **[1343]** *Assisted vertex delivery*

  ACHI codes for procedures to assist delivery are assigned in addition to one of the above codes.

Example 1

Patient admitted in labour (39/40). McRoberts manoeuvre performed, followed by vaginal delivery of health infant. Assign:

O83 *Other assisted single delivery*

Z37.0 *Single live birth*

90477-01 **[1343]** *Assisted vertex delivery*

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

Follow the ACHI Alphabetic Index:

Delivery (spontaneous) (vertex)
- assistance procedure (McRobert's manoeuvre) NEC *(see also specific interventions)*
  90477-00 **[1343]**
- assisted 90477-01 **[1343]**

Note that an exception to the above guidelines is the rare scenario where an infant is delivered before arrival at a hospital, but delivery is completed during the admission (ie delivery of the placenta) – see ACS 1548 *Puerperal/postpartum condition or complication* Example 7.

- The *Note* in ACS 1505 lists interventions that may be performed without affecting the assignment of O80 *Single spontaneous delivery*:

  Note: *Spontaneous delivery may include:*

  - *administration of Syntocinon in third stage labour*
  - *controlled cord traction (CCT)*
  - *epidural injection/infusion*
  - *episiotomy with repair*

- *fetal monitoring*
- *medica lor surgical:*
  - *augmentationof labour*
  - *induction*
- *suture of obstetric perineal laceration*

For classification purposes, once an assistance procedure (not listed above) is performed during the delivery episode of care (eg McRoberts manoeuvre, version, breech extraction), the delivery is ***not classified as spontaneous***

Therefore, assign O80 if the delivery is assisted by one of the interventions listed above. If an assistance procedure is performed and it is not in the list above, do not assign O80.

Example 2

Patient admitted in labour (39/40). Internal fetal monitoring performed, followed by vaginal delivery of healthy infant. Assign:

O80 *Single spontaneous delivery*

Z37.0 *Single live birth*

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

16514-00 **[1341]** *Internal fetal monitoring*

Follow the ACHI Alphabetic Index:

Delivery (spontaneous) (vertex) **90467-00 [1336]**
- assistance procedure (McRobert's manoeuvre) NEC *(see also specific interventions)*

…
- - fetal monitoring — *see Monitoring/fetal*

Monitoring
- fetal (CTG) (external)
- - internal (scalp) (via electrode(s)) 16514-00 **[1341]**

Example 3

Episiotomy performed to facilitate vaginal delivery of single term infant. Assign:

O80 *Single spontaneous delivery*

Z37.0 *Single live birth*

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

90472-00 **[1343]** *Episiotomy*

Follow the ACHI Alphabetic Index:

Delivery (spontaneous) (vertex) **90467-00 [1336]**
- assistance procedure (McRobert's manoeuvre) NEC *(see also specific interventions)*

- - episiotomy 90472-00 **[1343]**

Example 4

Manual removal of placenta performed for retained placenta following spontaneous vaginal delivery (39/40) of a single fetus, assign:

O83 *Other assisted single delivery*

O73.0 *Retained placenta*

Z37.0 *Single live birth*

90477-01 **[1343]** *Assisted vertex delivery*

90482-00 **[1345]** *Manual removal of placenta*

Follow the ACHI Alphabetic Index:

Delivery (spontaneous) (vertex)

- assisted 90477-01 **[1343]**

…

- placenta NEC

- - postpartum — *see Removal/placenta*

Removal

- placenta

- - by

- - - manual (part) (whole) 90482-00 **[1345]**

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Encephaloduroarteriosynangiosis (EDAS)

Q:

What code is assigned for encephaloduroarteriosynangiosis (EDAS)?

A:

Encephaloduroarteriosynangiosis (EDAS) is an indirect cerebral revascularisation intervention where a section of a superficial scalp artery is redirected through the dura mater onto the brain. New blood vessels grow from this artery into the brain to provide a source of blood to an ischaemic area. EDAS is performed for Moyamoya disease and symptomatic intracranial atherosclerosis (Columbia University Department of Neurological Surgery 2019; Laiwalla et al. 2017).

Assign 39818-00 **[21]** *Extracranial to intracranial bypass with superficial temporal artery graft* as a best fit for encephaloduroarteriosynangiosis.

Follow the ACHI Alphabetic Index:

Bypass

- extracranial to intracranial

- - with graft

- - - temporal artery (superficial) 39818-00 **[21]**

References:

Columbia University Department of Neurological Surgery 2019, *Encephaloduroarteriosynangiosis (EDAS)*, New York, viewed 18 December 2019, https://www.columbianeurosurgery.org/treatments/encephaloduroarteriosynangiosis-edas/.

Laiwalla, A.N., Kurth, F., Leu, K., Liou, R., Pamplona, J., Ooi, Y.C., Salamon, N., Ellingson, B.M. & Gonzalez, N.R. 2017, 'Evaluation of encephaloduroarteriosynangiosis efficacy using probabilistic independent component analysis applied to dynamic susceptibility contrast perfusion MRI', *American Journal of Neuroradiology*, vol. 38, no. 3, pp. 507–514, viewed 18 December 2019, http://www.ajnr.org/content/38/3/507.

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Ref No: Q3429 | Published On: 20-Mar-2020 | Status: Retired | Retired On: 1-Jul-2022

Malignant and metastatic melanotic neuroectodermal tumour

Q:

What codes are assigned for malignant and metastatic melanotic neuroectodermal tumour?

A:

Melanotic neuroectodermal tumour of infancy (MNTI) is a rare neoplasm of early infancy. Lesions most commonly affect the maxilla of infants in the first year of life, but may also occur in the mandible, skull, brain, epididymis and other rare locations. Most MNTIs are benign, but may be locally invasive. Malignant transformation and metastases may occur but are extremely rare (Kruse Lösler et al. 2006).

Two morphology codes for melanotic neuroectodermal tumour are included in the ICD-10-AM Tabular List Appendix A: *Morphology of neoplasms/Coded nomenclature for morphology of neoplasms*:

> ***Coded nomenclature of morphology of neoplasms***
>
> *M9363/0 Melanotic neuroectodermal tumour*
>
> ✪*M9363/1 Melanotic neuroectodermal tumour, uncertain whether benign or malignant*

In the absence of morphology codes for melanotic neuroectodermal tumour with behaviours /3 *Malignant, primary site* or /6 *Malignant, metastatic site*, assign as a best fit:

Topography code(s) from blocks:

C00–C75 *Malignant neoplasms, stated or presumed to be primary, of specified sites, except of lymphoid, haematopoietic and related tissue*

C76–C80 *Malignant neoplasms of ill-defined, secondary and unspecified sites*

- M9363/1 *Melanotic neuroectodermal tumour, uncertain whether benign or malignant*.

Amendments will be considered for a future edition.

References:

Kruse-Lösler, B., Gaertner, C., Bürger, H., Seper, L., Joos, U. & Kleinheinz, J. 2006, 'Melanotic neuroectodermal tumor of infancy: systematic review of the literature and presentation of a case', *Oral Surgery, Oral Medicine, Oral Pathology, Oral Radiology, and Endodontology*, vol. 102, issue 2, pp. 204–216, viewed, 30 October 2019, https://www.sciencedirect.com/science/article/pii/S1079210405006992?via%3Dihub.

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Mesorectal lymph nodes

Q:

What code is assigned for metastatic mesorectal lymph nodes?

A:

The mesorectum is the fatty tissue envelope of the rectum containing blood and lymph vessels, lymph nodes and autonomic nerves (Havenga et al. 2007). It is a subsection of the mesentery attached to the upper third of the rectum (Joseph 2018).

Where metastatic mesorectal lymph nodes not otherwise specified (NOS) is documented, seek clinical clarification as to the anatomic location of the lymph node. Where clinical consultation is not possible, assign C77.2 *(Secondary and unspecified malignant neoplasm of) Intra-abdominal lymph nodes* as a best fit.

Follow the ICD-10-AM Alphabetic Index:

Neoplasm, neoplastic

- lymph, lymphatic

- - gland (secondary)

- - - mesenteric (inferior) (superior) C77.2

References:

Havenga, K., Grossmann, I., DeRuiter, M. & Wiggers, T. 2007, 'Definition of total mesorectal excision, including the perineal phase: technical considerations', *Digestive Diseases*, vol. 25, pp. 44–50, viewed 5 December 2019, https://www.karger.com/Article/PDF/99169.

Joseph, R. 2018, *The mesentery*, TeachMeAnatomy, viewed 5 December 2019, https://teachmeanatomy.info/abdomen/viscera/mesentery/.

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Positive human papillomavirus (HPV) test result as indication for colposcopy

Q:

What code is assigned for human papillomavirus (HPV) with no other findings at colposcopy?

A:

On 1 December 2017, Australia moved to a new National Cervical Screening Program (NCSP), which uses primary human papillomavirus (HPV) nucleic acid testing (NAT), followed by reflex liquid-based cytology, to detect high-grade cervical disease (Hawkes 2018). Screening for HPV strains that cause cervical cancer has proven to be more sensitive than screening for abnormal cytology (Pap test). Women with abnormal cytology results often require a colposcopy to confirm if they need treatment (Porras et al. 2012).

Where a positive HPV test result is documented as the indication for colposcopy, but no associated condition is detected, apply the guidelines in ACS 0051 *Same day endoscopy – diagnostic/Classification*:

> …
>
> ***1.3 If there are no findings*** *at diagnostic endoscopy, assign a code for the indication/symptom as the principal diagnosis.*
>
> …

Assign R87.5 *Abnormal findings in specimens from female genital organs, abnormal microbiological findings*.

Follow the ICD-10-AM Alphabetic Index:

Abnormal, abnormality, abnormalities

- specimen

- - female genital organs (secretions) (smears) R87.-

The fourth character .5 *abnormal microbiological findings* is located in the ICD-10-AM Tabular List under block R83–R89 *Abnormal findings on examination of other body fluids, substances and tissues, without diagnosis*.

References:

Hawkes, D. 2018, 'Human papillomavirus testing as part of the renewed National Cervical Screening Program', *Australian Journal of General Practice*, vol. 47, issue 7, viewed 29 November 2019, https://www1.racgp.org.au/ajgp/2018/july/national cervical screening program.

Porras, C., Wentzenen, N., Rodriguez, A.C., Morales, J., Burk, R.D., Alfaro, M., Hutchinson, M., Herrero, R., Hildesheim, A., Sherman, M.E., Wacholder, S., Solomon, D. & Schiffman, M. 2012, 'Switch from cytology-based to HPV-based cervical screening: implications for colposcopy', *International Journal of Cancer*, vol. 130, no. 8, pp. 1879–1887, viewed 29 November 2019, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3162132/.

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S09.0 *Unspecified injury of head* and S00 *Superficial injuries of head*

Q:

Can codes for ‘abrasion’ or ‘contusion’ classified to category S00 *Superficial injuries of head* be assigned with S09.9 *Unspecified injury of head*?

A:

ACS 1905 *Closed head injury/loss of consciousness/concussion* states:

> *It is recognised that ‘head injury’ is a state or ‘condition’ in its own right and should be coded where appropriate, in addition to (any) lacerations or open wounds of the head.*

That is, assign S09.9 *Unspecified injury of head* with codes from category S01 *Open wound of head*, where ‘head injury’ and ‘open wound/laceration of head’ are both documented in the episode of care.

There is nothing in ICD-10-AM or the ACS to preclude the assignment of S09.9 with codes for ‘abrasion’ or ‘contusion’ classified to category S00 *Superficial injuries of head*.

However, note that as per the guidelines in ACS 1907 *Multiple injuries* and ACS 1916 *Superficial and soft tissue injuries*:

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

That is, do not assign codes from category S00 *Superficial injuries of head* with more severe injuries of the head classified to categories S01–S08 and S09.0–S09.2.

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Trapeziectomy with abductor pollicis longus (APL) suspensionplasty

Q:

What code is assigned for trapeziectomy with abductor pollicis longus (APL) suspensionplasty?

A:

Trapeziectomy is indicated for painful osteoarthritis of the carpometacarpal (CMC) joint of the thumb (Healthdirect Australia 2019). It involves removal of the trapezium, which is a cube-shaped bone in the wrist that sits beneath the base of the thumb (Healthdirect Australia 2019).

An abductor pollicis longus (APL) suspensionplasty is performed to stop the CMC joint from deforming and preserve thumb function. It uses a part of the flexor carpi radialis or APL tendons and binding it to strong suture material to suspend the base of the first metacarpal bone to the second metacarpal bone (Leclerq 2015; Renfree et al. 2017; Soejima et al. 2006).

For classification purposes, trapeziectomy with APL suspensionplasty are inherent components of arthroplasty. Therefore, assign 46324-00 **[1468]** *Arthroplasty of carpal bone* alone.

Follow the ACHI Alphabetic Index:

Arthroplasty

- wrist

- - carpal bone

- - - for joint replacement (with resection) 46324-00 **[1468]**

Amendments will be considered for a future edition.

References:

Healthdirect Australia 2019, *Trapeziectomy*, Healthdirect Australia, viewed 10 January 2020, https://www.healthdirect.gov.au/surgery/trapeziectomy.

Leclerq, C. 2015, 'Thumb CMCJ arthritis: a new technique of suspensionplasty (Mini tightrope)', *BMC Proceedings*, viewed 19 December 2019, https://bmcproc.biomedcentral.com/articles/10.1186/1753-6561-9-S3-A51.

Renfree, K.J., Odgers, R.A., Zhang, N. & Tillinghast, C. 2017, 'Long-term outcomes of APL suspensionplasty with no, partial, or complete trapezoid excision', *Journal of Hand Surgery*, vol. 42, issue 9, supplement, p. S30, viewed 10 January 2020, https://www.jhandsurg.org/article/S0363-5023(17)31061-4/fulltext.

Soejima, O., Hanamura, T., Kikuta, T., Iida, H. & Naito, M. 2006, 'Suspensionplasty with the abductor pollicis longus tendon for osteoarthritis in the carpometacarpal joint of the thumb', *Journal of Hand Surgery*, vol. 31, issue 3, pp. 425–428, viewed 10 January 2020, https://www.jhandsurg.org/article/S0363-5023(05)00925-1/abstract.

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Ref No: Q3454 | Published On: 20-Mar-2020 | Status: Retired | Retired On: 1-Jul-2022

Utilisation of multiple machine perfusion units for organ transplantation

Q:

How many times is 96231-00 **[1886]** *Machine perfusion for organ transplantation* assigned, when machine perfusion is utilised multiple times for separate organs?

A:

The *Code first* instructional note at 96231-00 **[1886]** *Machine perfusion for organ transplantation* implies that multiple procurement codes may be assigned with machine perfusion. Although ACS 0030 *Organ, tissue and cell procedure and transplantation* is not specific, the intention is that a single machine perfusion code is assigned when multiple organ procurements are performed.

Therefore, where machine perfusion is utilised, assign 96231-00 **[1886]** *Machine perfusion for organ transplantation* once only during an episode of care.

The guidelines in ACS 0020 *Bilateral/multiple procedures* do not apply to machine perfusion because it is not performed during different visits to theatre or via entry points/approaches to the body (ie machine perfusion is not performed directly on a patient).

Amendments will be considered for a future edition.

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Coronavirus disease 2019 (COVID-19)

Effective from 1 January 2020; Updated 27 March 2020

Coronaviruses are a large family of viruses that cause illness ranging from the common cold to more severe diseases such as Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS).

Coronavirus disease 2019 (COVID-19) is a disease caused by a new (or 'novel') strain of coronavirus (SARS-CoV-2) not previously identified in humans before the outbreak in Wuhan, Hubei Province, China.

Common signs of COVID-19 infection include respiratory symptoms such as cough, shortness of breath, breathing difficulties and fever. In severe cases, the infection can cause pneumonia, severe acute respiratory syndrome, kidney failure and death.

The World Health Organization (WHO) has advised:

- U07.1 *Emergency use of U07.1 [COVID-19, virus identified]* is to be assigned when COVID-19 has been documented as confirmed by laboratory testing.
- U07.2 *Emergency use of U07.2 [COVID-19, virus not identified]* is to be assigned when COVID-19 has been documented as clinically diagnosed COVID-19, including evidence supported by radiological imaging (ie where a clinical determination of COVID-19 is made but laboratory testing is inconclusive, not available or unspecified).

Emergency use code U06.0 *Emergency use of U06.0 [COVID-19, ruled out]* is to be assigned when laboratory testing for COVID-19 has been performed, but ruled out (ie negative test result).

In addition to the admitted patient data, the National Notifiable Disease Surveillance System[1] provides national surveillance of notifiable communicable diseases and tracks notifications, including notifications of COVID-19 [2].

CLASSIFICATION

Laboratory confirmed cases

Where laboratory confirmed COVID-19 is documented **with symptoms**, assign:

Principal diagnosis: A code for the symptom(s) or condition(s) as per the guidelines in ACS 0001 *Principal diagnosis*

Additional diagnoses: B97.2 *Coronavirus as the cause of diseases classified to other chapters* to identify the infectious agent

and

U07.1 *Emergency use of U07.1 [COVID-19, virus identified]*

Where laboratory confirmed COVID-19 is documented **without symptoms**, assign:

Principal diagnosis: B34.2 *Coronavirus infection, unspecified site*

Additional diagnosis: U07.1 *Emergency use of U07.1 [COVID-19, virus identified]*

Clinically diagnosed or probable COVID-19

Where clinically diagnosed or probable COVID-19 is documented **with symptoms**, assign:

Principal diagnosis: A code for the symptom(s) or condition(s) as per the guidelines in ACS 0001 *Principal diagnosis*

Additional diagnoses: B97.2 *Coronavirus as the cause of diseases classified to other chapters* to identify the infectious agent

and

U07.2 *Emergency use of U07.2 [COVID-19, virus not identified]*, to identify cases documented as clinically diagnosed COVID-19 but laboratory testing is inconclusive, not available or unspecified

Where clinically diagnosed or probable COVID-19 is documented **without symptoms**, assign:

Principal diagnosis: B34.2 *Coronavirus infection, unspecified*

Additional diagnosis: U07.2 *Emergency use of U07.2 [COVID-19, virus not identified]*, to identify cases documented as clinically diagnosed COVID-19 but laboratory testing is inconclusive, not available or unspecified

COVID-19 complicating pregnancy

Where laboratory confirmed or clinically diagnosed COVID-19 is documented as complicating pregnancy, the correct obstetric chapter code is O98.5 *Other viral diseases in pregnancy, childbirth and the puerperium*. Code the remainder of the episode in accordance with ACS 1521 *Conditions and injuries in pregnancy* and ACS 1500 *Diagnosis sequencing in obstetric episodes of care*.

Suspected COVID-19, ruled out

Where suspected COVID-19 is documented with symptoms, but is ruled out, assign:

Principal diagnosis: A code for the symptom(s) or condition(s) as per the guidelines in ACS 0001 *Principal diagnosis*

Additional diagnoses*: Either Z03.8 *Observation for other suspected diseases and conditions*

or

Z03.71 *Observation of newborn for suspected infectious condition*, for newborns (infants less than 28 days old),

and

U06.0 *Emergency use of U06.0 [COVID-19, ruled out]* to identify suspected but ruled out COVID-19

* From 1 January 2020, an exception has been made to ACS 0012 *Suspected conditions* to identify symptomatic presentations where COVID-19 has been suspected but then ruled out.

Transfer with suspected COVID-19

For individuals transferred with suspected COVID-19, meeting the criteria in ACS 0012 *Suspected conditions*, do not assign the emergency use codes U07.1, U07.2 or U06.0.

Supplementary guidelines for COVID-19 are available on the IHPA website [3].

1. National Notifiable Disease Surveillance System: http://www9.health.gov.au/cda/source/cda-index.cfm

2. COVID-19: https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm

3. IHPA website: https://www.ihpa.gov.au/what-we-do/icd-10-am-achi-acs-current-edition

References:

Australian Government Department of Health 2020, *Coronavirus (COVID-19) current situation and case numbers*, DOH, Canberra, viewed 25 March 2020, https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-current-situation-and-case-numbers.

Centers for Disease Control and Prevention 2020, *2019 Novel coronavirus*, US Department of Health and Human Services, viewed 25 March 2020, https://www.cdc.gov/coronavirus/index.html.

World Health Organization 2020, *Coronavirus disease (COVID-19) outbreak*, viewed 25 March 2020, https://www.who.int/emergencies/diseases/novel-coronavirus-2019.

Published 07 February 2020,
for implementation 01 January 2020.

Ref No: Q3439 | Published On: 16-Dec-2019 | Status: Retired | Retired On: 1-Jul-2022

Post tonsillectomy haemorrhage

Q:

Is ‘post tonsillectomy haemorrhage’ classified as a procedural complication?

A:

Haemorrhage is the most common and potentially devastating event after a tonsillectomy. There are two types of haemorrhage (Perth Children’s Hospital 2018):

- Primary haemorrhage where bleeding occurs within 24 hours after surgery; and
- Secondary haemorrhage where bleeding occurs between 24 hours to 14 days after surgery.

ACS 1904 *Procedural complications* states:

> *Conditions may arise during or in the period following a procedure. Some of these are considered to be ‘procedural complications’ while others are not. Qualifying terms such as ‘intraoperative’, ‘postoperative’ or ‘postprocedural’ may be documented in the clinical record, however these terms may only refer to the timing of an event that occurred during, or after, the procedure. Conditions described in this way should be assigned procedural complication codes only if they meet the following criteria:*
>
> - *Documentation clearly states that the condition arose as a complication of the procedure (the terms ‘secondary to’ or ‘due to’ infer a causal relationship in contrast to terms such as ‘postop’, ‘following’ or ‘associated with’)*
> - *Certain conditions where the relationship is inherent in the diagnosis (eg infection or bleeding of a surgical wound, stoma or anastomosis, wound dehiscence, transfusion related acute lung injury)*

‘Post tonsillectomy haemorrhage’ is classified as a procedural complication in ICD-10-AM as it meets the criteria in the second dot point above; that is, the relationship is considered inherent in the diagnosis.

Assign T81.0 *Haemorrhage and haematoma complicating a procedure, not elsewhere classified* where post tonsillectomy haemorrhage is documented. Follow the ICD-10-AM Alphabetic Index:

Haemorrhage, haemorrhagic

- postprocedural T81.0

Code also external cause and place of occurrence codes.

References:

Perth Children’s Hospital 2018, Post tonsillectomy haemorrhage, viewed 8 November 2019, https://pch.health.wa.gov.au/For-health-professionals/Emergency-Department-Guidelines/Post-tonsillectomy-haemorrhage

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Ref No: TN1511 | Published On: 16-Dec-2019 | Status: Retired | Retired On: 1-Jul-2022

Vaping-related disorders; use of WHO code for emergency use

Effective from 25 September 2019

Vaping-related disorders are disorders that result from inhaling a vaporised solution (aerosol) via an electronic delivery system. These products frequently contain flavourants, usually dissolved into propylene glycol and/or glycerine. They may also contain doses of nicotine, and other substances and additives. These disorders may also be documented as electronic cigarette related damage or disorders, or e-cigarette or vaping product use-associated lung injury (EVALI).

The exact causation of and mechanism leading to the disorders is currently unclear. The substance or substance combination leading to vaping-related disorders has not yet been identified. While lung disorders related to vaping are recognised, other organs may be affected as well. Although vaping devices may resemble cigarettes, they do not contain tobacco and it is not appropriate to assign Z72.0 *Tobacco use, current*.

Concern has arisen due to an increase in the incidence of vaping-related disorders internationally. As a result, the World Health Organization (WHO) has advised that **effective from 25 September 2019**, U07.0 *Emergency use of U07.0* is assigned for vaping-related disorders, to monitor vaping-related disorders internationally.

CLASSIFICATION

Where documentation states that a condition or symptom is vaping related, assign:

- A code for the condition as per the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*
- U07.0 *Emergency use of U07.0* as an additional diagnosis

Note: DO NOT assign U07.0 to flag that a patient uses a ‘vape device’.

Bibliography:

Australian Government Department of Health 2019, About e-cigarettes, DOH, Canberra, viewed 16 October 2019, https://www.health.gov.au/health-topics/smoking-and-tobacco/about-smoking-and-tobacco/about-e-cigarettes

Centers for Disease Control and Prevention 2019a, Outbreak of Lung Injury Associated with E-cigarette Use, or Vaping, US Department of Health and Human Services, viewed 1 October 2019, https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease.html

Centers for Disease Control and Prevention 2019b, THC Products May Play a Role in Outbreak of Lung Injury Associated with E-cigarette Use, or Vaping, US Department of Health and Human Services, viewed 1 October 2019, https://www.cdc.gov/media/releases/2019/p0927-thc-vaping.html

ICD-11 Foundation 2019, Vaping related disorder, viewed 2 October 2019, https://icd.who.int/dev11/f/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f1880731274

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for implementation 01 January 2020.

Ref No: Q3483 | Published On: 16-Dec-2019 | Status: Retired | Retired On: 1-Jul-2022

Assignment of a code for glaucoma with implantation of an iStent®

Q:

When a patient is admitted for implantation of an iStent®, is a diagnosis code for glaucoma assigned if there is no documentation of the term 'glaucoma' in the health care record?

A:

The iStent® procedure involves placement of a small titanium implant during minimally invasive glaucoma surgery (MIGS) to lower eye pressure and treat mild-to-moderate open-angle glaucoma (Eye Doctors of Washington 2019). Significant and safe reductions in intraocular pressure (IOP) and medication dosage have been observed after iStent® or iStent inject® implantation with concomitant cataract surgery (Guedes et al. 2019).

Question 10 of the 2018 HIMAA and NCCH Conference Eleventh Edition Education states:

> *Q10:*
>
> *Is a code also assigned for glaucoma when an iStent is performed?*
>
> *Answer:*
>
> *Yes, iStent intervention is only performed when a patient has both a cataract and glaucoma.*

Do not interpret the above advice as implying that a glaucoma code is assigned without specific documentation of 'glaucoma', when an iStent® is inserted.

> ACS 0010 *Clinical documentation and general abstraction guidelines/Roles and responsibilities in the documentation and abstraction process* states:
>
> *It is not the role of a clinical coder (or clinical documentation improvement specialist (CDIS)) to diagnose. Clinical documentation of accurate diagnoses is the responsibility of the clinician.*
>
> *The listing of clinical concepts (eg diseases and interventions) on the front sheet and/or the discharge summary (or equivalent) for an episode of care is the responsibility of the clinician. These responsibilities include identifying and documenting the principal diagnosis, and listing all additional diagnoses and interventions performed during the episode of care. Each diagnostic statement and intervention must be as informative as possible in order for the clinical coder to classify the clinical concept to the most specific ICD-10-AM or ACHI code.*

Follow the above guidelines from ACS 0010 when the indication for iStent® implantation is not documented. If documentation within the health care record is inadequate for complete and accurate classification, seek further information from the clinician.

References:

Eye Doctors of Washington 2019, iStent® for Microtrabecular Bypass, viewed 12 November 2019, https://www.edow.com/glaucoma/istent%20washington%20dc/

Guedes, R.A.P., Gravina, D.M., Lake, J.C. Guedes, V.M.P. Chaoubah, A. 2019, 'Intermediate results of iStent or iStent inject implantation combined with cataract surgery in a real-world setting: a longitudinal retrospective study', Ophthalmology and Therapy, vol. 8, no. 1, pp. 87–100, viewed 12 November 2019, https://www.ncbi.nlm.nih.gov/pubmed/30721523

Published 16 December 2019,
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Ref No: Q3475 | Published On: 16-Dec-2019 | Status: Retired | Retired On: 1-Jul-2022

Closed reduction of fracture of the acetabulum

Q:

What code is assigned for closed reduction of a fracture of the acetabulum?

A:

Closed reduction of an acetabulum fracture with internal fixation is classified in ACHI to 47498-00 **[1479]** *Internal fixation of fracture of acetabulum*. Follow the ACHI Alphabetic Index:

Reduction

- fracture (bone) (with cast) (with split)

- - acetabulum

- - - with internal fixation (closed) 47498-00 **[1479]**

ACHI does not include a code for closed reduction of an acetabulum fracture without internal fixation. Assign 90552-00 **[1491]** *Other repair of hip* by following the ACHI Alphabetic Index:

Repair

- hip NEC 90552-00 **[1491]**

Amendments may be considered for a future edition.

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Ref No: Q3377 | Published On: 15-Mar-2019 | Status: Retired | Retired On: 1-Jul-2022

Internal fixation of an unstable fracture without documentation of reduction

Q:

Can fracture reduction be assumed where there is documentation of internal fixation of an unstable fracture?

A:

Where internal fixation of an unstable fracture is performed without documentation of reduction, clinical coders can assume that reduction was performed along with the internal fixation.

Follow the Alphabetic Index at *Reduction/fracture/by site/with internal fixation* OR *Reduction/fracture/by site/open/with internal fixation.*

Amendments may be considered for a future edition.

References:

The Free Dictionary, *'Unstable fracture'*, viewed 12 November 2018, https://medical-dictionary.thefreedictionary.com/unstable+fracture

Published 15 March 2019,
for implementation 01 April 2019.

Ref No: Q3312 | Published On: 15-Mar-2019 | Status: Retired | Retired On: 1-Jul-2022

Hashimoto’s encephalopathy

Q:

What codes are assigned for Hashimoto’s encephalopathy?

A:

Hashimoto’s encephalopathy (HE) is also known as Hashimoto’s encephalitis or steroid-responsive encephalopathy associated with autoimmune thyroiditis (SREAT). The exact cause of HE is unknown but is thought to relate to autoimmune or other autoinflammatory processes. HE is not casually related to Hashimoto’s thyroiditis although Hashimoto’s thyroiditis is usually present in patients with HE (Genetic and Rare diseases Information Center 2014, Hashimoto’s Encephalopathy SREAT Alliance 2016).

Where there is documentation of Hashimoto’s encephalopathy (or Hashimoto’s encephalitis) assign G93.4 *Encephalopathy, unspecified.*

Follow the Alphabetic Index:

Encephalopathy (acute) G93.4

Where the cause of Hashimoto’s encephalopathy is documented follow the guidelines in ACS 0001 *Principal diagnosis/Problems and underlying conditions* and assign codes for both the condition and the underlying cause.

Amendments may be considered for a future edition.

References:

Genetic and Rare Diseases Information Center, *Hashimoto encephalopathy*, 2014, GARD, viewed 12 October 2018, https://rarediseases.info.nih.gov/diseases/8570/hashimoto-encephalopathy

Hashimoto’s Encephalopathy SREAT Alliance, *What is HR/SREAT,* 2016, HESA, viewed 8 November 2018, http://www.hesaonline.org/what_is_he/

Published 15 March 2019,
for implementation 01 April 2019.

Ref No: Q3314 | Published On: 15-Mar-2019 | Status: Retired | Retired On: 1-Jul-2022

Fat grafting by injection

Q:

What code is assigned for fat grafting by injection?

A:

Fat grafting via injection (fat transfer or lipomodelling) involves removal (via syringe) of fat cells from one part of the body and transferring them to another area of the body. Fat grafting via injection can help with facial scarring, lip augmentation, facial wrinkles and furrows (Gampper 2017; Macquillian 2017). This intervention differs from a traditional fat graft which is a more invasive, open intervention.

For fat grafting by injection, assign:

90660-00 **[1602]** *Administration of agent into skin and subcutaneous tissue*

Follow the Alphabetic Index:

Administration (around) (into) (local) (of) (therapeutic agent) NEC

- specified site

- - skin (collagen) (fat) (poly-L-lactic acid) (silicone) (subcutaneous tissue) 90660-00 **[1602]**

Amendments may be considered for a future edition.

References:

Gampper, TJ 2017, *Facial fat grafting,* Medscape, viewed 9 April 2018, https://emedicine.medscape.com/article/1283020-overview#a7

Macquillian, A 2017, 'Facial fat grafting', *Aesthetics Journal,* viewed 1 May 2018, https://aestheticsjournal.com/feature/facial-fat-grafting

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Ref No: Q3354 | Published On: 15-Mar-2019 | Status: Retired | Retired On: 1-Jul-2022

Follicular Lymphoma grade 1–2

Q:

What codes are assigned for follicular lymphoma grade 1-2?

A:

Follicular lymphoma is now the preferred name for follicle centre cell lymphoma. The grades do not reflect aggressiveness, but rather types: formerly grade 2 was mixed small cleaved and large cell, grade 1 was small cleaved cell, and grade 3 was large cell noncleaved. They are out of numerical code order because the synonyms were applied to existing codes (National Cancer Institute, 2018).

ACS 0233 *Morphology* states:

> *If a morphological diagnosis contains two histological terms which have different morphology codes, select the highest number as it is usually more specific.*

The morphology codes for follicular lymphoma grade 1 and grade 2 are:

M9695/3 *Follicular lymphoma,* grade 1

M9691/3 *Follicular lymphoma*, grade 2

Therefore, as per the guidelines in ACS 0233, where follicular lymphoma grade 1-2 is documented, assign the higher morphology code (and corresponding topography code) for follicular lymphoma grade 1:

C82.0 *Follicular lymphoma grade 1*

M9695/3 *Follicular lymphoma, grade 1*

Follow the ICD-10-AM Alphabetic Index:

Lymphoma

- follicular

- - grade 1 (M9695/3) C82.0

Note: this advice has also taken into consideration the International Classification of Diseases for Oncology Third Edition (ICD-O-3) guidelines; as ICD-10-AM incorporates ICD-O-3 concepts and logic in the classification of neoplasms

Reference:

National Cancer Institute, 2018 *New terms for existing codes,* viewed 18 December 2018, SEER training modules, https://training.seer.cancer.gov/icdo3/new/terms/existing.html

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for implementation 01 April 2019.

Ref No: Q3356 | Published On: 15-Mar-2019 | Status: Retired | Retired On: 1-Jul-2022

CNS Lymphoma

Q:

What codes are assigned for a primary CNS diffuse large B-cell lymphoma?

A:

ACCD acknowledges that the ICD-10-AM Alphabetic Index is inconsistent for classification of lymphomas and that the guidelines in ACS 0222 *Lymphoma* regarding the classification of extranodal lymphomas are contradictory to the Alphabetic Index in some cases.

For primary central nervous system diffuse large B-cell lymphoma, assign:

C72.9 *Malignant neoplasm, central nervous system, unspecified*

M9680/3 *Lymphoma, large B-cell, diffuse NOS*

Follow the ICD-10-AM Alphabetic Index:

Lymphoma (malignant)

- B-cell

- - diffuse large (anaplastic) (centroblastic) (DLBCL)

- - - primary

- - - - central nervous system (M9680/3)

- - - - - unspecified site C72.9

Amendments may be considered for a future edition.

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Ref No: Q3366 | Published On: 15-Mar-2019 | Status: Retired | Retired On: 1-Jul-2022

Aborted stroke

Q:

What code is assigned for aborted stroke?

A:

An aborted (or imaging-negative) stroke is defined as “an episode of neurological dysfunction caused by focal brain ischemia that resolves following thrombolysis or that is not manifest on neuroimaging” (Liberman et al, 2018).

Clinical advice supports classifying ‘aborted stroke’ to cerebral infarction, as only stoke due to an infarction (ie not haemorrhage) is treated by thrombolysis.

Therefore, where aborted stroke NOS (not otherwise specified) is documented, assign:

I63.9 *Cerebral infarction, unspecified*.

Follow the Alphabetic Index:

Stroke (apoplectic) (brain) (paralytic)

- ischaemic (see also Infarction/cerebral) I63.9

Infarct, infarction (of)

- cerebral I63.9

Amendments may be considered for a future edition of ICD-10-AM/ACHI/ACS.

References:

Liberman, A, Rostanski, S, Ruff, I, Meyer A, Maas, M Prabhakaran, S 2018 ‘Inter-rater Agreement for the Diagnosis of Stroke Versus Stroke Mimic’, *The Neurologist*, July 2018 - Volume 23 - Issue 4, viewed 15 November 2018, https://journals.lww.com/theneurologist/fulltext/2018/07000/Inter_rater_Agreement_for_the_Diagnosis_of_Stroke.2.aspx

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Ref No: Q3369 | Published On: 15-Mar-2019 | Status: Retired | Retired On: 1-Jul-2022

Open reduction and internal fixation of 4 or more sites of the zygomatic bone

Q:

What code is assigned for open reduction and internal fixation (ORIF) of 4 or more sites of the zygomatic bone?

A:

The term ‘site(s)’ in the code titles in ACHI block **[1368]** *Reduction of fracture of zygomatic bone* refer to the site/location of the fracture(s) across the zygoma.

Where documentation states ORIF of ‘4 or more sites’ of zygoma, assign 47771-01 **[1368]** *Open reduction of fracture of zygomatic bone with internal fixation, 3 sites* as a best fit.

Follow the ACHI Alphabetic Index:

Reduction

- fracture (bone) (with cast) (with splint)

- - zygoma, zygomatic arch (malar)

- - - open

- - - - with fixation

- - - - - internal

- - - - - - 3 sites 47771-01 **[1368]**

Where there is documentation of reduction of bilateral fractures of the zygoma, follow the guidelines in ACS 0020 *Bilateral/multiple procedures/Classification point 3.*

Amendments may be considered for a future edition.

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Ref No: Q3370 | Published On: 15-Mar-2019 | Status: Retired | Retired On: 1-Jul-2022

Notchplasty without knee reconstruction

Q:

What ACHI code is assigned for notchplasty performed without reconstruction of the knee?

A:

Notchplasty is a surgical intervention that consists of widening of the intercondylar femoral notch. It is often performed in conjunction with knee reconstruction procedures but is also performed independently for conditions such as notch impingement (Ferrari et al. 2017, Ranuccio et al. 2017).

In the absence of a specific code or ACHI Alphabetic index entries for notchplasty performed alone (ie not in conjunction with reconstruction procedures of the knee), clinical advice supports the assignment of 48424-07 **[1504]** *Ostectomy of distal femur* as a best fit.

Follow the Alphabetic Index:

Ostectomy NEC

- femur

- - distal 48424-07 **[1504]**

Amendments maybe considered for a future edition.

References:

Ferrari M, Mannava S, DePhillipo N, Sanchez G LaPrade R, 2017, *Notchplasty for the Arthroscopic Treatment of Limited Knee Extension*. Arthroscopy Techniques, viewed 17 October 2018, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5495028/

Ranuccio, F, Familiari, F, Tedesco, G, La Camera, F Gasparini, G 2017, *Effects of Notchplasty on Anterior Cruciate Ligament Reconstruction: A Systematic Review*, Joints, viewed 18 October 2018, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5738469/

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for implementation 01 April 2019.

Ref No: Q3379 | Published On: 15-Mar-2019 | Status: Retired | Retired On: 1-Jul-2022

Tonic-clonic seizures without documentation of epilepsy

Q:

What code is assigned for tonic-clonic seizures when there is no documentation of epilepsy?

A:

Tonic-clonic seizures are generalised seizures caused by electrical discharges involving both cerebral hemispheres. They are commonly referred to as grand mal seizures. Repeated tonic-clonic seizures are usually caused by epilepsy. Other causes include head injury, brain tumour, stroke, infections such as meningitis, encephalitis, low blood sugar and heavy use of drugs and alcohol (Jarman 2017; Mayo Clinic 2017; Schachter 2017).

Clinical clarification should be sought to determine the cause of the tonic-clonic seizures.

If the cause is not known or clinical clarification is not possible, assign G40.6- *Grand mal seizures, unspecified (with or without petit mal)* for tonic-clonic seizures not otherwise specified.

Follow the Alphabetic Index:

Grand mal

- seizure (with or without petit mal) G40.6-

Amendments may be considered for a future edition.

References:

Jarman, P, 2017, *Neurological disease*, Kumar and Clark's Clinical Medicine, Ninth Edition, pp795-892, The Netherlands, viewed 12 February 2019, https://www-clinicalkey-com-au.ezproxy1.library.usyd.edu.au/#!/content/book/3-s2.0-B9780702066016000214?scrollTo=%23hl0009870

Mayo Clinic, 2017, *Grandmal seizure*, Mayo Clinic, viewed 13 November 2018, https://www.mayoclinic.org/diseases-conditions/grand-mal-seizure/symptoms-causes/syc-20363458

Schachter, SC 2017, *Seizures in adults*, UpToDate, viewed 13 November 2018, https://www.uptodate.com/contents/seizures-in-adults-beyond-the-basics

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Ref No: Q3380 | Published On: 15-Mar-2019 | Status: Retired | Retired On: 1-Jul-2022

Alpha-methylacyl-CoA racemase (AMACR) deficiency

Q:

What code is assigned for Alpha-methylacyl-CoA racemase (AMACR) deficiency?

A:

Alpha-methylacyl-CoA (Alpha-methyl-acyl-CoA) racemase (AMACR) deficiency is a rare congenital disorder of metabolism, caused by an AMACR gene mutation. This mutation results in a deficiency of functional enzyme, leading to accumulation of pristanic acid in the blood. Those with AMACR deficiency may have a gradual loss in intellectual functioning, seizures, migraines, or acute episodes of brain dysfunction (encephalopathy) similar to stroke, involving altered consciousness and areas of damage (lesions) in the brain. Other features of AMACR deficiency may include sensorimotor neuropathy, spasticity, ataxia and problems with vision (Genetics Home Reference 2013).

Whist this condition is not classifiable in ICD-10-AM (or ICD-10), it has been included in ICD-11 as a metabolic disorder. Therefore, assign E88.8 *Other specified metabolic disorders* as a best fit.

Follow the Alphabetic Index:

Error

- metabolism, inborn — *see Disorder/metabolism*

Disorder (of)

- metabolism NEC

- - specified NEC E88.8

Note that E88.8 has an *Instructional* note: *Code first the manifestation(s), if known.*

Amendments may be considered for a future edition.

References:

Genetics Home Reference 2013, *Alpha-methylacyl-CoA racemase deficiency,* U.S. National Library of Medicine, U.S. Department of Health and Human Services, viewed 4 December 2018, https://ghr.nlm.nih.gov/condition/alpha-methylacyl-coa-racemase-deficiency

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for implementation 01 April 2019.

Ref No: Q3392 | Published On: 15-Mar-2019 | Status: Retired | Retired On: 1-Jul-2022

Neurocognitive disorder

Q:

What code is assigned for neurocognitive disorder?

A:

In the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), dementia was named major neurocognitive disorder (NCD). However, the term dementia may still be used as an acceptable alternative. The two terms are essentially different labels for the same condition; major NCD is equivalent to dementia. The DSM-5 also recognises a less severe level of cognitive impairment termed mild NCD. Mild NCD is equivalent to mild cognitive impairment and to prodromal dementia, again different labels for the same condition (Dementia Australia 2018).

Where there is documentation of ‘major neurocognitive disorder’, assign a code from the options listed under the lead term *Dementia*.

Where there is documentation of ‘mild neurocognitive disorder’, assign:

F06.7 *Mild cognitive disorder*

Follow the alphabetic index:

Disorder (of) — *see also Disease*

- cognitive

- - mild F06.7

Where neurocognitive disorder NOS (not otherwise specified) is recorded, seek clinical clarification as to the type or category of the neurocognitive disorder. Where clinical consultation is not possible, assign F06.7 *Mild cognitive disorder* as best fit.

Minor amendments will be made in Errata 1 for the Alphabetic Index, and further amendments may be considered for a future edition.

Reference:

Dementia Australia, *Diagnostic criteria for dementia,* 2018, Dementia Australia, viewed 29 November 2018, https://www.dementia.org.au/files/helpsheets/Helpsheet-DementiaQandA11-DiagnosticCriteriaForDementia_english.pdf

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Ref No: Q3396 | Published On: 15-Mar-2019 | Status: Retired | Retired On: 1-Jul-2022

Behavioural and psychological symptoms of dementia (BPSD)

Q:

Are additional diagnosis codes assigned for behavioural and psychological symptoms of dementia (BPSD)?

A:

Behavioural and psychological symptoms of dementia (BPSD) may develop in persons with any type of dementia.

Examples of BPSD include:

- delusions or hallucinations
- mood disturbance (eg depression, irritability)
- anxiety
- apathy
- agitation
- disinhibition (eg social inappropriateness, impulsivity, risk taking behaviour)
- wandering

BPSD may increase carer burden, distress the person with dementia, and result in institutionalisation and higher costs of care. However, some symptoms may have no impact on the provision of care (Macfarlane O'Connor 2016; myDr 2012; Woodward 2014).

Block R40–R46 *Symptoms and signs involving cognition, perception, emotional state and behaviour*:

> ***Excludes:*** those constituting part of a pattern of mental disorder (F00–F99)

The *Guidance in the use of ICD-10-AM* also states:

> **Note:** *Avoid indiscriminate coding of irrelevant information, such as symptoms or signs characteristic of the diagnosis.*

Therefore, where BPSD is documented in the clinical record, assign a code for the dementia. Do not assign additional diagnoses from Chapter 18 *Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified* unless the symptom is significant in its own right and treated independently (see also the *Note* at the beginning of Chapter 18).

References:

Macfarlane, S O'Connor, D 2016, 'Managing behavioural and psychological symptoms in dementia', *Australian Prescriber,* 2016;39:123-5, I Aug 2016, viewed 7 November 2018, https://www.nps.org.au/australian-prescriber/articles/managing-behavioural-and-psychological-symptoms-in-dementia

myDr 2012, *Dementia: behavioural and psychological symptoms,* Dr Me Pty Ltd, viewed 7 November 2018, https://www.mydr.com.au/seniors-health/dementia-behavioural-and-psychological-symptoms

Woodward, M 2014, 'Behavioural and psychological symptoms of dementia', in G Caplan (ed.), *Geriatric medicine: An introduction,* viewed 7 November 2018, https://books.google.com.au/books?hl=enlr=id=AfnwAwAAQBAJoi=fndpg=PA125dq=behavioural+and+psychological+symptoms+of+dementiaots=emYekucArUsig=oXI3k0aEKlWg4r9vhnvBEKIxQHs#v=onepageq=behavioural%20and%20psychological%20symptoms%20of%20dementiaf=false

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Ref No: Q3413 | Published On: 15-Mar-2019 | Status: Retired | Retired On: 1-Jul-2022

Rebubbling of DSEK/DSAEK graft

Q:

What code is assigned for rebubbling of a Descemet(‘s) stripping (automated) endothelial keratoplasty (DSEK/DSAEK) graft?

A:

Descemet(‘s) stripping (automated) endothelial keratoplasty (DSEK/DSAEK) is a partial thickness cornea transplant procedure that involves selective removal of the Descemet membrane and endothelium, followed by transplantation of donor corneal endothelium and corneal stroma. An air bubble is placed in the anterior chamber to support graft adherence (Ophthalmology and Visual Sciences 2016).

Graft dislocation/detachment may be treated with ‘rebubbling’ (ie addition of another air bubble) to achieve adhesion/reattachment of the graft (Chaurasia et al 2011).

Assign 42740-02 **[185]** *Administration of therapeutic agent into anterior chamber* as a best fit for ‘rebubbling of DSAEK’. Follow the Alphabetic Index:

Administration (around) (into) (local) (of) (therapeutic agent)

- specified site

- - anterior chamber (by paracentesis) (eye) 42740-02 **[185]**

References:

Chaurasia, S, Vaddavalli, P, Ramappa, M, Garg, P, Sangwan, V 2011, ‘Clinical profile of graft detachment and outcomes of rebubbling after Descemet stripping endothelial keratoplasty’, *British Journal of Ophthalmology,* Volume 95, Issue 11 , viewed 11 December 2018, https://bjo.bmj.com/content/95/11/1509

Ophthalmology and Visual Sciences 2016, *Descemet Stripping Automated Endothelial Keratoplasty (DSAEK),* University of Iowa Health Care, Iowa City, viewed 11 December 2018, https://webeye.ophth.uiowa.edu/eyeforum/tutorials/cornea-transplant-intro/4-DSAEK.htm

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Ref No: Q3278 | Published On: 15-Dec-2018 | Status: Retired | Retired On: 1-Jul-2022

Liver lacerations

Q:

What codes are assigned for liver lacerations documented by grade rather than severity (ie minor, moderate or major)?

A:

ICD-10 (and hence ICD-10-AM) classifies liver lacerations by severity (ie minor, moderate and major). However, clinicians may document liver lacerations using grades (ie grades 1-6).

As a best fit, where a liver laceration is documented using a grading system rather than a severity descriptor, assign:

- S36.13 *Minor laceration of liver* for Grade 1
- S36.14 *Moderate laceration of liver* for Grade 2
- S36.15 *Major laceration of liver* for Grade 3 and above.

Amendments may be considered for a future edition.

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Implantation of endoanchors/endostaples to the stent graft in endovascular aneurysm repair (EVAR)

Q:

What code is assigned for implantation of endoanchors/endostaples to the stent graft in endovascular aneurysm repair (EVAR)?

A:

Endovascular aneurysm repair (EVAR) with stent graft is performed for aortic aneurysms where a stent graft is inserted through a catheter via the femoral artery. The graft is expanded at the site of the aneurysm, reinforcing the weak portion of the aorta and allowing the blood to flow through the stent graft. Endoanchors/endostaples can be implanted during EVAR to secure a transmural fixation of the endograft to the aorta. The endoanchors can also be implanted as a separate procedure for complications of EVAR such as endovascular leaks or migrated stent grafts (de Vries 2017; UCSF Department of Surgery 2018).

Where endoanchors are inserted during the initial EVAR, it is not necessary to assign a separate code as it is inherent in the EVAR procedure.

Where endoanchors are inserted as a standalone procedure (eg for endograft migration or endovascular leaks), assign 33116-00 **[762]** *Endovascular repair of aneurysm* as best fit.

Follow the Alphabetic Index:

Repair

- aorta, aortic

- - endovascular (AAA stent) (aneurysm) (dissection) (endoluminal) 33116-00 **[762]**

Amendments may be considered for a future edition.

References:

de Vries, JP 2017, Is it time to insert endoanchors into routine EVAR, Journal of European Society for Vascular Surgery, vol 53, pp. 458-459, viewed 10 August 2018, https://www.ejves.com/article/S1078-5884(17)30054-0/pdf

UCSF Department of Surgery 2018, Endovascular Aneurysm repair, University of California San Francisco, viewed 10 August 2018, https://surgery.ucsf.edu/conditions--procedures/endovascular-aneurysm-repair.aspx

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Ref No: Q3310 | Published On: 15-Dec-2018 | Status: Retired | Retired On: 1-Jul-2022

Functional Neurological Disorder

Q:

What codes are assigned for functional neurological disorder?

A:

Functional neurological disorder (FND) is a broad term that includes conditions previously known as ‘conversion’ or ‘dissociative’ disorders. FND features neurological symptoms that cannot be explained by a neurological disease or other medical condition, however the symptoms cause significant distress or problems with functioning (Mayo Clinic 2017).

Assign as a best fit for functional neurological disorder one of the codes listed below by following the Alphabetic Index:

Disorder (of) — *see also Disease*

- conversion (*see also Disorder/dissociative*)
- dissociative F44.9
- - affecting
- - - motor function F44.4
- - - - and sensation F44.7
- - - sensation F44.6
- - specified NEC F44.88
- - transient, occurring in childhood and adolescence F44.82

For example, for limb weakness and paraesthesia due to functional neurological disorder, assign F44.7 *Mixed dissociative [conversion] disorders.*

Note: Do not assign codes for neurological symptoms (eg limb weakness, paraesthesia) of a functional neurological disorder code *(*see also *Note* at the beginning of Chapter 18 *Symptoms, signs and abnormal clinical findings, not elsewhere classified)*.

Amendments may be considered for a future edition.

References:

Mayo Clinic 2017, *Functional neurologic disorders/conversion disorder*, Mayo Clinic, viewed 8 May 2018,

https://www.mayoclinic.org/diseases-conditions/conversion-disorder/symptoms-causes/syc-20355197

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Ref No: Q3315 | Published On: 15-Dec-2018 | Status: Retired | Retired On: 1-Jul-2022

Drug seeking behaviour

Q:

What code is assigned for drug seeking behaviour?

A:

Within admitted inpatient episodes drug or medication seeking behaviour is defined as a pervasive pattern of requesting medications that have either little or no therapeutic efficacy for the presenting problem and/or in dosages exceeding therapeutic limits. Drug seeking behaviour may have many causes including undertreated pain, anxiety, sleep related issues, somatoform disorders, addiction, or maybe deceptive in nature where the individual is motivated by the desire to misuse medication for non-medical purposes (Bird Gulliver, Wolfsforf & Michas 2003, Butterfield 2014).

Where there is documentation of drug seeking behaviour and it is relevant to the episode of care:

- assign a code for the underlying cause (eg drug dependence) if documented with the episode.

or

- assign Z64.2 *Seeking and accepting physical, nutritional and chemical interventions known to be hazardous and harmful*, where there is no documentation or clinical confirmation of an underlying cause.

Follow the Alphabetic Index:

Seeking and accepting known hazardous and harmful

- chemical, nutritional or physical interventions Z64.2

Amendments may be considered for a future edition.

References:

Bird Gulliver, S, Wolfsforf, B, & Michas, A 2003, 'Chapter 11: Management of inappropriate medication-seeking behaviour', In LM Cohen DE McChargue & FL Collins (ed.) *The Health Psychology Handbook: Issues for the Behavioral Medicine Specialist,* Thousand Oaks, CA viewed on 16 May 2018, http://sk.sagepub.com/reference/hdbk_healthpsych/n11.xml

Butterfield, S 2014, *Dealing with drug-seeking behaviour*, ACP (American college of physicians) Hospitalist February 2014, Viewed 14 June 2018, https://acphospitalist.org/archives/2014/02/coverstory.htm

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Ref No: Q3318 | Published On: 15-Dec-2018 | Status: Retired | Retired On: 1-Jul-2022

Lipomodelling following breast reconstruction

Q:

What codes are assigned for lipomodelling following breast reconstruction?

A:

After breast reconstruction, there may be dents or irregularities in the outline (contour) of the reconstructed breast.

Lipomodelling (also known as 'lipofilling') after breast reconstruction is a same-day procedure that involves the injection of fat into the reconstructed breast, to fill dents or irregularities. Lipomodelling may also be performed as a breast enlargement procedure. The procedure involves removing fat from one body part (eg thigh, abdomen) and injecting into the breast. It may be necessary to repeat the procedure to achieve the desired result.

Lipomodelling is not usually performed until the reconstructed breasts have fully healed, which usually takes about 6–12 months (Macmillan Cancer Support 2015).

ACS 1204 *Plastic surgery* states:

> *When the condition is not specified, or is a term not recognised by ICD-10-AM (eg ageing face), assign Z41.1* Other plastic surgery for unacceptable cosmetic appearance *or Z42.*- Follow-up care involving plastic surgery *as the principal diagnosis, as appropriate.*

Therefore, when a patient is admitted following breast reconstruction for lipomodelling, assign

Z42.1 *Follow-up care involving plastic surgery of breast.*

Follow the ICD-10-AM Alphabetic Index:

Aftercare

- following surgery

- - plastic (of)

- - - breast Z42.1

Assign 90660-00 **[1602]** *Administration of agent into skin and subcutaneous tissue* by following the ACHI Alphabetic Index:

Administration

- specified site

- - skin (collagen) (fat) (poly-L-lactic acid) (silicone) (subcutaneous tissue) 90660-00 **[1602]**

Amendments may be considered for a future edition.

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Hormone Resistance in Prostate Cancer

Q:

Is Z07 *Resistance to anti-neoplastic drugs* assigned for 'hormone resistance' in prostate cancer?

A:

Hormone therapy may be administered to patients with prostate cancer (also known as androgen deprivation therapy (ADT)), to slow or prevent the growth of cancer cells. When these patients no longer respond to hormone therapy, the cancer is classified as 'androgen-independent prostate cancer' or 'hormone-refractory prostate cancer (HRPC)'. This is not an adverse effect of the hormone therapy.

The *Note* at Z07 *Resistance to antineoplastic drugs* states:

> *Assign Z07 as an additional code to identify resistance to antineoplastic drugs in the treatment of conditions classified in Chapter 2.*

See also the *Instructional* note at Chapter 2 *Neoplasms*:

> *Use additional code (Z07) to identify resistance to antineoplastic drugs.*

Therefore, where there is documentation of 'androgen-independent prostate cancer' or HRPC or hormone resistance in prostate cancer, assign:

- codes for the neoplasm(s) (see ACS 0236 *Neoplasm coding and sequencing*) and
- Z07 *Resistance to antineoplastic drugs*

Follow the ICD-10-AM Alphabetic Index:

Resistance, resistant (to)
- antineoplastic drug(s) Z07

Amendments may be considered for a future edition.

References

American Cancer Society 2018, *Hormone Therapy for Prostate Cancer*, viewed 15 October 2018 https://www.cancer.org/cancer/prostate-cancer/treating/hormone-therapy.html

Harvard University 2018, Androgen-independent Prostate Cancer, viewed 15 October 2018 https://www.harvardprostateknowledge.org/androgen-independent-prostate-cancer

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Ref No: Q3338 | Published On: 15-Dec-2018 | Status: Retired | Retired On: 1-Jul-2022

Endoscopic clipping of bleeding upper gastrointestinal lesions

Q:

What code is assigned for endoscopic clipping of bleeding upper gastrointestinal lesions?

A:

Upper gastrointestinal (UGI) bleeding may be caused by conditions such as peptic (ie gastric, duodenal) ulcer, Mallory-Weiss tear, angiodysplasia, arteriovenous malformation or Dieulafoy's lesions occurring in the stomach, duodenum and oesophagus.

There are several different endoscopic techniques for treatment of UGI bleeding including injection of sclerosants (eg epinephrine), thermal therapy (eg heat probes, Argon plasma coagulation) and placement of clips (eg endoclips), to close the blood vessels. Clipping devices are designed to grasp the submucosa, seal the underlying patent blood vessels, and/or to approximate the sides of lesions during endoscopy to potentially accelerate lesion healing. (Genetic and Rare Diseases Information Centre 2016; Kovacs Jensen 2011).

For endoscopic clipping of bleeding UGI lesions due to any cause, assign 90296-00 **[887]** *Endoscopic control of peptic ulcer or bleeding* as a best fit.

Follow the Alphabetic Index:

Clipping (of)

- peptic ulcer, endoscopic (duodenal) (gastric) 90296-00 **[887]**

Amendments may be considered for a future edition.

References:

Genetic and Rare Diseases Information Centre, 2016, *Dieulafoy lesion*, National Institute of Health, U.S. Department of Health Human Services, viewed 5 November 2018, https://rarediseases.info.nih.gov/diseases/10930/dieulafoy-lesion

Kovacs,T O G Jensen, D M 2011, Endoscopic therapy for severe ulcer bleeding. *Gastrointestinal endoscopy clinics of North America*, vol. 21, no. 4, pp. 681-696, viewed 5 November 2018, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3878947/78947/

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Ref No: Q3372 | Published On: 15-Dec-2018 | Status: Retired | Retired On: 1-Jul-2022

Drug induced postural hypotension

Q:

What codes are assigned for drug induced postural hypotension?

A:

Postural (orthostatic) hypotension is a condition that occurs when blood pressure falls significantly when standing up or resuming an upright position quickly. Symptoms include feeling dizzy, lightheaded, faint, falling and blurred vision. Drug induced postural (orthostatic) hypotension occurs when a medication (eg antihypertensive, beta blocker, antipsychotic) results in a drop in blood pressure (Cleveland Clinic 2018; Wedro n.d.).

Assign I95.19 *Other specified orthostatic hypotension* for drug induced postural (orthostatic) hypotension. Follow the Alphabetic Index (Section I):

Hypotension

- orthostatic

- - specified NEC I95.19

- postural

- - specified NEC I95.19

Assign a code from categories Y40-Y59 *Drugs, medicaments and biological substances causing adverse effects in therapeutic use* to identify the drug or medicament (see ICD-10-AM Alphabetic Index Section III *Table of Drugs and Chemicals*).

Also assign a code for place of occurrence:

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

OR

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

Follow the Alphabetic Index (Section II):

Place of occurrence of external cause

- health service area (not specified as this facility) NEC Y92.23

- - this facility Y92.24

Amendments may be considered for a future edition.

References:

Cleveland Clinic 2018, *Orthostatic hypotension,* Cleveland Clinic, Ohio, viewed 31 July 2018, https://my.clevelandclinic.org/health/diseases/9385-orthostatic-hypotension

Wedro, B n.d., *Orthostatic hypotension (low blood pressure when standing)*, MedicineNet.com, viewed 31 July 2018, https://www.medicinenet.com/orthostatic_hypotension/article.htm#orthostatic_hypotension_definition_and_facts

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Ref No: Q3389 | Published On: 15-Dec-2018 | Status: Retired | Retired On: 1-Jul-2022

Terminology for malnutrition

Q:

Is malnourished or malnourishment classified as per malnutrition?

A:

Malnutrition is a noun, defined as “deficiencies, excesses or imbalances in a person’s intake of energy and/or nutrients” (WHO 2016).

Malnourishment, also a noun, is synonymous with malnutrition. Malnourished is the adjectival form, used to refer to someone affected by malnutrition/malnourishment.

The ICD-10-AM *General arrangement of the Alphabetic Index of Diseases/Structure* states:

> *In some diagnostic statements, the disease condition is expressed in adjectival form. Sometimes, the index lists both forms but often only the noun form will be found and the clinical coder must make the necessary transformation.*

Therefore, where the terms ‘malnourished’, ‘malnourishment’ or ‘malnutrition’ are documented in the clinical record and meet the criteria in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*, assign an appropriate code as listed under the lead term *Malnutrition* in the ICD-10-AM Alphabetic Index.

Amendments may be considered for a future edition.

References:

World Health Organization (WHO) 2016, *What is malnutrition? Online Q&A,* viewed 11 October 2018, http://www.who.int/features/qa/malnutrition/en/

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Ref No: Q3261 | Published On: 15-Sep-2018 | Status: Retired | Retired On: 1-Jul-2022

Intraoperative radiation therapy

Q:

What code is assigned for intraoperative radiation therapy (IORT)?

A:

Intraoperative radiation therapy (IORT) is used for patients with certain breast, gynaecological, prostate and colorectal cancers. It is an intensive radiation treatment that is administered at the time of surgery and allows precise localisation of the tumour with minimal damage to surrounding tissues or structures. IORT may be used alone but it is typically performed in combination with other treatments such as surgical resection of the tumour, conventional radiotherapy, or chemotherapy.

Clinical advice confirms that IORT is a form of brachytherapy where an applicator is placed on the exposed tumour bed immediately after the tumour is removed. This applicator is connected to a unit that delivers a concentrated dose of radiation to the surgical cavity. The applicator is removed after the radiation delivery (Cancer Council NSW 2017; Cancer Treatment Centers of America 2018; Peter MacCallum Cancer Centre 2018; Radiation Oncology 2017).

Where intraoperative radiation therapy is documented without further information, assign a code for *Brachytherapy/by site/high dose rate*.

For example, assign 90764-01 **[1791]** *Brachytherapy, intracavitary, high dose rate* for IORT of the breast.

Follow the Alphabetic Index:

Brachytherapy

- intracavitary NEC

- - high dose rate 90764-01 **[1791]**

Amendments may be considered for a future edition.

References:

Cancer Council NSW, Types of brachytherapy 2017, Cancer Council NSW, Woolloomooloo, viewed 07 May 2018, https://www.cancercouncil.com.au/cancer-information/cancer-treatment/radiation-therapy/brachytherapy/types-of-brachytherapy/#temporary

Cancer Treatment Centers of America, Intraoperative radiation therapy 2018, CTCA, Zion, viewed 13 February 2018, https://www.cancercenter.com/treatments/intraoperative-radiation-therapy/

Peter MacCallum Cancer Centre, Intraoperative radiation therapy (IORT) 2018, MacCallum Cancer Centre, Melbourne, viewed 13 February 2018, https://www.petermac.org/services/treatment/radiation-therapy/types-radiation-therapy/intraoperative-radiation-therapy-iort

Radiation Oncology Targeting Centre, Brachytherapy 2017, Faculty of Radiation Oncology, The Royal Australian and New Zealand College of Radiologists, Sydney, viewed 26 June 2018, https://www.targetingcancer.com.au/radiation-therapy/brachytherapy/

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Ref No: Q3284 | Published On: 15-Sep-2018 | Status: Retired | Retired On: 1-Jul-2022

Fracture blisters

Q:

What code is assigned for fracture blister?

A:

Fracture blisters arise on skin overlying an acute bony fracture, or more rarely, they may occur after bone/joint surgery (eg arthroplasty). Fracture blisters occur on tight, thin skin with minimal soft tissue between the skin and underlying bone (eg ankle, wrist, elbow, foot, distal tibia). Fracture blisters are caused by shearing forces on the skin created by angulation of a bony fracture, post traumatic oedema and/or local tissue hypoxia. Other risk factors for fracture blisters include peripheral vascular disease, hypertension and diabetes mellitus. The presence of fracture blisters may complicate and delay fracture repair, and may result in chronic ulcers or infection, and prolong hospital admission (Cheng 2015; Nall 2018; Uebbing et al 2011; Wheeless 2012).

Clinical advice confirms that fracture blisters following a traumatic fracture are complications of the underlying fracture, not the original trauma that resulted in the bone fracture.

Where a fracture blister occurs following a traumatic fracture and meets the criteria in ACS 0002 *Additional diagnoses*, assign:

- a code for Blister/by site
- X58 *Exposure to other specified factors* as the external cause code, to differentiate the external cause of the fracture blister from the external cause of the traumatic fracture.

Where a fracture blister occurs following bone/joint surgery, follow the guidelines in ACS 1904 *Procedural complications*.

Amendments will be considered for a future edition.

References:

Cheng, H 2015, *Fracture blister,* DermNet New Zealand (New Zealand Dermatological Society), viewed 13 December 2017, https://www.dermnetnz.org/topics/fracture-blister

Nall, R 2018 *Fracture blister,* Healthline, viewed 9 July 2018, https://www.healthline.com/health/fracture-blisters

Uebbing, C, Walsh, m, Miller, J, Abraham, M & Arnold, C 2011, 'Fracture blisters', *Western Journal of Emergency Medicine,* 2011 Feb; 12(1): 131-133, viewed 13 December 2017, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3088393/

Wheeless, C 2012, *Fracture blisters,* Wheeless' Textbook of Orthopaedics (Presented by Duke Orthopaedics), viewed 13 December 2017, http://www.wheelessonline.com/ortho/fracture_blisters

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Ref No: Q3287 | Published On: 15-Sep-2018 | Status: Retired | Retired On: 1-Jul-2022

Removal of thrombus from central venous catheter

Q:

What code is assigned for the administration of a thrombolytic agent to a thrombotic occluded central venous catheter?

A:

Thrombolytic agents (eg alteplase) may be used for the removal of thrombotic occlusions of central venous catheters (CVC) by breaking down the blood clot within the catheter (Baskin et al. 2012). This intervention is similar to flushing a venous catheter lumen with normal saline to maintain its patency, and is less invasive than catheter direct thrombolytic therapy, which is a percutaneous intervention usually performed under anaesthesia.

Therefore, where a thrombolytic agent is administered to breakdown a blood clot in an occluded CVC (to maintain patency), assign 92058-01 **[1922]** *Other procedures related to pharmacotherapy,* as a best fit by following the Alphabetic Index:

Maintenance (of)

- catheter, implanted (for administration of pharmacotherapy) NEC 92058-01 **[1922]**
- - vascular (central venous catheter) (Hickman's line) (permacath) (without reservoir) 92058-01 **[1922]**

Amendments will be considered for a future edition.

References:

Baskin, JL, Reiss, U, Wilimas, JA, Metzger, ML, Ribeiro, RC, Pui, C-H & Howard, SC 2012, 'Thrombolytic therapy for central venous catheter occlusion', *Haematologica: the haematology journal*, vol. 97, no. 5, pp. 641-650, viewed 31 March 2018, PubMed Central database. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3342964/

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Ref No: Q3301 | Published On: 15-Sep-2018 | Status: Retired | Retired On: 1-Jul-2022

Intraductal Papillary Mucinous Neoplasm (IPMN)

Q:

What code is assigned for IPMN of the pancreas in the absence of further histological and clinical information regarding morphology and neoplasm behaviour?

A:

Intraductal papillary mucinous neoplasms (IPMN) of the pancreas are characterised by papillary growths within the pancreatic ductal system with thick mucin secretion, and are at risk for undergoing malignant transformation (Machado, al Qadhi & al Wahibi 2015).

The ICD-10-AM Alphabetical Index currently does not list a default morphology and behaviour code for IPMN.

Neoplasms with risk of malignant transformation (ie malignant potential) are classified to behaviour code /1 *Uncertain whether benign or malignant* as per the ICD-10-AM Appendix A *Morphology of neoplasms*:

> **MORPHOLOGY OF NEOPLASMS**
>
> *The morphology code numbers consist of five digits; the first four identify the histological type of the neoplasm and the fifth, following a slash or solidus, indicates its behaviour. The one digit behaviour code is as follows:*
>
> */0 Benign*
>
> */1 Uncertain whether benign or malignant*
>
> *Borderline malignancy*
>
> *Low malignant potential*
>
> *Uncertain malignant potential*

The morphology code numbers include the behaviour code appropriate to the histological type of neoplasm; this behaviour code should be changed if the other reported information makes this appropriate.

Therefore, assign as a best fit for pancreatic IPMN NOS (not otherwise specified):

D37.71 *Neoplasm of uncertain or unknown behaviour of oral cavity and digestive organs, pancreas.*

M8473/1 *Papillary mucinous cystadenoma, borderline malignancy*

Follow the Alphabetic Index:

Neoplasm, neoplastic

- pancreas (uncertain or unknown behaviour) D37.71

Tumour (M8000/1) — *see also Neoplasm/uncertain behaviour*

- papillary (M8050/0) — *see also Papilloma*

- - mucinous

- - - intraductal (of) (with)

- - - - low malignant potential (M8473/1) D39.1

Note that D39.1 *Neoplasm of uncertain or unknown behaviour of ovary* is **not** assigned, as per ICD-10-AM Appendix A *Morphology of neoplasms*:

> *Occasionally a problem arises when a site given in a diagnosis is different from the site indicated by the site-specific code. In such instances, the given Chapter 2 code should be ignored and the appropriate code for the site included in the diagnosis should be used.*

Amendments will be considered for a future edition.

References:

Machado, N, al Qadhi, H, & al Wahibi, K 2015, 'Intraductal Papillary Mucinous Neoplasm of Pancreas'. *North American Journal of Medical Sciences*, *7*(5), 160–175, viewed 4 April 2018, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4462811

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Ref No: Q3325 | Published On: 15-Sep-2018 | Status: Retired | Retired On: 1-Jul-2022

Arthroscopic ACL reconstruction with meniscectomy

Q:

What ACHI codes are assigned for an arthroscopic anterior cruciate ligament reconstruction with meniscectomy?

A:

The anterior cruciate ligament (ACL) is an important ligament in the knee, which provides stability during rotational movements such as turning, twisting and sidestepping. An ACL injury often includes damage to other knee structures such as bone, cartilage or meniscus. Treatment of meniscal tears with an ACL injury may be performed by a partial or total meniscectomy during the ACL reconstruction. A meniscectomy involves excision or removal of some or all of the meniscus (Mosby's Medical Dictionary 2009; Physiopedia 2018; Orthosports 2009).

For arthroscopic reconstruction of the ACL with a meniscectomy, assign 49539-00 **[1522]** *Arthroscopic reconstruction of knee* and 49560-03 **[1503]** *Arthroscopic meniscectomy of knee.*

Follow the Alphabetic Index:

Reconstruction

- ligament

- - cruciate or collateral, knee (open)

- - - arthroscopic (closed) 49539-00 **[1522]**

Meniscectomy

- knee (open) (total)

- - arthroscopic (closed) (partial) (total) 49560-03 **[1503]**

Amendments will be considered for a future edition.

References:

Mosby's Medical Dictionary 2009, *'Meniscectomy'*, viewed 21 May 2018, https://medical-dictionary.thefreedictionary.com/meniscectomy

Orthosports 2009, *ACL reconstruction*, viewed 26 June 2018, http://www.orthosports.com.au/content_common/pg-acl-reconstruction.seo

Physiopedia 2018, *Arthroscopic meniscectomy*, viewed 26 June 2018, https://www.physio-pedia.com/Arthroscopic_Meniscectomy

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Ref No: Q3353 | Published On: 15-Sep-2018 | Status: Retired | Retired On: 1-Jul-2022

Cervical Screening Test

Q:

What code is assigned for the Cervical Screening Test?

A:

Australia introduced the Cervical Screening Test (CST) in December 2017 to replace the Pap (Papanicolaou) smear test. Collection of cells for the CST is performed using the same method as for the Pap test. Pathologists use the CST to detect the presence of the human papillomavirus (HPV), which can develop into cervical cancer, whereas the Pap test is used to identify cell changes in the cervix (Department of Health 2018).

Assign 92130-00 **[1862]** *Papanicolaou smear study*, as a best fit, for the Cervical Screening Test.

Amendments will be considered for a future edition.

References:

Australian Government Department of Health 2018, *National Cervical Screening Program,* viewed 2 July 2018, http://www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/about-the-new-test

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Ref No: Q3273 | Published On: 15-Jun-2018 | Status: Retired | Retired On: 1-Jul-2022

Current complications of AMI

Q:

When assigning a code for a current complication following AMI (I23.-), can you also assign a code from I21.- or I22.- to identify the specific type of AMI/subsequent MI as the cause of the complication?

A:

The ICD-10-AM *Conventions/Multiple condition coding* states:

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

Therefore, assign I23.0 *Haemopericardium as current complication following acute myocardial infarction* with either a code from category I21 *Acute myocardial infarction* or I22 *Subsequent myocardial infarction* (to identify the specific type of AMI/subsequent MI as the underlying condition).

Follow the Alphabetic Index:

Haemopericardium

- following acute myocardial infarction (current complication) I23.0

Infarct, infarction (of)

- myocardium, myocardial (acute or with a stated duration of 4 weeks or less) I21.9
- - anterior (anteroapical) (anterolateral) (anteroseptal) (transmural) (wall) I21.0
- - inferior (diaphragmatic) (inferolateral) (inferoposterior) (transmural) (wall) I21.1
- - lateral (transmural) (wall) I21.2
- - non-ST elevation I21.4
- - nontransmural I21.4
- - NSTEMI I21.4
- - posterior (transmural) (true) I21.2
- - septal (transmural) I21.2
- - specified site (transmural) NEC I21.2
- - ST elevation NEC I21.3
- - STEMI NEC I21.3
- - - specified site — *see Infarct/myocardium by site*
- - subendocardial (acute) (nontransmural) I21.4
- - subsequent (extension) (recurrent) (reinfarction) I22.9
- - - anterior (wall) I22.0

- - - diaphragmatic (wall) I22.1
- - - inferior (wall) I22.1
- - - specified NEC I22.8
- - transmural NEC I21.3

Amendments may be considered for a future edition.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

References:

Singh, V 2017, *Pericardial effusion imaging*, Medscape, viewed 7 November 2017, https://emedicine.medscape.com/article/349447-overview

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Ref No: Q3212 | Published On: 15-Jun-2018 | Status: Retired | Retired On: 1-Jul-2022

Toenail avulsion

Q:

What code is assigned for a total toenail removal where the nail bed was left intact?

A:

There are many reasons for a total or partial nail to be removed, such as recurrent infections or disease within the nail, damage due to injury, ingrown nails or pain, or to repair a nail growth abnormality (DoveMed 2015).

Avulsion of the nail is performed by grasping the sectioned nail with forceps and easing the nail free of the nail bed. Phenol is then applied directly to the nail matrix (The Royal Australian College of General Practitioners 2016).

Currently there is no ACHI code for a total toenail avulsion. Therefore, if the nail bed is left intact, and destruction to the matrix is by application of phenol, acid, electrocautery or laser, assign

47916-00 **[1632]** *Partial resection of ingrown toenail*, as a *best fit*, for a total toenail avulsion (regardless of indication) by following the Alphabetic Index:

Removal — *see also Excision*

- nail

- - toe

- - - ingrown

- - - - partial (by phenolisation) (electrocautery) (laser) (sodium hydroxide or acid) 47916-00 **[1632]**

Amendments will be considered for a future edition.

Reference:

DoveMD, Nail Removal 2015, DoveMed, Champaign viewed 9 March 2018, http://www.dovemed.com/common-procedures/procedures-surgical/nail-removal/

The Royal Australian College of General Practitioners, *Partial nail avulsion and matricectomy for ingrown toenails* 2016, RACGP, East Melbourne, viewed 9 August 2017, http://www.racgp.org.au/download/Documents/HANDI/HANDI_Ingrown-toenails.pdf

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Ref No: Q3280 | Published On: 15-Jun-2018 | Status: Retired | Retired On: 1-Jul-2022

Denervation of proximal interphalangeal joint

Q:

What code is assigned for denervation of proximal interphalangeal joint?

A:

A denervation procedure involves the surgeon identifying the nerve that transmits pain signals from a joint back to the brain, and dissecting that nerve. Proximal interphalangeal joint denervation is a simple surgical option for patients with painful finger joint arthritis. The denervation does not cure the finger joint arthritis, however the pain is reduced, and pre-surgery joint motion is maintained (Flint 2016; Madsen et al. 2017).

For denervation of a proximal interphalangeal joint, assign 39324-01 **[74]** *Open neurotomy of superficial peripheral nerve.*

Follow the Alphabetic Index:

Division (freeing)

- nerve

- - peripheral

- - - open (superficial) 39324-01 **[74]**

Amendments will be considered for a future edition.

References:

Flint, J 2016, 'Using joint denervation to treat arthritis in the hand, wrist, elbow', *Flagstaff Business News,* 27 April, viewed 11 December 2017, http://www.flagstaffbusinessnews.com/using-joint-denervation-treat-arthritis-hand-wrist-elbow/

Madsen, RJ, Stone, LA, Knapp, JB Solomon, JS 2017, 'Joint denervation in the digits: technique and patient satisfaction', *Annals of Plastic Surgery*, vol 00, pp. 1-5, viewed 11 December 2017, OvidInsights Beta, https://insights.ovid.com/crossref?an=00000637-900000000-97604

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for implementation 01 July 2018.

Ref No: Q3196 | Published On: 15-Mar-2018 | Status: Retired | Retired On: 1-Jul-2022

Assignment of specific sepsis codes with or without positive blood culture on pathology

Q:

Can a specific sepsis code be assigned in the absence of a positive blood culture?

A:

Where there is documentation of:

- sepsis, with a positive blood culture for a specific organism on pathology (see ACS 0110 *SIRS, Sepsis, severe sepsis and septic shock* examples 2 and 5) or
- sepsis by type of organism (for example Staph aureus sepsis)

assign an appropriate specific sepsis code (such as A41.0 *Sepsis due to Staphylococcus aureus*) by following the Alphabetic Index at *Sepsis/by type of organism*.

Where there is documentation of sepsis, without a positive blood culture on pathology (see ACS 0110 example 4), assign A41.9 *Sepsis, unspecified*.

Note that sepsis must be documented to assign a sepsis code (A00–B99, P36.- or P37.52), irrespective of positive or negative blood cultures. Do not assign a code for sepsis based on a positive blood culture without documentation of sepsis.

Amendments will be considered for a future edition.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

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for implementation 01 April 2018.

Ref No: Q3217 | Published On: 15-Mar-2018 | Status: Retired | Retired On: 1-Jul-2022

Wound dehiscence/breakdown of an amputation stump

Q:

What codes are assigned for wound dehiscence/breakdown of an amputation stump?

A:

Assign the following codes for wound dehiscence/breakdown of an amputation stump for consistency with dehiscence of wound following insertion of prosthetic devices, implants or grafts:

T81.3 *Disruption of operation wound, not elsewhere classified*

Y83.5 *Amputation of limb(s)*

Y92.23 *Health service area, not specified as this facility* or Y92.24 *Health service area, this facility*

Z89.- *Acquired absence of limb*

Follow the Alphabetic Index (Section I):

Absence
- extremity (acquired) Z89.9
- - lower (above knee) (unilateral) Z89.6
- - - with upper extremity (any level) Z89.8
- - - below knee (unilateral) Z89.5
- - - bilateral (any level) Z89.7
- - - - with upper extremity (any level) Z89.8
- - upper (unilateral) Z89.2
- - - bilateral (any level) Z89.3
- foot and ankle (acquired) (unilateral) Z89.4
- hand and wrist (acquired) (unilateral) Z89.1

Complication(s) (from) (of)
- wound
- - dehiscence T81.3

Follow the External causes of injury Alphabetic Index (Section II):

Complication(s) (delayed) (medical or surgical procedure) (of or following)
- amputation of limb(s) Y83.5

Place of occurrence of external cause
- health service area (not specified as this facility) NEC Y92.23
- - this facility Y92.24

Note: T87.6 *Other and unspecified complication of amputation stump* is a residual code and does not provide specificity on the type of complication (ie dehiscence). The presence and site of an amputation stump are identified by the assignment of Y83.5 and a code from category Z89.

Amendments will be considered for a future edition.

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for implementation 01 April 2018.

Ref No: Q3169 | Published On: 15-Dec-2017 | Status: Retired | Retired On: 1-Jul-2022

Short gut syndrome (short bowel syndrome)

Q:

What code is assigned for short gut syndrome (short bowel syndrome)?

A:

Short gut syndrome (short bowel syndrome) is a malabsorptive state characterised by loss of digestive and absorptive functions. Underlying causes include:

- extensive surgical resection of intestine for trauma, tumours, necrotising enterocolitis and Crohn's disease
- congenital/perinatal defects in the gastrointestinal tract, such as intestinal atresia, volvulus, necrotising enterocolitis
- diseases with associated loss of absorption of nutrients, such as inflammatory bowel disease or Crohn's disease
- radiation enteritis.

Short gut syndrome leads to an inability to maintain protein-energy, fluid, electrolyte, or micronutrient balances on a conventionally accepted, normal oral diet (Vipperla & O'Keefe 2014).

Assign K91.2 *Postprocedural malabsorption, not elsewhere classified* for postprocedural short gut syndrome.

Assign K90.9 *Intestinal malabsorption* for short gut syndrome not specified as postprocedural.

Follow the Alphabetic Index:

Malabsorption

- syndrome K90.9

- - postprocedural K91.2

Where there is documentation of an underlying cause, apply the guidelines in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses.*

Amendments will be considered for a future edition.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

References:

Vipperla, K & O'Keefe, S 2014, Short bowel syndrome, First Consult, viewed 31 July 2117, https://www-clinicalkey-com-au.ezproxy1.library.usyd.edu.au/#!/content/medical_topic/21-s2.0-2001203

Published 15 December 2017,
for implementation 01 January 2018.

Ref No: Q3168 | Published On: 15-Dec-2017 | Status: Retired | Retired On: 1-Jul-2022

Medial patellofemoral ligament (MPFL) reconstruction

Q:

What code is assigned for a medial patellofemoral ligament (MPFL) reconstruction?

A:

The medial patellofemoral ligament (MPFL) is mainly responsible for the medio-lateral stabilisation of the patella. When the patella is dislocated, the ligament is damaged leading to patella instability. Medial patellofemoral ligament reconstruction is the surgical treatment, which involves using a hamstring tendon autograft to replace the ligament (Panni et al, 2013).

Clinical advice confirms that a medial patellofemoral ligament (MPFL) reconstruction is classified to 49503-01 **[1520]** *Patellofemoral stabilisation.* Follow the Alphabetic Index:

Stabilisation

- patella (patellofemoral) 49503-01 **[1520]**

Amendments will be considered for a future edition.

References:

Panni, A, Cerciello, S, Vasso, M 2013 'Patellofemoral instability: surgical treatment of soft tissues', *Joints*, 1(1), pp34–39, viewed 10 May 2017, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4295690/

Published 15 December 2017,
for implementation 01 January 2018.

Ref No: Q3171 | Published On: 15-Dec-2017 | Status: Retired | Retired On: 1-Jul-2022

Extended spectrum beta-lactamase (ESBL) resistance

Q:

Is documentation of ESBL with an infection evidence of antibiotic resistance?

A:

Extended spectrum beta-lactamase (ESBL) are enzymes produced by certain bacteria (eg *Escherichia coli* and *Klebsiella pneumoniae*) that break down antibiotics and result in antibiotic resistance (Essex Health Protection Unit 2006; Rupp Fey 2003).

ACS 0112 *Infection with drug resistant microorganisms/Classification* states:

> *The presence of an infection (wound infection, urinary tract infection, pneumonia, etc) must be documented and coded in accordance with ACS 0002* Additional diagnoses *before additional codes can be assigned for the organism, or the condition coded as being due to the organism. If the clinician has documented in the record that the organism causing the infection is resistant to an antibiotic or other antimicrobial drugs, then the appropriate code from Z06.-* Resistance to antimicrobial drugs *must be assigned as an additional code to identify the antibiotic or other antimicrobial agent to which the organism is resistant.*

Therefore, where there is documentation of an infection with an ESBL producing organism, assign the following codes for consistency with the guidelines in ACS 0112:

- a code for the infection
- a code for the causative organism (if the organism is not included in the infection code)
- Z06.53 *Extended spectrum beta-lactamase (ESBL) resistance.*

References:

Essex Health Protection Unit, Factsheet on ESBLs 2006, Health Protection Agency, Essex, viewed 19 April 2017, http://www.gha.gi/wp-content/uploads/Infection-Control-ESBL-Factsheet-HPA.pdf

Rupp, ME Fey, PD 2003, 'Extended spectrum beta-lactamase (ESBL)-producing Enterobacteriaceae: considerations for diagnosis, prevention and drug treatment', vol. 63, no. 4, pp. 353-365, viewed19 April 2017, PubMed.gov database. https://www.ncbi.nlm.nih.gov/pubmed/12558458

Published 15 December 2017,
for implementation 01 January 2018.

Ref No: Q3183 | Published On: 15-Dec-2017 | Status: Retired | Retired On: 1-Jul-2022

Hemiarthroplasty of elbow

Q:

What code is assigned for hemiarthroplasty of the elbow?

A:

Hemiarthroplasty of the elbow, also known as partial arthroplasty of the elbow or unicompartmental elbow replacement, is performed for very specific conditions such as distal humerus fractures not amenable to open reduction and internal fixation, avascular necrosis and nonunions (Desai et al. 2016).

Assign 49115-00 **[1418]** *Total arthroplasty of elbow* as a best fit for hemiarthroplasty of the elbow, by following the Alphabetic Index:

Arthroplasty

- elbow NEC

- - for joint replacement 49115-00 **[1418]**

Amendments will be considered for a future edition.

References:

Desai, SJ et al. 2016, *Hemiarthroplasty of the elbow: the effect of implant size on joint congruency*, Journal of Shoulder and Elbow Surgery, vol. 25, pp. 297-303, viewed 13 July 2017, http://www.jshoulderelbow.org/article/S1058-2746(15)00542-X/pdf

Published 15 December 2017,
for implementation 01 January 2018.

Ref No: Q3133 | Published On: 15-Sep-2017 | Status: Retired | Retired On: 1-Jul-2022

Osseointegration of limb implants on amputees

Q:

What is the principal diagnosis for osseointegration of limb implants on amputees?

A:

An osseointegration prosthesis for both upper and lower limb amputees consists of a titanium stem which is directly implanted into the bone. It is known as osseointegration because the biocompatibility of the titanium allows the implant to become integrated into the bone giving rise to stability and future bone ingrowth. The internal implant is connected to the external limb prosthesis through a dual adaptor which passes through a small opening in the skin (stoma). The procedure is performed either as a single surgery or in two stages.

Stage one is where the implant is inserted into the residual bone.

Stage two involves the creation of a stoma at the base of the amputated stump and connecting the dual adaptor to the titanium implant which is already integrated in the bone. The external limb prosthesis can then be attached (Burkett et al. 2014).

Osseointegration of limb implants are classified as reconstructive surgery, therefore in determining the diagnosis code assignment follow the guidelines in ACS 1204 *Plastic surgery*.

Where a patient is admitted for an osseointegration limb implant, regardless of whether the procedure is performed in a single stage or two stages, assign as principal diagnosis:

Z42.3 *Follow-up care involving plastic surgery of upper extremity*

or

Z42.4 *Follow-up care involving plastic surgery of lower extremity*

Follow the Alphabetic Index:

Surgery

- reconstructive (following healed injury or operation)

- - lower limb Z42.4

- - upper limb Z42.3.

Assign Z89.- *Acquired absence of limb* as an additional diagnosis.

Amendments will be considered for a future edition of ICD-10-AM.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

References:

Burkett, B, Frossard, LA, Berg, D & Formosa, D 2014, The cost and time effectiveness of osseointegration compared to the traditional socket prosthesis, In *Research That Matters: Communicate Collaborate Celebrate, 2014 University Research Week*, University of the Sunshine Coast, Maroochydore, Australia, pp. 27, viewed 26 May 2017, http://eprints.qut.edu.au/84787/

Published 15 September 2017,
for implementation 01 October 2017.

Ref No: Q3119 | Published On: 15-Sep-2017 | Status: Retired | Retired On: 1-Jul-2022

Angiomyomatous hamartoma of the lymph node

Q:

What code is assigned for angiomyomatous hamartoma of the lymph node?

A:

Angiomyomatous hamartoma (AMH) of the lymph node is a benign vascular lesion characterised by partial replacement of normal lymphatic nodes with proliferation of blood vessels, smooth muscle cells with or without adipose tissue and fibrous tissue. Inguinal and femoral lymph nodes are commonly involved, while popliteal lymph node involvement is uncommon (Mridha et al. 2015).

Treatment is by excision of the lymph node.

Assign:

D36.0. *Benign neoplasm of lymph nodes*

and

M8000/0 *Neoplasm, benign*

Follow the Alphabetic Index:

Neoplasm, neoplastic

- lymph, lymphatic
- - gland
- - - inguinal, inguinal D36.0
- - node — *see also Neoplasm/lymph/gland*

Tumour

- benign (unclassified) (M8000/0) — *see Neoplasm/benign*

Amendments will be considered for a future edition.

Reference:

Mridha, AR et al, 2015, Angiomyomatous Hamartoma of Popliteal Lymph Node: An Unusual Entity, *Journal of Pathology and Translational Medicine* 49(2), 156–158, Published online 2015 Mar 12. doi: 10.4132/jptm.2013.08.08 viewed 31 May 2017. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4367112/

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Ref No: Q3172 | Published On: 15-Sep-2017 | Status: Retired | Retired On: 1-Jul-2022

Migratory polyarthritis/polyarthropathy

Q:

How do you code migratory polyarthritis where the underlying cause is specified as a condition other than rheumatic fever?

A:

The indexing of *Polyarthritis, polyarthropathy/migratory* in ICD-10-AM is consistent with ICD-10, and defaults the classification of migratory polyarthritis to the aetiology (underlying cause), rheumatic fever:

Polyarthritis, polyarthropathy

- migratory — *see Fever/rheumatic*

Migratory polyarthritis is a type of rapid onset arthritis (joint inflammation) that progressively spreads to affect multiple joints over a period of days, usually as the original joint(s) affected are recovering. Migratory polyarthritis occurs as the result of another (inflammatory) condition, especially one that causes weakening of the immune system.

Migratory polyarthritis may be a complication of rheumatic fever, which occurs following an untreated streptococcal bacterial infection. Migratory polyarthritis may also be caused by a number of other conditions, for example: viral hepatitis B and C, human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS), systemic lupus erythematosus (SLE), whipple's disease, sarcoidosis or Lyme disease (Cherney 2016, Coleman 2017, Mies & Francis 2003, Rull & Tidy 2017).

Where migratory polyarthritis is documented with an underlying cause other than rheumatic fever, assign an appropriate code listed under the lead term *Arthritis,* by following the Alphabetic Index:

Polyarthritis, polyarthropathy

- due to or associated with other specified conditions — *see Arthritis*

Amendments to ICD-10-AM will be considered for a future edition.

References:

Cherney, K 2016, *What Is Migratory Arthritis?* Healthline Media, viewed 8 March 2017, http://www.healthline.com/health-slideshow/migratory-arthritis#newsletterSlide

Coleman, R 2017, *Migratory Polyarthritis – Causes, Symptoms, Cure And Treatment,* Health Resource, viewed 8 March 2017, http://www.healthresource4u.com/migratory-polyarthritis-causes-symptoms-cure-and-treatment.html

Mies Richie, A, & Francis, M.L 2003, 'Diagnostic Approach to Polyarticular Joint Pain', *American Family Physician*, 2003 Sep 15;68(6):1151-1160, viewed 8 March 2017, http://www.aafp.org/afp/2003/0915/p1151.html

Rull, G & Tidy, C 2017, *Acute Polyarthritis*, Patient Platform Limited, viewed 8 March 2017, http://patient.info/doctor/acute-polyarthritis

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for implementation 01 October 2017.

Ref No: Q3176 | Published On: 15-Sep-2017 | Status: Retired | Retired On: 1-Jul-2022

Prophylactic internal fixation

Q:

How do you code prophylactic internal fixation of bone (without a current fracture)?

A:

Prophylactic (internal) fixation of bone is performed for impending pathological fracture (that is, patients at risk of pathological fracture, but **without a current fracture**). Prophylactic fixation is performed to stabilise and protect the bone, alleviate pain, and improve weight-bearing/ mobilisation. The intervention is usually performed on long bones (eg femur, humerus, tibia) (Miller et al. 2011, O'Donnell 2017, van der Hulst et al. 1994).

The current ACHI classification of fixation of bones assumes that the procedure is performed for a fracture. It is inappropriate to assign codes from blocks that classify fixation/reduction of fracture for prophylactic internal fixation (that is, where there is risk of pathological fracture, but **without a current fracture**).

Where prophylactic internal fixation of any bone is performed (for example, insertion of femoral nail for a patient with bone metastases who is at risk of pathological fracture but does not have a current fracture), assign 47921-00 **[1554]** *Insertion of internal fixation device, not elsewhere classified,* by following the Alphabetic Index:

Insertion

- fixation device

- - bone

- - - orthopaedic (pin) (plate) (wire) 47921-00 **[1554]**

Amendments will be considered for a future edition.

References

Miller, BJ, Soni, EE, Gibbs, CP & Scarborough, MT 2011, 'Intramedullary nails for long bone metastases: why do they fail?', Orthopedics, 2011 Apr 11;34(4), viewed 7 March 2017, https://www.ncbi.nlm.nih.gov/pubmed/21469628

O'Donnell, P 2017, Impending Fracture Prophylactic Fixation, Lineage Medical Inc, viewed 7 March 2017, http://www.orthobullets.com/pathology/8002/impending-fracture-and-prophylactic-fixation

van der Hulst, RR, van den Wildenberg, FA, Vroemen, JP & Greve, JW 1994, 'Intramedullary nailing of (impending) pathologic fractures', The Journal of Trauma, 1994 Feb;36(2):211-5, viewed 7 March 2017, https://www.ncbi.nlm.nih.gov/pubmed/8114139

Published 15 September 2017,
for implementation 01 October 2017.

Ref No: Q3082 | Published On: 15-Jun-2017 | Status: Retired | Retired On: 1-Jul-2022

Septic shower

Q:

What code is assigned for septic shower?

A:

Septic shower:

- is the sudden systemic influx of colonised pathogens
- most commonly associated with an in situ/implanted device
- often follows infusion of fluids into an in situ/implanted device
- may result in septic shock.

Where septic shower is documented as associated with the presence of a device, assign an appropriate code from T82-T85 by following the Alphabetic Index at *Sepsis/due to/device, implant or graft*/by type of device.

Assign codes for sepsis and septic shock as per the guidelines in ACS 0110 *SIRS, sepsis, severe sepsis and septic shock*. Assign external cause and place of occurrence codes, as applicable.

Amendments will be considered for a future edition of ICD-10-AM.

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Ref No: Q3096 | Published On: 15-Jun-2017 | Status: Retired | Retired On: 1-Jul-2022

Urosepsis

Q:

Is the indexing at the lead term *Urosepsis* a sequencing instruction?

A:

The indexing at the lead term *Urosepsis* in the Alphabetic Index is:

> **Urosepsis** — *see Sepsis AND Infection, infected (opportunistic)/urinary (tract) NEC*

The *See* reference in the above indexing:

- directs coders to two lead terms, as two codes are assigned to classify urosepsis
- is **not** a sequencing instruction.

Apply the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses* to determine whether sepsis or urinary tract infection (UTI) is the principal diagnosis for each individual case, based on the clinical documentation.

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Removal of external fixation involving removal of pins and/or wires

Q:

How do you code removal of external fixation involving removal of pins and/or wires?

A:

Pins and wires in internal fixation are part of the fixation device itself; pins and wires in external fixation are an anchoring component of the external fixator.

For removal of external fixation involving removal of (anchoring) pins and wires, assign 47948-00 **[1554]** *Removal of external fixation device.*

Amendments to ACHI will be considered for a future edition.

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for implementation 01 July 2017.

Ref No: Q2958 | Published On: 15-Mar-2017 | Status: Retired | Retired On: 1-Jul-2022

Decompressive laminectomy of thoracic and lumbar spine by posterior approach

Q:

What is the correct code for decompressive laminectomy of thoracic and lumbar spine by posterior approach?

A:

In the absence of a specific code or index entries for posterior decompressive laminectomy of thoracic and lumbar spine, clinical advice supports the assignment of the following codes as best fit:

40345-00 **[47]** *Decompression of thoracic spinal cord via costotransversectomy*

and

90024-XX **[48]** *Decompression of lumbar spinal canal*

Amendments to ACHI will be considered for a future edition.

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for implementation 01 April 2017.

Ref No: Q3091 | Published On: 15-Mar-2017 | Status: Retired | Retired On: 1-Jul-2022

Reduction of manubriosternal joint dislocation

Q:

What is the appropriate code for reduction of a manubriosternal joint dislocation?

A:

The sternum has three distinct parts: the manubrium, the body of the sternum, and the xiphoid process. A manubriosternal dislocation is a rare injury, resulting from direct chest trauma such as in a motor vehicle accident or as an indirect compression injury.

Block **[1377]** *Reduction of fracture/dislocation of neck or thorax* classifies reduction of fracture of sternum, as well as reduction of fracture/dislocation of rib as per the Alphabetic Index:

Reduction

- dislocation (bone) (with cast) (with splint)

- - rib (closed) (with internal fixation) 90610-00 **[1377]**

- - - open 90610-01 **[1377]**

…

- fracture (bone) (with cast) (with splint)

- - rib (closed) (with internal fixation) 90610-00 **[1377]**

- - - open 90610-01 **[1377]**

…

- - sternum (closed) (with fixation) 47466-00 **[1377]**

- - - open 47467-00 **[1377]**

In the absence of Alphabetic Index entries for *Reduction/dislocation/sternum*, apply the logic for indexing of reduction of fracture/dislocation of rib (see above) and assign 47466-00 **[1377]** *Closed reduction of fracture of sternum* or 47467-00 **[1377]** *Open reduction of fracture of sternum* for reduction of sternal dislocation (eg reduction of a manubriosternal joint dislocation) as a best fit.

Amendments to ACHI will be considered for a future edition.

Published 15 March 2017,
for implementation 01 April 2017.

Ref No: Q3073 | Published On: 15-Dec-2016 | Status: Retired | Retired On: 1-Jul-2022

Same-day admissions for chemotherapy/ pharmacotherapy for neoplasm(s) and neoplasm related conditions

Q:

What are the correct codes to assign for same-day admissions for administration of Neulasta, IV hydration or other prophylactic pharmacotherapy?

A:

Neulasta is a drug used to treat or prevent neutropenia in patients with neoplasms or undergoing pharmacotherapy. It is administered subcutaneously and must be administered 24 hours post pharmacootherapy to avoid interaction.

Same-day episode of care for administration of intravenous (IV) hydration is also a common pharmacotherapy protocol to treat or prevent dehydration and/or kidney function disorders in patients undergoing pharmacotherapy, as these are common neoplasm/pharmacotherapy related conditions.

ACS 0044 *Pharmacotherapy* states:

> *For classification purposes, pharmacotherapy is defined as: "The administration of any therapeutic substance (usually a drug), excluding blood and blood products."*

Therefore, for a same-day episode of care for administration of Neulasta, IV hydration or other prophylactic pharmacotherapy (which meets the definition of pharmacotherapy as stated above) for a patient with a neoplasm or neoplasm related condition, assign:

- Z51.1 *Pharmacotherapy session for neoplasm* as principal diagnosis
- a code for the neoplasm being treated as the first additional diagnosis (see also ACS 0236 *Neoplasm coding and sequencing*)
- additional diagnosis code(s) for any neoplasm related condition or neoplasm treatment related conditions(s) meeting the criteria in ACS 0002 *Additional diagnoses.*
- Assign the appropriate ACHI code(s), for example:
- 96200-00 **[1920]** *Subcutaneous administration of pharmacological agent, antineoplastic agent* for administration of Neulasta
- 96199-00 **[1920]** *Intravenous administration of pharmacological agent, antineoplastic agent* for administration of IV hydration

Note: As per Example 2 in ACS 0044 *Pharmacotherapy* and the Instructional note at block **[1920]** *Administration of pharmacotherapy*, the extension -00 *Antineoplastic agent* is assigned for agents used in the treatment of neoplasms and/or neoplasm related conditions.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

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Ref No: Q3097 | Published On: 15-Dec-2016 | Status: Retired | Retired On: 1-Jul-2022

Laminectomy

Q:

What is the appropriate code to assign for documentation of laminectomy without further specificity?

A:

A laminectomy is a surgical excision of the angled segments of bone (laminae) of the vertebra to gain access to the structures associated with the spinal cord. A laminectomy is performed to reduce pressure on the spinal nerve roots or the spinal cord, but may also provide access (ie the operative approach) for removal of intervertebral discs (discectomy) or spinal lesions/tumours.

Where there is documentation of ‘laminectomy’ without any further specificity, clinical consultation should be sought to clarify the purpose of the laminectomy ie for ‘decompression’ and/or any other procedures performed.

If, after clinical consultation (or if consultation is not possible), ‘laminectomy’ was not associated with other procedures or clarified further, follow the Alphabetic Index:

Laminectomy

- decompressive — see Decompression/spinal

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Insufficiency fracture

Q:

How should insufficiency fractures be classified?

A:

An insufficiency fracture is a type of pathological or stress fracture that occurs as a result of normal physiological stress on abnormal bone. These fractures are seen in patients with conditions such as osteoporosis, rheumatoid arthritis, Paget's disease, osteomalacia, diabetes, and sometimes as a result of radiotherapy. These fractures are usually located in the vertebra, tibia or fibula or the calcaneus in the foot.

Assign an appropriate code from the Alphabetic Index at:

Fracture

- pathological (cause unknown) M84.4-

- - with osteoporosis M80.9-

- - - disuse M80.2-

- - - drug-induced M80.4-

- - - idiopathic M80.5-

- - - postmenopausal M80.0-

- - - postoophorectomy M80.1-

- - - postprocedural malabsorption M80.3-

- - - specified NEC M80.8-

- - due to neoplastic disease NEC (M8000/1) (*see also Neoplasm*) D48.9† M90.7-*

For insufficiency fractures in a patient with osteoporosis NOS, assign M80.9- *Unspecified osteoporosis with pathological fracture.* Where the type of osteoporosis is known, assign a code from one of the options at *Fracture/pathological/with osteoporosis* (see above).

Amendments will be considered for a future edition of ICD-10-AM.

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for implementation 01 January 2017.

Ref No: Q3076 | Published On: 15-Sep-2016 | Status: Retired | Retired On: 1-Jul-2022

Insertion of leadless/transvenous pacemaker

Q:

What is the code assignment for insertion of a leadless/transvenous pacemaker?

A:

A leadless/transvenous pacemaker is a single chamber pacemaker device that does not require the use of wired leads to provide an electrical connection between the pulse generator and the heart. It is implanted directly in the right ventricle of the heart through a catheter via the femoral or jugular vein. The steroid eluting electrode that delivers pacing is located within the device.

There is no specific code in ACHI for this procedure. Clinical advice indicates that 38353-00 [**650**] *Insertion of cardiac pacemaker generator* does not fully reflect the procedure of placing a leadless pacemaker. The extra complexity, resources and potential risk for more complications in placing the pacemaker generator transvenously are similar to that reflected in 38350-00 [**648**] *Insertion of permanent transvenous electrode into other heart chamber(s) for cardiac pacemaker*.

Therefore for insertion of a leadless/transvenous pacemaker, assign:

38353-00 [**650**] *Insertion of cardiac pacemaker generator*

and

38350-00 [**648**] *Insertion of permanent transvenous electrode into other heart chamber(s) for cardiac pacemaker*

Improvements to ACHI will be considered for a future edition.

Published 15 September 2016,
for implementation 01 October 2016.

Ref No: Q3041 | Published On: 15-Jun-2016 | Status: Retired | Retired On: 1-Jul-2022

External fixation using pins or wires

Q:

When external fixation using pins or wires is documented should this be coded as external fixation or internal fixation?

A:

Application of external fixation devices (including those involving pins and wires but not involving correction of limb deformity, fracture reduction, limb lengthening, mandible, maxilla or pelvis surgery) are classified in ACHI to 50130-00 **[1550]** *Application of external fixation device, not elsewhere classified* as clarified in the *Note* at this code which states:

> *This code classifies external fixation devices, not classified elsewhere, that are invasive (ie applied to bone). External fixation devices that are noninvasive are classified elsewhere.*

Follow the Alphabetic Index:

Fixation

- bone

- - external (invasive) 50130-00 **[1550]**

Amendments to ACHI will be considered for a future edition.

Published 15 June 2016,
for implementation 01 July 2016.

Ref No: TN1037 | Published On: 13-Feb-2016 | Status: Retired | Retired On: 1-Jul-2022

Zika virus; use of WHO code for emergency use

Effective from 21 December 2015

Zika virus (synonymously known as Zika fever and Zika virus infection) is a mosquito-borne viral disease caused by Zika virus (ZIKV). Symptoms include mild fever, rash, headaches, arthralgia, myalgia, asthenia, and non-purulent conjunctivitis. Symptoms appear between three to twelve days after the mosquito vector bite. One in four people may not develop symptoms, but in those who are affected the disease is usually mild with symptoms that last between two and seven days, and usually clears from the blood within a week.

A recent concern has arisen due to an increase in the incidence of Zika virus internationally, with possible links between the infection in pregnant women and subsequent birth defects (including microcephaly). As a result, the WHO has advised that **effective from 21 December 2015** U06.9 *Emergency use of U06.9* is to be assigned to monitor Zika virus internationally.

Zika virus is currently classified to A92.8 *Other specified mosquito-borne viral fevers.* This is a residual code that classifies a number of disease concepts and so WHO have requested that U06.9 is assigned for all cases of Zika virus from 21 December 2015 to facilitate unique identification of Zika virus for global monitoring.

Therefore, in the event that cases of Zika virus are confirmed, assign both:

A92.8 *Other specified mosquito-borne viral fevers* and

U06.9 *Emergency use of U06.9.*

For confirmed Zika virus in pregnant patients, assign:

O98.5 *Other viral diseases in pregnancy, childbirth and the puerperium*

with A92.8 and U06.9 as additional diagnoses.

Assign P00.2 *Fetus and newborn affected by maternal infectious and parasitic diseases* if maternal infection with Zika virus is documented as affecting a fetus or newborn (meeting the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses)*. However, do not assign A92.8 or U06.9 to the infant's episode of care unless the infant has documentation of confirmed (congenital) Zika virus.

Where patients are transferred to another facility for *suspected Zika virus*, follow the guidelines in ACS 0012 *Suspected conditions* and assign:

A92.8 *Other specified mosquito-borne viral fevers*

Z75.6 *Transfer for suspected condition*

Do not assign U06.9 for patients transferred with unconfirmed cases of Zika virus.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

References

Centers for Disease Control and Prevention 2016, *'Questions and answers for pediatric healthcare providers: infants and Zika virus infection,* viewed 2 February 2016 http://www.cdc.gov/zika/hc-providers/qa-pediatrician.html

Medew, J, Miletic, D & Flitton, D 2016, 'Six cases of Zika virus in Australia last year as pregnant women warned not to travel', *The Sydney Morning Herald,* 26 January, viewed 1 February 2016, http://www.smh.com.au/national/urgent-travel-warning-for-pregnant-australian-women-at-risk-of-zika-virus-20160125-gmdv5u.html

Pan American Health Organisation n.d. '*Zika virus infection',* viewed 17 December 2015 http://www.paho.org/hq/index.php?option=com_topics&view=article&id=427&Itemid=41484&lang=en

Published 03 February 2016,
for implementation 21 December 2015.

Ref No: Q2988 | Published On: 15-Dec-2015 | Status: Retired | Retired On: 1-Jul-2022

Limbal stem cell deficiency and resulting corneal conjunctivalisation

Q:

What is the correct diagnosis code to assign for limbal stem cell deficiency resulting in corneal conjunctivalisation?

A:

Limbal Stem Cell Deficiency (LSCD) is characterised by a loss or deficiency of the stem cells in the limbus (the edge of the cornea where it joins the sclera) which act as a 'barrier' to conjunctival epithelial cells preventing them from migrating on to the corneal surface. When these stem cells are lost, the corneal epithelium is unable to repair and renew itself, resulting in epithelial breakdown and defects leading to corneal conjunctivalisation, neovascularisation, scarring and chronic inflammation, which may lead to corneal opacity and visual impairment or blindness. Causes of LSCD may be genetic, idiopathic or acquired such as infection, trauma and drugs.

Corneal conjunctivalisation is the pathological process whereby the conjunctival epithelial cells in the limbus migrate on to the corneal surface to replace the normal corneal epithelium.

Limbal stem cell deficiency resulting in corneal conjunctivalisation should be classified to H18.8 *Other specified disorders of cornea* following the Index pathway:

Disease

- cornea

- - specified NEC H18.8

Assign external cause codes as appropriate.

Improvements to ICD-10-AM will be considered for a future edition.

Published 15 December 2015,
for implementation 01 January 2016.

Ref No: Q2942 | Published On: 15-Sep-2015 | Status: Retired | Retired On: 1-Jul-2022

Congestive cardiac failure (CCF) and left ventricular failure (LVF)

Q:

How do you code congestive cardiac failure (CCF) and left ventricular failure (LVF)?

A:

The following codes should be assigned for congestive heart/cardiac failure (CHF/CCF) and left ventricular failure (LVF):

Assign I50.0 *Congestive heart failure* for:

- CHF/CCF with or without acute pulmonary oedema
- CHF/CCF with LVF

Assign I50.1 *Left ventricular failure* for:

- LVF without mention of CHF/CCF
- Acute pulmonary oedema with mention of heart disease or non-congestive heart failure

See also ACS 0920 *Acute pulmonary oedema*.

Improvements to ICD-10-AM and the ACS will be considered for a future edition.

Published 15 September 2015,
for implementation 01 October 2015.

Ref No: Q2975 | Published On: 15-Sep-2015 | Status: Retired | Retired On: 1-Jul-2022

Micturition syncope

Q:

How do you code micturition syncope?

A:

Micturition syncope is a sudden transient loss of consciousness caused by a fall in blood pressure and decreased blood supply to the brain during or after urination and is most common after awakening from a deep sleep at night. Sudden decompression of the bladder superimposed on low blood pressure and heart rate during sleep can lead to hypotension and circulatory collapse. Vagal stimulation during straining on micturition may also result in hypotension and bradycardia. Precipitating factors include dehydration, excess alcohol, and antihypertensive and antidepressant medication.

Assign R55 *Syncope and collapse* for micturition syncope.

Do not assign a urinary symptom code such as R39.8 *Other and unspecified symptoms and signs involving the urinary system* as the syncope is not specifically related to or caused by any disorder or abnormality of the urinary system or I95.9 *Hypotension, unspecified* as low blood pressure is inherent in syncope.

Published 15 September 2015,
for implementation 01 October 2015.

Ref No: Q2986 | Published On: 15-Sep-2015 | Status: Retired | Retired On: 1-Jul-2022

Os acromiale

Q:

What is the correct code to assign for os acromiale?

A:

The acromial process of the scapula begins as separate osseous centres, which gradually fuse. The fusion process begins around age 15, and is normally complete by age 25. Os acromiale is a developmental disorder in which there is failure of fusion of these osseous centres of the scapula, resulting in the acromion being joined to the scapular spine by fibrous tissue rather than by bony union. The disorder may be completely painless and symptom free, but may also be associated with shoulder impingement, and rotator cuff pathology.

Assign M89.21, *Other disorders of bone development and growth, shoulder region*, for os acromiale by following the index pathway:

Disorder (of)

- bone

- - development and growth NEC M89.2-

with fifth character: 1 shoulder region

Indexing improvements will be considered for a future edition of ICD-10-AM.

Published 15 September 2015,
for implementation 01 October 2015.

Ref No: Q2881 | Published On: 15-Jun-2015 | Status: Retired | Retired On: 1-Jul-2022

Hoarding disorder

Q:

What is the correct code to assign for hoarding disorder?

A:

Hoarding disorder is characterized by persistent difficulty discarding or parting with possessions, regardless of their actual value, as a result of a strong perceived need to save the items and to distress associated with discarding them. Hoarding disorder results in the accumulation of a large number of possessions that congest and clutter active living areas to the extent that their intended use is substantially compromised (DSM-5, 2013).

ICD-10-AM and its parent classification ICD-10 do not have a specific code for hoarding disorder. Both the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5), published by the American Psychiatric Association and the World Health Organization (WHO) ICD-11 Beta Draft classify hoarding disorder to obsessive compulsive and related disorders.

Therefore, hoarding disorder should be classified to F42.8 *Other obsessive-compulsive disorders* following the index pathway:

Disorder (of)

- obsessive-compulsive

- - specified NEC F42.8

Additional codes such as Z58.8 *Other problems related to physical environment* and Z59.1 *Inadequate housing* should also be assigned where these situations are documented and meet the criteria in ACS 0002 *Additional diagnoses*.

Improvements to ICD-10-AM will be considered for a future edition.

Reference:

American Psychiatric Association (2013), Diagnostic and statistical manual of mental disorders, Fifth edition,(DSM-5). doi, 10.1176/9780890425596

Published 15 June 2015,
for implementation 01 July 2015.

Ref No: Q2909 | Published On: 15-Jun-2015 | Status: Retired | Retired On: 1-Jul-2022

Epiphysiodesis of tibia

Q:

What is the correct code for epiphysiodesis of the tibia?

A:

Epiphysiodesis is a minimally invasive surgical procedure to slow or stop bone growth at epiphyseal (growth) plates located at either end of long bones such as the femur, tibia and fibula. This procedure is typically used in children to correct discrepancies in limb length.

Whilst usually performed on both the tibia and fibula, in older children, the procedure is sometimes performed on the tibia alone.

For epiphysiodesis of the tibia, assign 48503-00 **[1520]** *Epiphysiodesis of tibia and fibula* following the index pathway:

Epiphysiodesis

- tibia

- - with fibula 48503-00 **[1520]**

Improvements to ACHI will be considered for this procedure in a future edition.

Published 15 June 2015,
for implementation 01 July 2015.

Ref No: Q2876 | Published On: 15-Mar-2015 | Status: Retired | Retired On: 1-Jul-2022

Total femur replacement

Q:

How do you code total femur resection with reconstruction including total femur replacement?

A:

Total femur replacement is a rare procedure, alternatively known as:

- Total femur endoprosthetic replacement
- Endoprosthetic femoral replacement
- Total femoral endoprosthetic reconstruction
- Total femur arthroplasty
- Total femur resection, and reconstruction with total femur replacement.

The last dot point above most accurately describes the intervention; resection of the whole femur with joint reconstruction, and replacement of the femur using metallic endoprosthesis. This procedure was originally performed for primary bone and soft tissue sarcomas, as a limb preservation/salvage procedure, an alternative to amputation.

More recently, indications have included:

- Multiple failed total hip or total knee arthropathies
- Chronic infections or other complications following multiple open reductions with internal fixation (ORIF) of the femur
- Complex periprosthetic fractures not amenable to other treatments.

Total femur replacement is considered for the above indications when patients have insufficient residual bone to support implantation of a revision arthroplasty prosthesis or fixation device. The procedure may require extensive soft tissue dissection (including detachment of relevant muscles) and reconstruction of the joints above and below (ie knee and hip).

ACHI contains a code for this procedure, created when the procedure was primarily performed for primary bone and soft tissue sarcomas. However, regardless of the indication for the procedure, assign the following code for total femur replacement (or any of its synonymous terms):

50218-03 **[1570]** *En bloc resection of lesion of long bone of lower limb with replacement of adjacent joint*.

The indication for the procedure will be identified by the assignment of an appropriate ICD-10-AM code.

Amendments will be considered for a future edition of ACHI.

Published 15 March 2015,
for implementation 01 April 2015.

Ref No: Q2679 | Published On: 15-Dec-2013 | Status: Retired | Retired On: 1-Jul-2022

Coronary Optical Coherence Tomography (OCT) and Intravascular ultrasound (IVUS)

Q:

What codes should be assigned for Coronary OCT and IVUS?

A:

Coronary Optical Coherence Tomography (OCT) is a catheter based invasive imaging system that uses near infra-red light providing a high resolution image in vivo of the coronary arteries. This technology enables the extent of atherosclerosis to be seen within the artery and is being used to check previously implanted stents as some patients, like diabetics, are predisposed to re-stenosis of the stent.

Intravascular ultrasound (IVUS) is a catheter based invasive imaging system that uses sound waves to provide an image of the coronary artery walls and plaque deposits.

Both of these techniques are increasingly being used in percutaneous coronary interventions due to the detail of the images they are able to provide over the more traditional coronary angiograms.

There are no procedure codes in ACHI to distinguish these techniques, however as they are both catheter based imaging techniques used on coronary arteries, they should be classified to **[668]** *Coronary angiography* following either the lead term **Catheterisation** or **Angiography**.

Consideration will be given to incorporating these techniques within block **[668]** *Coronary angiography* for a future edition of ACHI.

Published 15 December 2013,
for implementation 01 January 2014.

Ref No: Q2611 | Published On: 15-Oct-2010 | Status: Retired | Retired On: 1-Jul-2022

Open reduction and internal fixation (ORIF) proximal femur

Q:

The index lookup below assigns ORIF femur to 47528-01 *Open reduction of fracture of femur with internal fixation*, which has an excludes note 'for that of proximal femur (47519-00 **[1479]**)'. However, 47519-00 **[1479]** *Internal fixation of fracture of trochanteric or subcapital femur* does not capture that this was an open reduction. Is this excludes in the correct spot? Is it correct that for ORIF of the proximal femur (subcapital, trochanteric etc) that code 47519-00 be assigned instead of 47528-01? The indexing doesn't seem to support the excludes notes as the proximal femur sites are not indexed under the open reduction?

Reduction

- fracture (bone) (with cast) (with splint)
- - femur (closed) 47516-01 **[1486]**
- - - with internal fixation (cross) (intramedullary) 47531-00 **[1486]**
- - - - neck 47519-00 **[1479]**
- - - - pertrochanteric 47519-00 [**1479**]
- - - - proximal 47519-00 **[1479]**
- - - - subcapital 47519-00 **[1479]**
- - - - subtrochanteric 47519-00 [**1479**]
- - - - trochanteric 47519-00 **[1479]**
- - - epiphysis (capital) (slipped) 47525-00 **[1493]**
- - - open 47528-00 **[1486]**
- - - - with internal fixation (cross) (intramedullary) 47528-01 **[1486]**
- - - - epiphysis (capital) (slipped) 47525-01 **[1493]**

A:

This is an example of where the Conventions used in the ACHI Alphabetic Index are applied:

> "PREPOSITIONAL TERMS Wherever a preposition from the list below immediately follows a lead term or subterm, they always take precedence over symbols, numbers and the alphabetic sequence of subterms:

- as
- by
- for
- with
- without"

Therefore, the correct code assignment for ORIF of the proximal femur (subcapital, trochanteric etc) is 47519-00 **[1479]** *Internal fixation of fracture of trochanteric or subcapital femur*, following the prepositional subterm 'with' in the index pathway:

Reduction

- fracture (bone) (with cast) (with splint)
- - femur (closed) 47516-01 **[1486]**
- - - with internal fixation (cross) (intramedullary) 47531-00 **[1486]**
- - - - proximal 47519-00 **[1479]**

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

Published 15 October 2010,
for implementation 01 November 2010.

Ref No: TN199 | Published On: 15-Jun-2010 | Status: Retired | Retired On: 1-Jul-2022

Fracture of hip prosthesis due to trauma

Q:

ACS 1309 *Dislocation or complication of hip prosthesis* states:

> 'Assign the code S73.0- *Dislocation of hip* with an additional diagnosis code of Z96.64 *Presence of hip implant* when a patient sustains a dislocation of a hip prosthesis...'

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

A:

The guidelines in ACS 1309 *Dislocation or complication of hip prosthesis* do apply to fractures of hip prostheses due to trauma. Appropriate injury and external cause of injury codes should be assigned to reflect the trauma. T84.0 *Mechanical complication of internal joint prosthesis* should be assigned where the conditions listed in T82.0 are specified as due to the joint prosthesis, as per the inclusion term at T84.0 and also following the criteria in ACS 1309 *Dislocation or complication of hip prosthesis*.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

Published 15 June 2010,
for implementation 01 July 2010.

Ref No: TN208 | Published On: 15-Jun-2007 | Status: Retired | Retired On: 1-Jul-2022

Timeframe for Meniscal/Ligament Tears of Knee

Q:

Could the NCCH please consider the institution of a timeframe for meniscal/ligament tears of knee, which defines ‘old’ and ‘current’?

A:

The NCCH has researched this issue, including how injury timeframes are dealt with in other classifications. Unfortunately, it is impossible to be definitive in this regard. Each case should be reviewed on its merits and coders should ultimately be guided by documentation and seek clarification from the clinician. To publish timeframes for old and current is extremely difficult due to differences in treatment protocols for these injuries. Some patients with meniscal tears are treated conservatively while others are treated with surgical repair. Some may initially be treated conservatively but then require surgical repair at a later date. Coders should be guided by the definitions in ACS 1906 *Current and Old Injuries*. If it still cannot be determined whether the injury is acute or not, then follow ACS 1319 *Meniscus/Ligament Tear of Knee, NOS* and assume the injury is old.

Published 15 June 2007,
for implementation 01 July 2007.

Ref No: TN221 | Published On: 15-Mar-2004 | Status: Retired | Retired On: 1-Jul-2022

Excision of radial head prosthesis

A query was received by the NCCH regarding ‘excision of radial head prosthesis’. The operation report for this procedure described, *‘right elbow, lateral incision, capsule divided, excision of excessive intracapsular scar tissue and hypertrophic bone, radial head prosthesis excised’*.

Currently there is no code to classify removal of this type of device in ACHI. Clinical advice suggests that the procedure is technically similar to excising bone from the radius.

Classification

Following clinical advice, the NCCH suggests that documentation of ‘excision of radial head prosthesis’ should be coded as 48406-03 **[1426]** *Ostectomy of radius*.

Published 15 March 2004,
for implementation 01 April 2004.

Ref No: Q3639 | Published On: 15-Sep-2021 | Status: Retired | Retired On: 1-Jul-2022

Autoimmune autonomic ganglionopathy

Q:

What code is assigned for autoimmune autonomic ganglionopathy?

A:

Autoimmune autonomic ganglionopathy (AAG) is a type of autonomic neuropathy in which the body's own immune system attacks the receptor of the ganglia (part of the peripheral autonomic nerve fiber) (WHO 2020).

AAG manifestations vary from person to person. Symptoms may include severe orthostatic hypotension, fainting, constipation, fixed and dilated pupils, urinary retention, and dry mouth and eyes (GARD 2021).

The correct code to assign for AAG is G90.8 *Other disorders of autonomic nervous system.*

Follow the ICD-10-AM Alphabetic Index:

Disorder (of)

- autonomic nervous system

- - specified NEC G90.8

Amendments to ICD-10-AM will be considered for a future edition.

Reference

Genetic and Rare Diseases centre (GARD) (2021), *Autoimmune autonomic ganglionopathy*, viewed 7 May 2021, <https://rarediseases.info.nih.gov/diseases/11917/autoimmune-autonomic-ganglionopathy>.

World Health Organization (WHO) (2020), ICD-11 Mortality and Morbidity Statistics (MMS), viewed 7 May 2021, <https://icd.who.int/browse11/l-m/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f1029892421>.

Published 15 September 2021,
for implementation 01 October 2021.

Ref No: Q3516 | Published On: 15-Dec-2021 | Status: Retired | Retired On: 1-Jul-2022

Lynch syndrome

Q:

What codes are assigned for same-day endoscopy for Lynch syndrome?

A:

Lynch syndrome is a genetic disorder that causes an increased risk of developing cancers. The most common cancer in people with Lynch syndrome is colorectal (large bowel) cancer. However, having Lynch syndrome does not necessarily result in developing cancer. The most common check-up is a colonoscopy to examine large intestinal tract (Cancer Australia n.d.; Centers for Disease Control and Prevention 2020).

Where Lynch syndrome is documented as the indication for same-day screening endoscopy apply the guidelines in ACS 0052 *Same-day endoscopy - Surveillance*:

- Assign Z12.1 *Special screening examination for neoplasm of intestinal tract* as principal diagnosis if no cancer is detected or has ever been detected. ACS 0052 states:

  Assign as principal diagnosis:

  - *an appropriate code from categories Z11, Z12 and Z13 Special screening examination for… if screening for a disease pre-cursor (risk factor) or other factor and no disease is detected or has ever been detected*

  Follow the ICD-10-AM Alphabetic Index:

  Screening

  - Lynch syndrome Z12.1

- Assign a code from category C18 *Malignant neoplasm of colon*, or C19 *Malignant neoplasm of rectosigmoid junction*, where a malignant neoplasm is detected.

Do not follow the ICD-10-AM Alphabetic Index at the lead terms *Lynch syndrome* or *Syndrome/Lynch* unless a malignant neoplasm has been detected.

Improvements to ICD-10-AM are proposed for Twelfth Edition.

References:

Cancer Australia, n.d, *Lynch Syndrome*, viewed 01 December 2021, <https://www.canceraustralia.gov.au/affected-cancer/lynch-syndrome>.

Centers for Disease Control and Prevention 2020, *Lynch Syndrome*, viewed 01 December 2021, <https://www.cdc.gov/genomics/disease/colorectal_cancer/lynch.htm>.

Ref No: TN1537 | Published On: 01-May-2020 | Status: Retired | Retired On: 1-Jul-2022

COVID-19 Admitted care FAQs Part 1: Application of U06.0 *Emergency use of U06.0 [COVID-19, ruled out]*

Q:

In what circumstances is U06.0 *Emergency use of U06.0 [COVID-19, ruled out]* assigned?

A:

Health care facilities may test inpatients for SARS-CoV-2 where COVID-19 is a differential diagnosis or there is a decision to rule out COVID-19 for other reasons. COVID-19 may be a differential diagnosis in conditions such as influenza, pneumonia and heart failure.

Where laboratory testing for SARS-CoV-2 is negative and COVID-19 has not been clinically diagnosed, assign U06.0 *Emergency use of U06.0 [COVID-19, ruled out]* as an additional diagnosis. Additional codes for observation for suspected conditions or exposure to communicable diseases may be assigned if applicable.

DO NOT assign U06.0 where COVID-19 is clinically ruled out alone (ie not verified by a negative laboratory test result for SARS-CoV-2).

Published 01 May 2020,
for implementation 01 May 2020.

Ref No: TN1537 | Published On: 01-May-2020 | Status: Retired | Retired On: 1-Jul-2022

COVID-19 Admitted care FAQs Part 1: Transfer for suspected COVID-19

Q:

Where a patient is transferred with multiple suspected conditions and suspected COVID-19 is one of them, is a COVID-19 emergency use code assigned?

A:

Where a patient is transferred for a suspected condition, apply the guidelines in ACS 0012 *Suspected conditions*:

- If a single condition is suspected, assign a code for the suspected condition.
- If **more than one suspected condition** is documented as the differential diagnosis:
  - assign code(s) for the documented symptom(s)

  OR
  - if there are no symptom(s) documented, assign codes for all suspected conditions.

See examples 1 and 2 below.

Transfer for suspected COVID-19, example 1:

Hospital	A	B
Scenario	Patient is admitted with shortness of breath and fever after returning from a cruise where other individuals were known to have COVID-19. Documentation states 'Patient exposed to COVID-19 during recent cruise. ?COVID-19 ?influenza other ?viral infection'. Patient is transferred to Hospital B for laboratory testing to exclude a diagnosis of COVID-19.	Patient is received from Hospital A for investigation of '?COVID-19 ?influenza ?other viral infection'. Laboratory testing is performed to exclude a diagnosis of COVID-19. Test results were negative for SARS-CoV-2. COVID-19 is documented as ruled out and the patient is diagnosed with influenza.

Codes assigned	Principal diagnosis: R06.0 *Dyspnoea* Additional diagnoses: R50.9 *Fever, unspecified* Z03.8 *Observation for other suspected diseases and conditions* Z20.8 *Contact with and exposure to other communicable diseases* Z75.6 *Transfer for suspected condition*	Principal diagnosis: J11.1 *Influenza with other respiratory manifestations, virus not identified* Additional diagnosis: Z20.8 *Contact with and exposure to other communicable diseases* U06.0 *Emergency use of U06.0 [COVID-19, ruled out]*
Rationale	COVID-19 is suspected as one of three differential diagnoses. It is not laboratory confirmed, clinically diagnosed or ruled out; therefore, an emergency use code is not assigned. R06.0 and R50.9 are assigned as there was more than one suspected condition documented as differential diagnoses. Z03.8 is assigned as symptoms suggestive of COVID-19 were documented and it was noted as a possible diagnosis. Z20.8 is assigned to identify exposure to known COVID-19 as documented by the clinician. Z75.6 is assigned as the patient was transferred for investigation of suspected conditions. B97.2 is not assigned as there are multiple suspected conditions so only symptoms are coded.	After study, influenza was determined to be the principal diagnosis. Z20.8 is assigned to identify exposure to known COVID-19 as documented by the clinician. Z03.8 is not assigned as the symptoms were confirmed to be due to influenza and COVID-19 was ruled out. COVID-19 is documented as ruled out; therefore, U06.0 is assigned as an additional diagnosis.

Transfer for suspected COVID-19, example 2:

Hospital	A	B	A
Scenario	Patient is admitted with viral pneumonia due to ?COVID-19. There is no documentation of exposure; however, due to recent travel overseas, patient is transferred to Hospital B specifically for laboratory testing to exclude a diagnosis of COVID-19.	Patient is received from Hospital A with viral pneumonia due to ?COVID-19. Laboratory testing is performed to exclude COVID-19. Test results for SARS-CoV-2 were documented as negative. Patient was transferred back to Hospital A for ongoing care.	Patient is transferred back to Hospital A from Hospital B with a diagnosis of viral pneumonia.
Codes assigned	Principal diagnosis: J12.8 *Other viral pneumonia* Additional diagnoses: B97.2 *Coronavirus as the cause of diseases classified to other chapters* Z75.6 *Transfer for suspected condition*	Principal diagnosis: J12.9 *Viral pneumonia, unspecified* Additional diagnosis: U06.0 *Emergency use of U06.0 [COVID-19, ruled out]*	Principal diagnosis: J12.9 *Viral pneumonia, unspecified*
Rationale	COVID-19 is suspected to have caused the viral pneumonia. B97.2 is assigned to reflect the suspected viral agent. A U07 emergency use code is not assigned as it has not been confirmed by laboratory testing or clinically diagnosed. Z75.6 is assigned to identify that the patient is being transferred for investigation of a suspected condition. Z20.8 is not assigned because only a history of recent overseas travel is documented by a clinician, not a documented history of exposure to a confirmed case of COVID-19.	After study, viral pneumonia was determined to be the principal diagnosis, and COVID-19 was ruled out following laboratory testing; therefore, U06.0 is assigned.	After study, viral pneumonia continues to be the principal diagnosis, with no specific virus identified. COVID-19 was ruled out at Hospital B; therefore, U06.0 is not assigned.

Published 01 May 2020,
for implementation 01 May 2020.

Ref No: TN1537 | Published On: 01-May-2020 | Status: Retired | Retired On: 1-Jul-2022

COVID-19 Admitted care FAQs Part 1: Assignment of code for exposure to COVID-19

Q:

When is Z20.8 *Contact with and exposure to other communicable diseases* assigned in relation to COVID-19?

A:

Where suspected COVID-19 is ruled out, or the patient is transferred to another facility to undergo testing for SARS-CoV-2, an additional code Z20.8 *Contact with and exposure to other communicable diseases* may be assigned to indicate a documented history of exposure to COVID-19 as determined by a clinician.

For classification purposes, exposure to, or contact with, a confirmed case of COVID-19 must be determined and documented by a clinician. Z20.8 is not assigned in the following scenarios:

- patient-reported exposure to COVID-19 alone
- documentation of recent overseas travel, or contact with individuals that have recently travelled overseas

Where COVID-19 is confirmed, a history of exposure is inherent in the assignment of emergency use codes U07.1 *Emergency use of U07.1 [COVID-19, virus identified]* or U07.2 *Emergency use of U07.2 [COVID-19, virus not identified]*, and an additional code for Z20.8 is not assigned.

Published 01 May 2020,
for implementation 01 May 2020.

Ref No: TN1537 | Published On: 01-May-2020 | Status: Retired | Retired On: 1-Jul-2022

COVID-19 Admitted care FAQs Part 1: Condition onset flag for COVID-19

Q:

Which condition onset flag (COF) value is applied to the emergency use codes for COVID-19?

A:

ACS 0048 *Condition onset flag* defines COF 2 Condition not noted as arising during the episode of admitted patient care as:

> *A condition previously existing or suspected on admission such as the presenting problem, a comorbidity or chronic disease*

An example is provided:

- *a condition that has not been documented at the time of admission, but clearly did not develop after admission (eg newly diagnosed diabetes mellitus, malignancy and morphology).*

Where a patient is admitted for known or suspected COVID-19, apply COF 2 to the emergency use codes.

However, in the specific circumstance where exposure to COVID-19 is documented as occurring during the episode of admitted care, assign COF 1. For example, assign COF 1 where a patient contracts COVID-19 through exposure to an individual in a health care setting, who has tested positive to SARS-CoV-2.

When it is uncertain whether a condition was present at admission or arose during the episode, assign COF 2 as per ACS 0048 *Condition onset flag/Guide for use*, point 6:

> *When it is difficult to decide if a condition was present at the beginning of the episode of admitted patient care or if it arose during the episode, assign COF 2.*

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Ref No: TN1537 | Published On: 01-May-2020 | Status: Retired | Retired On: 1-Jul-2022

COVID-19 Admitted care FAQs Part 1: Code assignment from Chapter 1 *Certain infectious and parasitic diseases* in episodes of COVID-19

Q:

What is the difference between assignment of B97.2 *Coronavirus as the cause of diseases classified to other chapter*s and B34.2 *Coronavirus infection, unspecified site*?

A:

B97.2 *Coronavirus as the cause of diseases classified to other chapters* is assigned as an additional diagnosis to specify the infectious agent, where documentation indicates that symptom(s) or condition(s) are related to laboratory confirmed, or clinically diagnosed or probable COVID-19. B97.2 is not acceptable as a principal diagnosis (Example 1).

B34.2 *Coronavirus infection, unspecified site* is assigned to classify asymptomatic infection, where documentation indicates a confirmed case of COVID-19 in an asymptomatic patient. B34.2 may be assigned as a principal diagnosis (Example 2).

Example 1:

Patient admitted with shortness of breath and subsequently tested positive for SARS-CoV-2.

Principal diagnosis: R06.0 *Dyspnoea* (as per ACS 0001 *Principal diagnosis*)

Additional diagnoses: B97.2 *Coronavirus as the cause of diseases classified to other chapters*

U07.1 *Emergency use of U07.1 [COVID-19, virus identified]*

Example 2:

Asymptomatic patient admitted with documented exposure to a confirmed case of COVID-19 and subsequently tested positive for SARS-CoV-2.

Principal diagnosis: B34.2 *Coronavirus infection, unspecified site*

Additional diagnosis: U07.1 *Emergency use of U07.1 [COVID-19, virus identified]*

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COVID-19 Admitted care FAQs Part 1: False negative laboratory test result for SARS-CoV-2 and COVID-19

Q:

Is U07.2 *Emergency use of U07.2 [COVID-19, virus not identified]* assigned for a clinical diagnosis of COVID-19, despite a negative laboratory test result?

A:

In laboratory testing, a negative test result means that the virus causing COVID-19 was not found in the test sample. For many individuals, this means that COVID-19 is not the cause of their symptoms or condition. However, it is possible for some individuals to receive a negative result in error (ie false negative), meaning they may have the virus causing COVID-19 even though it is not detected (Centres for Disease Control and Prevention 2020).

Where COVID-19 is clinically diagnosed, despite a negative laboratory test result, assign U07.2 *Emergency use of U07.2 [COVID-19, virus not identified]*.

Reference:

Centres for Disease Control and Prevention 2020, *Fact sheet for patients: CDC - 2019-nCoV Real-Time RT-PCR Diagnostic Panel*, United States Department of Health & Human Services, viewed 28 April 2020, https://www.cdc.gov/coronavirus/2019-ncov/downloads/Factsheet-for-Patients-2019-nCoV.pdf.

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Ref No: TN1537 | Published On: 01-May-2020 | Status: Retired | Retired On: 1-Jul-2022

COVID-19 Admitted care FAQs Part 1: Assignment of Z11.5 *Special screening examination for other viral diseases* to rule out COVID-19

Q:

What is screening by a mandated authority, and in what circumstance is Z11.5 *Special screening examination for other viral diseases* assigned in the context of screening for COVID-19?

A:

Screening mandated by an authority is performed where an authority, such as a government, compels testing of individuals who:

- are asymptomatic
- have no documented history of exposure.

Assign Z11.5 *Special screening examination for other viral diseases* as a principal diagnosis when screening for COVID-19, as described above, is performed (ie in rare circumstances where the only reason for admission is to screen for the presence of SARS-CoV-2). Screening should not be confused with a decision to routinely test for SARS-CoV-2 during an admitted episode of care.

Where COVID-19 is ruled out on screening (as defined above), assign U06.0 *Emergency use of U06.0 [COVID-19, ruled out]* as an additional diagnosis.

Where COVID-19 has been confirmed as a result of screening (as defined above), assign B34.2 *Coronavirus infection, unspecified site* as the principal diagnosis and U07.1 *Emergency use of U07.1 [COVID-19, virus identified]* as an additional diagnosis.

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COVID-19 Admitted care FAQs Part 2: Application of U06.0 *Emergency use of U06.0 [COVID-19, ruled out]* for admitted patients with a negative test result for SARS-CoV-2 (COVID-19)

Q:

When is U06.0 *Emergency use of U06.0 [COVID-19, ruled out]* assigned?

A:

Health care facilities may routinely test admitted patients for SARS-CoV-2 (eg in the absence of symptoms suggestive of COVID-19).

U06.0 *Emergency use of U06.0 [COVID-19, ruled out]* is assigned where there is clinical documentation that COVID-19 has been ruled out following laboratory testing, irrespective of the indication or whether the patient has been discharged before the test results are received.

U06.0 is not assigned based on observation of a test result alone as per the guidelines in ACS 0010 *Clinical documentation and general abstraction guidelines/Test results and medication charts*:

> *Do not use test result values, descriptions, medication charts, symbols and abbreviations in isolation to inform code assignment.*

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for implementation 25 May 2020.

Ref No: TN1540 | Published On: 25-May-2020 | Status: Retired | Retired On: 1-Jul-2022

COVID-19 Admitted care FAQs Part 2: COVID-19 complicating pregnancy

Q:

What codes are assigned for pregnancy complicated by COVID-19?

A:

Where COVID-19, diagnosed either clinically or by laboratory testing, is complicating pregnancy as per the guidelines in ACS 1521 *Conditions and injuries in pregnancy*, apply the guidelines in the Coding Rule *Coronavirus disease 2019 (COVID-19)*:

Where laboratory confirmed or clinically diagnosed COVID-19 is documented as complicating pregnancy, the correct obstetric chapter code is O98.5 *Other viral diseases in pregnancy, childbirth and the puerperium*. Code the remainder of the episode in accordance with ACS 1521 *Conditions and injuries in pregnancy* and ACS 1500 *Diagnosis sequencing in obstetric episodes of care*.

Example 1:

Admission to hospital for acute lower respiratory tract infection (LRTI) secondary to COVID-19 (laboratory confirmed SARS-CoV-2) complicating pregnancy.

Principal diagnosis:	O99.5 *Diseases of the respiratory system in pregnancy, childbirth and the puerperium*
Additional diagnoses:	J22 *Unspecified acute lower respiratory tract infection*
	O98.5 *Other viral diseases in pregnancy childbirth and the puerperium*
	B97.2 *Coronavirus as the cause of diseases classified to other chapters*
	U07.1 *Emergency use of U07.1 [COVID-19, virus identified]*

Rationale: In this episode, the patient is admitted with a LRTI, secondary to SARS-CoV-2 infection (COVID-19). The principal diagnosis is assigned to O99.5 with J22 reflecting the LRTI complicating pregnancy. The COVID-19 infection is classified in accordance with the COVID-19 coding rule by assigning O98.5 first, followed by B97.2 for the symptomatic COVID-19 and the appropriate emergency use code.

Example 2:

A patient with fever and cough is clinically diagnosed with COVID-19 complicating pregnancy (SARS-CoV-2 testing unavailable).

Principal diagnosis:	O99.8 *Other specified diseases and conditions in pregnancy, childbirth and the puerperium*
Additional diagnoses:	R50.9 *Fever, unspecified*
	R05 *Cough*


IHACPA

O98.5 *Other viral diseases in pregnancy childbirth and the puerperium*

B97.2 *Coronavirus as the cause of diseases classified to other chapters*

U07.2 *Emergency use of U07.2 [COVID-19, virus not identified]*

Rationale: In this episode, the patient is admitted with symptoms and clinically diagnosed as having COVID-19. The principal diagnosis is assigned to O99.8, with R50.9 and R05 to reflect the COVID-19 symptoms complicating pregnancy. COVID-19 is classified in accordance with the COVID-19 coding rule by assigning O98.5 first, followed by B97.2 for the symptomatic COVID-19 and U07.2 to reflect the clinical diagnosis of COVID-19.

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Ref No: TN1540 | Published On: 25-May-2020 | Status: Retired | Retired On: 1-Jul-2022

COVID-19 Admitted care FAQs Part 2: Clinical variation in documentation of COVID-19

Q:

How do variations in clinical terminology and documentation of COVID-19 (eg ‘viral illness – COVID-19’ or ‘Coronavirus infection’) affect code assignment?

A:

Apply the guidelines in the Coding Rule *Coronavirus disease 2019 (COVID-19)*, irrespective of the varying terminology used to describe COVID-19. That is, classify the episode according to the presentation and whether the presentation occurs with a documented clinical manifestation, symptom or is asymptomatic.

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COVID-19 Admitted care FAQs Part 2: Laboratory tests to identify COVID-19

Q:

Can laboratory tests such as an antibody serology test be used to inform assignment of an emergency use code for coronavirus disease 2019 (COVID-19)?

A:

Testing for COVID-19 can include nucleic acid detection tests, using polymerase chain reaction (PCR) to detect SARS-CoV-2 viral ribonucleic acid, or serology tests to detect human antibodies (ie immunoglobulins or Ig) against SARS-CoV-2 (Therapeutic Goods Administration 2020). Documentation of these tests can include ‘swabs’, PCR and blood serology tests.

Antibodies are produced after a person is infected with SARS-CoV-2. Serology tests can demonstrate the presence of these antibodies, and therefore whether someone has been infected (Centres for Disease Control and Prevention 2020; Therapeutic Goods Administration 2020).

Clinical advice confirms that documentation of COVID-19 with confirmation from laboratory testing, including antibody serology testing, can be used to assign U07.1 *Emergency use of U07.1 [COVID-19, virus identified]* as these tests specifically identify COVID-19.

Where COVID-19 is ruled out, refer to the guidance in COVID-19 FAQ admitted care Part 2 - *Application of U06.0 Emergency use of U06.0 [COVID-19, ruled out] for admitted patients with a negative test result for SARS-CoV-2 (COVID-19)*.

References:

Centers for Disease Control and Prevention 2020, *Serology Testing for COVID-19*, United States Department of Health & Human Services, viewed 14 May 2020, https://www.cdc.gov/coronavirus/2019-ncov/lab/serology-testing.html.

Therapeutic Goods Administration 2020, *COVID-19 point-of-care tests*, Australian Government Department of Health, viewed 14 May 2020, https://www.tga.gov.au/covid-19-point-care-tests.

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Ref No: TN1541 | Published On: 17-Sep-2020 | Status: Retired | Retired On: 1-Jul-2022

COVID-19 Admitted care FAQs Part 3: Assignment of symptoms in patients with COVID-19

The COVID-19 pandemic is unprecedented, unique and evolving. Similarly, the classification of COVID-19 is unprecedented, unique and evolving.

At the beginning of the pandemic a decision was made, in Australia, to distinguish the classification of symptomatic COVID-19 admitted episodes from asymptomatic admitted episodes as it was considered this information would be useful in understanding the disease in the future.

Symptoms are not normally coded when a condition has been definitively diagnosed and so the classification of COVID-19 is unique in this respect.

There are complexities in the symptomatic versus asymptomatic nature of COVID-19 presentations, as the type and onset of symptoms are variable and may be related to causes other than COVID-19.

The following principles apply to the classification of symptoms in COVID-19 admitted episodes of care:

Scenario	Classification
COVID-19 has been confirmed and symptoms are present that are attributable to a definitive condition not associated with COVID-19	Codes for symptoms are not assigned, in accordance with normal coding practice
COVID-19 has been confirmed and symptoms are present that are attributable to a definitive condition associated with COVID-19, such as pneumonia or a respiratory tract infection	Codes for symptoms are not assigned, in accordance with normal coding practice
COVID-19 has been confirmed and symptoms are present, that are not attributable to a definitive condition or any other cause	Codes for symptoms are assigned for the classification of COVID-19
COVID-19 has been confirmed and symptoms are present or develop during the episode of care that are not attributable to a definitive condition or any other cause	Codes for symptoms are assigned for the classification of COVID-19

Where a symptom arising during the admitted episode is assigned as a principal diagnosis, follow ACS 0048 *Condition onset flag* to assign a condition onset flag (COF) of 2 *Condition not noted as arising during the current episode of care*, in accordance with *Guide for use point* 3.

Where there is uncertainty as to whether symptoms are attributable to COVID-19, confirmation should be sought from the treating clinician.

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for implementation 17 September 2020.

Ref No: TN1541 | Published On: 17-Sep-2020 | Status: Retired | Retired On: 1-Jul-2022

COVID-19 Admitted care FAQs Part 3: Assignment of COVID-19 emergency use codes in admitted episodes of care for transferred patients

The assignment of the COVID-19 emergency use codes are guided by clinical documentation, and supported by the test results.

Each COVID-19 related admitted episode of care must be reviewed on a case by case basis.

Where COVID-19 is documented as a suspected condition before transfer, apply the guidelines in ACS 0010 *Clinical documentation and general abstraction guidelines/Test results and medication charts* to assign the relevant emergency use code in that episode:

- where the laboratory test confirms a negative COVID-19 result, assign U06.0 *Emergency use of U06.0 [COVID-19, ruled out]*
- where the laboratory test confirms a positive COVID-19 result, assign U07.1 *Emergency use of U07.1 [COVID-19, virus identified]*

See also COVID-19 FAQ Part 3: Clinical documentation to support assignment of U06.0 *Emergency use of U06.0 [COVID-19, ruled out]*.

Published 17 September 2020,
for implementation 17 September 2020.

Ref No: TN1541 | Published On: 17-Sep-2020 | Status: Retired | Retired On: 1-Jul-2022

COVID-19 Admitted care FAQs Part 3: Clinical documentation to support assignment of U06.0 *Emergency use of U06.0 [COVID-19, ruled out]*

Australia enacted U06.0 *Emergency use of U06.0 [COVID-19, ruled out]* to identify activity related to the testing of COVID-19 in accordance with the National Partnership on COVID-19 Response.

Assign U06.0 *Emergency use of U06.0 [COVID-19, ruled out]* where clinical documentation indicates that testing for COVID-19 has occurred but the presence of COVID-19 has been ruled out by virtue of a negative test result for SARS-CoV-2. The specific terminology of 'ruled out' is not required in order to assign this code.

U06.0 *Emergency use of U06.0 [COVID-19, ruled out]* is only assigned in the episode where the laboratory test was performed.

Published 17 September 2020,
for implementation 17 September 2020.

Ref No: TN1556 | Published On: 20-Aug-2021 | Status: Retired | Retired On: 1-Jul-2022

COVID-19 Admitted care FAQs Part 4: Code assignment and sequencing for COVID-19 vaccines causing adverse effects in therapeutic use

Q:

What is the correct code assignment and sequencing for a condition documented as an adverse effect of a COVID-19 vaccine?

A:

Minor and unspecified adverse reactions (complications) to non-serum vaccines are classified to T88.1 *Other complications following immunisation, not elsewhere classified*; such as eczema, reaction (allergic) and rash in accordance with the ICD-10-AM Alphabetic Index.

Coding Rule *COVID-19 vaccines causing adverse effects in therapeutic use* provided an example of such an adverse reaction, allergic urticaria, where T88.1 is assigned. In this example, an additional code was added for specificity (L50.0 *Allergic urticaria*).

For other specified adverse effects (complications) of a COVID-19 vaccination, such as pulmonary embolism, assign an appropriate chapter code and appropriate external cause codes.

In all instances of an adverse effect of a COVID-19 vaccination assign U07.7 *Emergency use of U07.7 [COVID-19 vaccines causing adverse effects in therapeutic use]* in addition to appropriate external cause codes where clinical documentation indicates the adverse effect is due to a COVID-19 vaccination.

In the March 2021 Coding Rule, the first example was intended to demonstrate application of U07.7 *Emergency use of U07.7 [COVID-19 vaccines causing adverse effects in therapeutic use]*, and is not a directive that T88.1 is to be assigned as principal diagnosis in all scenarios where an adverse effect of a COVID-19 vaccination is documented.

Improvements to this area of the classification are being progressed for the next edition of ICD-10-AM.

See also Coding Rule *COVID-19 vaccines causing adverse effects in therapeutic use*.

See also Coding Rule *Allergens and anaphylaxis*.

Published 20 August 2021,
for implementation 20 August 2021.

Ref No: TN1556 | Published On: 20-Aug-2021 | Status: Retired | Retired On: 1-Jul-2022

COVID-19 Admitted care FAQs Part 4: Assignment of emergency use code for the need for COVID-19 vaccination

Q:

Why was an emergency use code not implemented for the need for a COVID-19 vaccination?

A:

The World Health Organization (WHO) released two emergency use codes in early 2021 to classify the need for vaccination against Coronavirus disease 2019 (COVID-19) and adverse effects of COVID-19 vaccines.

In March 2021, Coding Rule *COVID-19 vaccines causing adverse effects in therapeutic use* was released to implement U07.7 *Emergency use of U07.7 [COVID-19 vaccines causing adverse effects in therapeutic use]*.

A code to classify the *need for immunisation against COVID-19* was not implemented in Australia following a decision to report COVID-19 vaccinations in the admitted setting as a non-admitted patient service event under COVID-19 vaccination clinic (10.21): https://www.ihpa.gov.au/publications/rules-coding-and-reporting-covid-19-episodes-care.

Published 20 August 2021,
for implementation 20 August 2021.

Ref No: Q3775 | Published On: 15-Mar-2022 | Status: Retired | Retired On: 1-Jul-2022

History of positive result on COVID-19 rapid antigen test

Q:

Is a previous positive rapid antigen test (RAT) result for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) conducted by a patient at home (ie outside the health facility) sufficient to assign U07.3 *Personal history of COVID-19*?

A:

Coding Rule, titled *Classification of post COVID-19 conditions*, advises to assign U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* as an additional diagnosis where clinical documentation indicates that the patient has previously confirmed coronavirus disease 2019 (COVID-19) that is no longer current.

Documentation of a positive result of a rapid antigen test for SARS-CoV-2, that has been conducted by the patient at home (ie outside of the health facility) is not by itself confirmation of a past COVID-19 diagnosis.

Assign U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* where clinical documentation indicates a previously confirmed COVID-19 diagnosis that is no longer current.

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for implementation 01 April 2022.

Ref No: Q3766 | Published On: 15-Mar-2022 | Status: Retired | Retired On: 1-Jul-2022

Use of rapid antigen test results for COVID-19 emergency use code assignment

Q:

Are rapid antigen test results considered laboratory tests for the purposes of assigning emergency use codes for COVID-19?

A:

Rapid antigen tests (RATs) detect the presence of specific proteins of the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) virus. RATs are more accurate when used by individuals with symptoms or those who have been in contact with a coronavirus disease 2019 (COVID-19) patient. RATs are not as accurate if people are asymptomatic. False positive or false negative results may be provided (TGA 2021).

The World Health Organization (WHO) has advised:

- U07.1 *Emergency use of U07.1 [COVID-19, virus identified]* is to be assigned when COVID-19 has been documented as confirmed by laboratory testing.
- U07.2 *Emergency use of U07.2 [COVID-19, virus not identified]* is to be assigned when COVID-19 has been documented as clinically diagnosed COVID-19, including evidence supported by radiological imaging (ie where a clinical determination of COVID-19 is made but laboratory testing is inconclusive, not available or unspecified).

Clinical advice has confirmed that RATs are not a laboratory test, but are being used as confirmation of a COVID-19 diagnosis.

Assign U07.1 *Emergency use of U07.1 [COVID-19, virus identified]* when there is documentation of COVID-19 confirmed by a positive **laboratory** test for SARS-CoV-2 (such as polymerase chain reaction (PCR) test).

Assign U07.2 *Emergency use of U07.2 [COVID-19, virus not identified]* when there is documentation of COVID-19 confirmed via a **non-laboratory** test (such as an x-ray or a RAT) or where laboratory testing is inconclusive, not available or unspecified.

Do not assign Z03.8 *Observation for other suspected diseases and conditions* or U06.0 *Emergency use of U06.0 [COVID-19, ruled out]* based on a negative SARS-CoV-2 RAT result. Assign these codes only when a laboratory test has been performed and the result rules out COVID-19.

This advice was provided to jurisdictions for dissemination on 13 January 2022 and confirmed existing advice regarding the assignment of COVID-19 emergency use codes and other associated codes.

Reference:

Therapeutic Goods Administration 2021, *How testing works for COVID-19*, viewed 11 January 2022, <https://www.tga.gov.au/how-testing-works-covid-19#presence-rat>.

World Health Organisation 2021, *Antigen-detection in the diagnosis of SARS-CoV-2 infection*, viewed 14 January 2022, <https://www.who.int/publications/i/item/antigen-detection-in-the-diagnosis-of-sars-cov-2infection-using-rapid-immunoassays>.

Published 15 March 2022,
for implementation 01 April 2022.

Ref No: Q3776 | Published On: 15-Mar-2022 | Status: Retired | Retired On: 1-Jul-2022

Vaccine-induced immune thrombotic thrombocytopenia syndrome

Q:

What code is assigned for vaccine-induced immune thrombotic thrombocytopenia syndrome (VITTS)?

A:

Thrombosis with thrombocytopenia syndrome (TTS) is a rare and specific syndrome. It occurs when a person has blood clots (thrombosis) as well as low platelet counts (thrombocytopenia). It is also referred to as 'vaccine-induced immune thrombotic thrombocytopenia' (VITT) syndrome (Healthdirect 2021).

Coding Rule titled *Code assignment and sequencing for COVID-19 vaccines causing adverse effects in therapeutic use,* advises to assign an appropriate chapter code and external cause codes for specified adverse effects (complications) of a COVID-19 vaccination.

Assign D69.5 *Secondary thrombocytopenia* for VITT syndrome (VITTS).

Follow the ICD-10-AM Alphabetic Index:

Thrombocytopenia, thrombocytopenic

- secondary D69.5

Assign U07.7 *Emergency use of U07.7 [COVID-19 vaccines causing adverse effects in therapeutic use]* in addition to external cause codes where clinical documentation indicates that a patient has experienced an adverse effect due to a COVID-19 vaccination.

Improvements to this area of the classification have been included in ICD-10-AM Twelfth Edition.

See also Coding Rule *COVID-19 vaccines causing adverse effects in therapeutic use*.

See also Coding Rule *Code assignment and sequencing for COVID-19 vaccines causing adverse effects in therapeutic use*.

References:

Healthdirect 2021, *Thrombosis with thrombocytopenia syndrome (TTS)*, viewed 25 January 2022, <https://www.healthdirect.gov.au/thrombosis-with-thrombocytopenia-syndrome-tts>.

Published 15 March 2022,
for implementation 01 April 2022.

Ref No: Q3757 | Published On: 15-Dec-2021 | Status: Retired | Retired On: 1-Jul-2022

Testing for evidence of a previous SARS-CoV-2 infection

Q:

What code should be assigned where a patient is tested for evidence of a previous SARS-CoV-2 infection?

A:

Coding Rule *Application of U06.0 Emergency use of U06.0 [COVID-19, ruled out]* confirms that health care facilities may test admitted patients for SARS-CoV-2 infection where COVID-19 is a differential diagnosis or there is a decision to rule out COVID-19 for other reasons.

Where a patient is tested with an intention to look for evidence of previous COVID-19 infection, rather than an acute/current COVID-19 infection, do not assign U06.0.

Assign an additional diagnosis of U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* where clinical documentation indicates that the patient has previously confirmed COVID-19 that is no longer current, or U07.4 *Emergency use of U07.4 [Post COVID-19 condition]* where clinical documentation indicates a current condition is due to previous COVID-19.

See also Coding Rule *Classification of post COVID-19 conditions*.

Published 15 December 2021,
for implementation 01 January 2022.

Ref No: Q2645 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 1-Jul-2022

Z03 Medical observation and evaluation for suspected diseases and conditions

Q:

Is it appropriate to assign a code from Z03 *Medical observation and evaluation for suspected diseases and conditions, ruled out* according to ACS 1617 *Neonatal sepsis/risk of sepsis* in the following scenarios:

Scenario 1:

Mother has a PPROM, baby is born prematurely and antibiotics are administered. However 'risk of sepsis' is not documented.

Scenario 2:

Mother goes into spontaneous premature labour without PPROM, and baby is born prematurely and antibiotics are administered.

Again, 'risk of sepsis' is not documented.

A:

Clinical coders should not assume 'risk of sepsis' in the scenarios described and should instead seek clinical confirmation that antibiotics are being administered for 'risk of sepsis' in order to assign Z03 *Medical observation and evaluation for suspected diseases and conditions, ruled out*.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: Q2686 | Published On: 15-Dec-2011 | Status: Retired | Retired On: 1-Jul-2022

Clinical diagnosis versus histology

Q:

A patient is admitted for excision of a ‘dermal cyst’ from the arm. The clinician documents ‘dermal cyst’ both pre and post surgery, however, the histology shows the lesion to be an angiomyoma. Should the guideline in ACS 0010 *Clinical documentation and general abstraction guidelines*, be followed, which states, “In the event that an investigation result varies from the clinical documentation, such as a clinical diagnosis of gastric ulcer with ‘no evidence of ulcer’ reported on histopathology, the case should be referred to the clinician.”

Or should the ACS 0010 guideline, be followed, which states, “Laboratory, x-ray, pathological and other diagnostic results should be coded where they clearly add specificity to already documented conditions.”

A:

In the scenario cited, the clinician has documented a clinical diagnosis of ‘dermal cyst’ in the absence of histological examination. However, histology reveals an ‘angiomyoma’, which appears contradictory to the original clinical diagnosis. If the clinician was asked to confirm the diagnosis with the benefit of the histology report, the question is, would the documentation be ‘dermal cyst’ or ‘angiomyoma’? As per the guidelines in ACS 0010 *Clinical documentation and general abstraction guidelines*, “In the event that an investigation result varies from the clinical documentation..., the case should be referred to the clinician.”

ACS 0010 also states, “It is important to seek clinical advice where necessary for clarification of discrepancies between investigation results and clinical documentation.” Therefore, where there is discrepancy between the clinical diagnosis and histology, as cited in this scenario, clinical verification should be sought prior to code assignment.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

Published 15 December 2011,
for implementation 01 January 2012.

Ref No: Q2714 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 1-Jul-2022

Foot ulcer/diabetic ulcer with other documented cause

Q:

When a foot ulcer is specified as a venous or pressure ulcer and the patient has diabetes mellitus (DM), can E1-.69 **Diabetes mellitus with other specified complication* be assigned given there is a documented cause other than the diabetes mellitus?

A:

Please refer to ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision. The index pathway *Diabetes, with* does not infer a causal relationship but rather represents conditions (often termed 'complications') which occur commonly with diabetes mellitus. When diabetes mellitus exists with foot ulcer, E1-.69 **Diabetes mellitus with other specified complication* can be assigned following the index pathway *Diabetes, diabetic, with, ulcer, foot*. An appropriate code for the ulcer may also be assigned according to ACS 0401, *Rule 4b*.

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: Q2734 | Published On: 15-Mar-2014 | Status: Retired | Retired On: 1-Jul-2022

Delirium with dementia

Q:

How do you classify delirium in a patient with dementia?

A:

Where delirium is specifically documented in a patient who also has dementia, assign F05.1 *Delirium superimposed on dementia* by following the index pathways:

Delirium, delirious (acute or subacute) (not alcohol- or drug-induced) F05.9

…

- superimposed on dementia F05.1

Note: the documentation does not have to specify superimposed on dementia. The term superimposed implies delirium **with** dementia.

(see also Coding Rules: Confusion or delirium with dementia)

Published 15 March 2014,
for implementation 01 April 2014.

Ref No: Q2737 | Published On: 15-Dec-2011 | Status: Retired | Retired On: 1-Jul-2022

Morphology of recurrent mediastinal tumour

Q:

What is the appropriate morphology code to assign in the following scenario? Patient admitted with recurrence of mediastinal tumour where original biopsy revealed “malignant cystic histiocytoma - M8830/3”. Supplementary histology report states morphology to be “malignant ossifying fibromyxoid tumour - M8842/3”. Note only /0 and /1 are contained in Appendix A: *Morphology of neoplasms*. Approximately a year later, the recurrence is resected and histology now states “high grade undifferentiated sarcoma - M8805/3”. Clinician states it is a recurrence of original tumour.

A:

Where there is doubt about the correct morphology code to assign due to ambiguous documentation in the clinical record, clinical coders should be guided by the principles in ACS 0010 *Clinical documentation and general abstraction guidelines*, which state:

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

- verification of diagnoses recorded on the front sheet and/or the discharge summary which are not supported in the clinical record, **and**
- clarification of discrepancies between investigation results and clinical documentation”
- For the scenario cited:
- the original morphology code (M8830/3 *Malignant fibrous histiocytoma*) should not be assigned as it appears to have been superseded by the supplementary report.
- in the first instance, confirmation should be sought from the clinician as to the correct morphology code to assign.
- where clinical confirmation is not possible clinical coders should be guided by the histopathology report in the current episode of care and assign M8805/3 *Undifferentiated sarcoma*.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

Published 15 December 2011,
for implementation 01 January 2012.

Ref No: Q2841 | Published On: 15-Jun-2014 | Status: Retired | Retired On: 1-Jul-2022

Microscopically controlled serial excision of skin lesions

Q:

How many times should 31000-00 **[1626]** *Microscopically controlled serial excision of lesion(s) of skin* be assigned, if the patient has multiple sections taken from one lesion?

A:

Microscopically controlled serial excision of a skin lesion (Mohs chemosurgery) involves sections of tissue being excised around the target lesion and examined microscopically for evidence of neoplastic cells. The patient is held in recovery after each section is excised and is taken back into the operating room for further tissue removal if the findings are positive. This process may include a number of returns to the operating room (stages) and a number of sections being removed for a single lesion, until all neoplastic cells are removed. Clinically, this procedure is identified as one operative episode/visit to theatre. Therefore, the guidelines in ACS 0020 *Bilateral/Multiple procedures, Multiple procedures, Classification, (point) 1* do not apply.

Regardless of the number of stages or sections removed for a single lesion, this procedure fulfils the criteria in ACS 0020 *Bilateral/Multiple procedures, Classification, (point)5*:

5. Skin or subcutaneous lesion removal, excision or biopsy

   For multiple excisions or biopsies or removals performed on:

   - separate skin lesions: assign relevant code(s) as many times as it is performed
   - same lesion: assign relevant code once

Therefore, where this procedure is performed on a single lesion, assign 31000-00 **[1626]** *Microscopically controlled serial excision of lesion(s) of skin* once only, as implied by the terms serial excision in the code title. This code would only be assigned more than once if it was performed for multiple lesions during the same visit to theatre.

Amendments to ACHI and the ACS will be considered for a future edition.

Published 15 June 2014,
for implementation 01 July 2014.

Ref No: Q2867 | Published On: 15-Sep-2014 | Status: Retired | Retired On: 1-Jul-2022

ACS 0925 *Hypertension and related conditions*

Q:

Please clarify the classification guidelines in ACS 0925 *Hypertension and related conditions* and whether hypertension should be assigned in accordance with ACS 0002 *Additional diagnoses* when hypertension is present with heart or/and kidney disease but no causal relationship is documented between the conditions?

A:

The guidelines in ACS 0925 *Hypertension and related conditions* provide advice with respect to the classification of hypertension and in particular the classification of hypertension with another disease concept, pre-coordinated in a single code. The following advice is provided to clarify the content of this standard:

Where a causal relationship between hypertension and heart and/or kidney disease is stated, for example, heart and/or kidney disease 'due to hypertension' or 'hypertensive' heart and/or kidney disease, assign a code from:

- I11 *Hypertensive heart disease* for certain heart conditions (listed in I50.- or I51.4–I51.9) due to hypertension
- I12 *Hypertensive kidney disease* for certain kidney conditions (listed in N00–N07, N18.-, N19 or N26) due to hypertension
- I13 *Hypertensive heart and kidney disease*, when both hypertensive heart disease (I11) and hypertensive kidney disease (I12) are present.

Secondary hypertension is caused by another condition such as renal artery stenosis or phaeochromocytoma. When hypertension is stated to be 'due to' or 'secondary to' other conditions, assign an appropriate code from category I15 *Secondary hypertension*.

Where hypertension and heart or/and kidney disease are present but with no documented relationship between the conditions, assign I10 *Essential (primary) hypertension* when it meets the criteria in ACS 0002 *Additional diagnoses*.

The standard has been revised for the Ninth Edition to provide clarity.

Published 15 September 2014,
for implementation 01 October 2014.

Ref No: Q2883 | Published On: 15-Sep-2014 | Status: Retired | Retired On: 1-Jul-2022

Closure of ileostomy with resection

Q:

Is a separate code required for resection/excision of bowel with 30562-01 **[899]** *Closure of ileostomy with restoration of bowel continuity, without resection* as without resection is a nonessential modifier in the index?

A:

30562-01 **[899]** *Closure of ileostomy with restoration of bowel continuity, without resection* includes resection of small sections (freshening) (trimming) from the end of the stoma (exteriorised bowel/doughnuts) and distal intestine prior to anastomosis.

Resection/excision of intestine in excess of this freshening/trimming should be coded in addition to the closure of ileostomy code. This may occur if the diseased section of bowel was not resected prior to creation of the ileostomy or when further pathology is found during the closure procedure.

Where there is no documentation of further pathology of the bowel requiring resection, a separate code for the resection should not be assigned.

Published 15 September 2014,
for implementation 01 October 2014.

Ref No: Q2939 | Published On: 15-Jun-2015 | Status: Retired | Retired On: 1-Jul-2022

Endoscopic ultrasound (EUS)

Q:

What is the correct procedure code for biopsy of a lesion using EUS guidance?

A:

Endoscopic ultrasound (EUS) is similar to other endoscopies but with an ultrasound probe attached at the end of the endoscope, which permits both visualisation and tissue sampling of gastrointestinal walls and structures surrounding the gastrointestinal tract. EUS is primarily used for assessing lesions in the gastrointestinal tract, but has increasingly been used for evaluating lesions of adjacent organs such as lung, mediastinum, left kidney, adrenal gland and lymph nodes (intra-thoracic and intra-abdominal).

When biopsy of a lesion is performed under EUS guidance, assign an appropriate code for the type of endoscopy (e.g. gastroscopy, gastroscopy with biopsy) and 30688-00 **[1949]** *Endoscopic ultrasound*. For example, EUS guided FNA (fine needle aspiration) biopsy of pancreas, assign:

30075-16 **[977]** *Biopsy of pancreas*

30473-00 **[1005]** *Panendoscopy to duodenum*

30688-00 **[1949]** *Endoscopic ultrasound*

Improvements to ACHI will be considered for a future edition.

Reference

Vilmann, P. & Saftoiu, A. (2006). Endoscopic ultrasound-guided fine needle aspiration biopsy: equipment and technique. J Gastroenterol Hepatol. Vol 21(11), pages 1646-55. DOI: 10.1111/j.1440-1746.2006.04475.x

Published 15 June 2015,
for implementation 01 July 2015.

Ref No: Q2960 | Published On: 15-Jun-2015 | Status: Retired | Retired On: 1-Jul-2022

Revision procedure for obesity

Q:

What codes are assigned for laparoscopic gastric bypass performed on a patient who previously had a sleeve gastrectomy?

A:

As per the instructional note at 30514-01 **[889]** *Revision procedure for obesity*, assign first a code for the obesity procedure performed, followed by 30514-01 **[889]**:

30512-03 **[889]** *Laparoscopic gastric bypass*

30514-01 **[889]** *Revision procedure for obesity*

The following inclusion terms have been added to 30514-01 **[889]** for ACHI Ninth Edition, to clarify code assignment:

Revision (reoperation) of:

- biliopancreatic diversion
- duodenal jejunal bypass
- gastric bypass
- gastroplasty
- ileal interposition
- sleeve gastrectomy

30514-01 **[889]** should not be assigned for revision/replacement of gastric band or gastric band reservoir.

Published 15 June 2015,
for implementation 01 July 2015.

Ref No: Q3016 | Published On: 15-Dec-2015 | Status: Retired | Retired On: 1-Jul-2022

Revision procedures for obesity

Q:

Can 30514-01 **[889]** Revision procedure for obesity be assigned in addition to codes from block **[881]** Gastrostomy, gastro-enterostomy or gastro-gastrostomy?

A:

30514-01 **[889]** *Revision procedure for obesity* is **only** assigned as an additional code with any of the specific obesity procedures listed as inclusion terms at 30514-01 in the Tabular List (*Code first*: obesity procedure(s) performed (see block **[889]**)):

- biliopancreatic diversion (30512-02 **[889]** *Biliopancreatic diversion*)
- duodenal-jejunal bypass (90940-00 **[889]** *Duodenal-jejunal bypass [DJ bypass]*)
- gastric bypass (30512-00 **[889]** *Gastric bypass* or 30512-03 **[889]** *Laparoscopic gastric bypass*)
- gastroplasty (30511-08 **[889]** *Gastroplasty*)
- ileal interposition (90941-00 **[889]** *Ileal interposition*)
- sleeve gastrectomy (30511-10 **[889]** *Sleeve gastrectomy [SG]*)

Each of the above procedures requires a change to the patient's anatomy. The assignment of 30514-01 **[889]** is a flag to indicate that the procedure is more complex due to anatomical changes from a previous obesity procedure.

30515-00 **[881]** *Gastro-enterostomy* may be assigned with gastric bypass or biliopancreatic diversion as per the instructional notes (*code also when performed: gastro-enterostomy*). This includes when gastric bypass or biliopancreatic diversion are performed following a previous failed obesity procedure. *Gastro-enterostomy* or *gastro-gastrostomy* may also be performed without a code from block **[889]** following a failed obesity procedure.

If *gastro-enterostomy* or *gastro-gastrostomy* is performed following a failed obesity procedure **without** one of the above obesity procedures from block **[889]**, assign 30515-00 **[881]** *Gastro-enterostomy* or 30375-31 **[881]** *Gastro-gastrostomy,* as applicable but do not assign 30514-01 **[889]** *Revision procedure for obesity* as an additional code.

The *code also when performed* notes at 30515-00 **[881]**, 30375-31 **[881]** and 30514-01 **[889]** will be deleted as part of the third errata to Ninth Edition, December 2015.

Published 15 December 2015,
for implementation 01 January 2016.

Ref No: Q2991 | Published On: 15-Dec-2015 | Status: Retired | Retired On: 1-Jul-2022

Inadvertent or intentional removal of devices requiring replacement

Q:

What is the correct code to assign when a device or tube is inadvertently or intentionally removed requiring replacement, e.g. a gastrostomy tube being pulled out or falling out requiring replacement?

A:

Mechanical complications are device malfunctions or failures. Devices can fail or malfunction because they are improperly implanted, break down, wear out or migrate out of position.

A gastrostomy tube or device which is inadvertently or intentionally pulled out is not a device malfunction or failure and is not to be classified as a mechanical complication.

Inadvertent removal of a gastrostomy tube may require review or replacement; it should not be classified to T85.5 *Mechanical complication of gastrointestinal prosthetic devices, implants and grafts*. However, assign Z43.1 *Attention to gastrostomy* if the gastrostomy received attention or management during the episode of care.

Published 15 December 2015,
for implementation 01 January 2016.

Ref No: Q3064 | Published On: 15-Jun-2017 | Status: Retired | Retired On: 1-Jul-2022

Deconditioning

Q:

What are the correct codes to assign for deconditioning?

A:

Deconditioning is a term used to describe a decrease in muscle mass and other physiologic changes that result from either aging or immobility or both, and contribute to overall weakness (Graf, 2006).

Deconditioning is also known as sarcopenia, which is described as low muscle mass plus low muscle strength or low physical performance. Sarcopenia was approved for addition to ICD-10 in October 2016 by the World Health Organisation (WHO) Update Reference Committee as an *Inclusion* term at M62.5 *Muscle wasting and atrophy, not elsewhere classified*.

Therefore, assign M62.50 *Muscle wasting and atrophy, not elsewhere classified, multiple sites* for deconditioning, following the Alphabetic Index:

Atrophy, atrophic

- muscle, muscular M62.5-

or

Wasting

- muscle NEC M62.5-

Where there is documentation of the underlying cause of the deconditioning, apply the guidelines in ACS 0001 *Principal diagnosis/problems and underlying conditions* or ACS 0002 *Additional diagnoses/Problems and underlying conditions*.

Amendments to the classification will be considered for a future edition.

Reference:

Graf, C 2006, *Functional Decline in Hospitalized Older Adults: It's often a consequence of hospitalization, but it doesn't have to be*, viewed 24 May 2016, http://www.ncbi.nlm.nih.gov/pubmed/16481783?ordinalpos=5itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_RV Medline

Published 15 June 2017,
for implementation 01 July 2017.

Ref No: Q3086 | Published On: 15-Mar-2017 | Status: Retired | Retired On: 1-Jul-2022

Insertion of seton for pilonidal disease

Q:

What code is assigned for insertion of seton for pilonidal disease?

A:

Pilonidal disease ranges from asymptomatic hair-containing cysts and sinuses to chronic infection of cysts (also called pilonidal abscess) that develop at the natal cleft (the groove between the buttocks) and do not heal. A pilonidal sinus (or blind fistula) is a small hole, pit or abnormal channel that goes from the infection site in the deeper tissues to the surface of the skin.

A seton is used on fistulas to assist healing by allowing the fistula tract to drain while preventing the wound from healing over. There are two types of seton: a non-cutting seton (referred to as draining, or loose seton), and a cutting seton where the seton is tightened intermittently over a period of time to slowly cut tissue while a scar forms or the wound heals behind the seton loop.

In the absence of a specific code for insertion of seton for pilonidal disease, as seton is a form of drainage assign 30676-00 **[1659]** *Incision of pilonidal sinus or cyst* by following the Alphabetic Index:

Drainage

- cyst

- - pilonidal 30676-00 **[1659]**

Amendments to ACHI will be considered for a future edition.

Published 15 March 2017,
for implementation 01 April 2017.

Ref No: Q3105 | Published On: 15-Mar-2017 | Status: Retired | Retired On: 1-Jul-2022

Hyperplastic rectosigmoid polyp

Q:

What code is assigned for hyperplastic rectosigmoid polyp?

A:

The large intestine is comprised of: the caecum, appendix, colon (ascending, transverse, descending and sigmoid), rectum, and the anus. The rectosigmoid junction is the part of the large intestine where the distal sigmoid colon transitions into the rectum.

There is no specific site code in ICD-10-AM for hyperplastic rectosigmoid polyps.

Assign K63.58 *Other polyp of colon* by following the Alphabetic Index:

Polyp, polypus

- colon NOS

- - hyperplastic K63.58

Amendments to ICD-10-AM Alphabetic Index will be considered for a future edition.

Published 15 March 2017,
for implementation 01 April 2017.

Ref No: Q3147 | Published On: 15-Mar-2017 | Status: Retired | Retired On: 1-Jul-2022

Selection of morphology codes from pathology reports

Q:

Should coders use the summary or the microscopic section of the pathology report to determine the correct morphology code?

A:

ACS 0010 *Clinical documentation and general abstraction guidelines/Findings that provide more specificity about a diagnosis* states:

> *Laboratory, x-ray, pathological and other diagnostic results should be coded where they clearly add specificity to already documented conditions that meet the criteria for a principal diagnosis (see ACS 0001* Principal diagnosis*) or an additional diagnosis (see ACS 0002* Additional diagnoses*).*

A discharge summary is a summation of the whole episode of care; similarly the summary on a pathology report provides a brief summation of the body of the report. The entire pathology report must be used to abstract information for the purposes of clinical coding and therefore determine the correct morphology code.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

Published 15 March 2017,
for implementation 01 April 2017.

Ref No: Q3164 | Published On: 15-Dec-2017 | Status: Retired | Retired On: 1-Jul-2022

Bursectomy of other joint

Q:

What code is assigned for bursectomy of a site that is not indexed?

A:

Bursae are fluid-filled sacs that lubricate and cushion soft tissues adjacent to joints and the surrounding soft tissue such as muscles and tendons, and help the joint move smoothly. The size of a bursa varies from person to person. They may be present from birth but may also develop later depending on the individual and their activity (Funiciello 2012, Winchester Hospital 2016).

Where bursectomy of one of the sites listed below is documented, assign an appropriate code by following the Alphabetic Index:

Bursectomy

- calcaneum 30111-00 **[1566]**
- hand 30107-01 **[1566]**
- olecranon 30111-00 **[1566]**
- patella 30111-00 **[1566]**

Where bursectomy is documented as either ‘large’ or ‘small’ only, assign an appropriate code by following the Alphabetic Index:

Bursectomy

- large NEC 30111-00 **[1566]**
- small NEC 30107-01 **[1566]**

In all other cases, assign 30107-01 **[1566]** *Excision of small bursa* by following the Alphabetic Index:

Bursectomy 30107-01 **[1566]**

Amendments will be considered for a future edition.

References:

Funiciello, M, Arthritis-Health 2012, What Is a Bursa?, Arthritis-health, Deerfield, viewed 14 April 2017, https://www.arthritis-health.com/types/bursitis/what-bursa

Winchester Hospital, *Bursectomy* 2016, Winchester Hospital, viewed 19 April 2017, http://www.winchesterhospital.org/health-library/article?id=947490.

Published 15 December 2017,
for implementation 01 January 2018.

Ref No: Q3321 | Published On: 15-Dec-2018 | Status: Retired | Retired On: 1-Jul-2022

Fungal pneumonia

Q:

What codes are assigned for fungal pneumonia, not elsewhere classified (NEC)?

A:

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

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

Fungal infections are classified in ICD-10-AM to category B35-B49 *Mycoses.* For fungal pneumonia NEC assign:

J16.8 *Pneumonia due to other specified infectious organisms*

B48.8 *Other specified mycoses*

Follow the Alphabetic Index:

Pneumonia

- in (due to)

- - specified

- - - organism NEC J16.8

Mycosis, mycotic

- specified NEC B48.8

It is noted that there is inconsistency within the ICD-10-AM in regard to classification of infectious agents.

This may be reviewed for a future edition.

Published 15 December 2018,
for implementation 01 January 2019.

Ref No: Q3378 | Published On: 15-Mar-2019 | Status: Retired | Retired On: 1-Jul-2022

Hookwire localisation of extramammary lesions

Q:

What code is assigned for hookwire localisation of lesions other than breast lesions (ie extramammary lesions)?

A:

Guide/hook wire localisation (biopsy) of lesions is a technique performed with specific interventional imaging procedures (ie ultrasound, mammography, computerised tomography (CT) etc). For example, CT may be performed to identify the location, size and shape of a lesion. A cannula needle housing a hook wire is inserted using CT guidance and placed close to the lesion. When the outer cannula needle is withdrawn, the horn of the hook wire remains anchored to the lesion, and the patient is transferred to the operating theatre for excisional biopsy of the lesion, which is identified by the location of the hook wire (Li et al 2012).

Where guide/hook wire localisation (biopsy) of a lesion other than the breast (ie extramammary) is performed, do not assign an ACHI code for the guide/hook wire localisation component, as per the guidelines in ACS 0016 *General procedure guidelines,* as it is inherent in the excisional biopsy procedure performed.

References:

Li, W, Wang, Y, He, X, Li, G, Wang, S, Xu, L Yuan, Z 2012, 'Combination of CT-guided hookwire localization and video-assisted thoracoscopic surgery for pulmonary nodular lesions: Analysis of 103 patients', *Oncology letters,* Oct; 4(4): 824–828, viewed 17 September 2018, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3506590/

Published 15 March 2019,
for implementation 01 April 2019.

Ref No: Q3451 | Published On: 16-Dec-2019 | Status: Retired | Retired On: 1-Jul-2022

ACHI code for percutaneous cholecystostomy

Q:

What code is assigned for percutaneous cholecystostomy if 'trocar' is not documented in the clinical record?

A:

Cholecystostomy involves placement of a drainage catheter in the gallbladder to prevent the gallbladder from becoming too swollen (Stanford Children's Hospital n.d.). Percutaneous cholecystostomy (PC) is an alternative treatment to cholecystectomy, which allows immediate decompression and drainage of the inflamed gallbladder in some high-risk surgery patients such as the critically ill or patients with multiple comorbidities (Pablo Juan 2015).

Seldinger and trocar are two widely used percutaneous drainage techniques for catheter placement into vascular and nonvascular anatomical spaces (Hilal et al. 2017).

The indexing at *Cholecystostomy/trocar* is incorrect. Assign 90348-00 **[961]** *Percutaneous aspiration of gallbladder* for percutaneous cholecystostomy, including where trocar or Seldinger technique is documented. Follow the ACHI Alphabetic Index:

Aspiration

- gallbladder

- - percutaneous (closed) (needle) 90348-00 **[961]**

The ACHI Alphabetic Index at *Cholecystostomy/trocar* will be amended in Eleventh Edition Errata 4.

References:

Hilal, G.T., Mustafa, O., Rusen, A., Fahrettin, K., Fatma, A.E.O., Baki, H. Utku, M.Y. 2017, 'Comparison of seldinger and trocar techniques in the percutaneous treatment of hyatid cysts', Word Journal of Radiology, vol. 9, no. 11, viewed 11 November 2019, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5714805/

Pablo, A.B. Juan, J.D.P. 2015, 'Ultrasound guided percutaneous cholecystostomy in acute cholecystitis: case vignette and review of the technique', Journal of Ultrasound, vol. 18, no. 4, viewed 11 November 2019, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4630280/

Standford Children's Hospital, What is a cholecystostomy? Standford Children's Hospital, viewed 11 November 2019, https://www.stanfordchildrens.org/en/topic/default?id=cholecystostomy-22-cholecystostomy

Published 16 December 2019,
for implementation 01 January 2020.

Ref No: Q3490 | Published On: 16-Mar-2021 | Status: Retired | Retired On: 1-Jul-2022

Glaucoma drainage device insertion and cataract extraction

Q:

What is the sequencing for cataract and glaucoma diagnosis codes?

For intervention codes, is it necessary to follow the *Code first* instruction in the ACHI Tabular List at 42705-00 **[200]** *Extraction of crystalline lens with implantation of trans-trabecular drainage device* and assign a code for cataract extraction, even if the type of cataract extraction is not documented?

A:

Diagnosis codes for cataract and glaucoma are sequenced in accordance with the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*.

For intervention codes, the *Code first* instruction must be followed and a code for extraction of crystalline lens must be assigned first with 42705-00 **[200]** *Extraction of crystalline lens with implantation of trans-trabecular drainage device*. Where the type of cataract extraction is not documented, assign 42698-05 **[200]** *Other extraction of crystalline lens*.

Follow the ACHI Alphabetic Index:

Extraction

- lens (crystalline) NEC 42698-05 **[200]**

An update in this area of classification is being progressed for Twelfth Edition.

Published 16 March 2021,
for implementation 01 April 2021.

Ref No: Q3530 | Published On: 22-Jun-2020 | Status: Retired | Retired On: 1-Jul-2022

Latarjet procedure

Q:

What codes are assigned for Latarjet procedure?

A:

Latarjet procedure, also known as Latarjet-Patte procedure, is a surgical option for treatment of recurrent shoulder dislocation, congenital deformity or trauma in the presence of glenoid bone loss (Hurley et al. 2019). This procedure can be performed both open and arthroscopically. The Latarjet procedure involves transferring part of the coracoid process and the adjacent tendon to the anterior glenoid rim to improve stability (Hurley et al. 2019).

Where Latarjet procedure is performed by an open approach, assign:

48930-00 **[1404]** *Stabilisation of shoulder*

48242-00 **[1569]** *Bone graft with internal fixation, not elsewhere classified*

Where Latarjet procedure is performed arthroscopically, assign:

48957-00 **[1404]** *Arthroscopic stabilisation of shoulder*

48242-00 **[1569]** *Bone graft with internal fixation, not elsewhere classified*

Follow the ACHI Alphabetic Index:

Stabilisation

- joint (see also Arthrodesis)
- - shoulder 48930-00 **[1404]**
- - - arthroscopic 48957-00 **[1404]**

Graft (repair)

- bone
- - with
- - - internal fixation NEC 48242-00 **[1569]**

Amendments will be considered for a future edition.

References:

Hurley, E.T., Lim Fat, D., Farrington, S.K. & Mullett, H. 2019, 'Open versus arthroscopic Latarjet procedure for anterior shoulder instability: a systematic review and meta-analysis', *American Journal of Sports Medicine*, vol. 47, no. 5, pp. 1248–1253. https://doi.org/10.1177%2F0363546518759540.

Published 22 June 2020,
for implementation 01 July 2020.

Ref No: Q3659 | Published On: 15-Dec-2021 | Status: Retired | Retired On: 1-Jul-2022

Gonioscopy-Assisted Transluminal Trabeculotomy (GATT) and AB-interno canaloplasty (ABiC)

Q:

What codes are assigned for Gonioscopy-Assisted Transluminal Trabeculotomy (GATT) and AB-interno canaloplasty (ABiC)?

A:

Gonioscopy-Assisted Transluminal Trabeculotomy (GATT) and AB-interno canaloplasty (ABiC) are both forms of minimally invasive glaucoma surgery (MIGS). They are performed for treatment of glaucoma in combination with procedures for the treatment of cataract.

GATT is performed via micro-incisions in the cornea, after which, the trabecular meshwork is cut. An advantage of the GATT approach is that there is less scar tissue and subsequent surgeries have a significantly higher rate of success (Glaucoma Associates of Texas 2021).

ABiC uses an illuminated microcatheter technology called iTrack to viscodilate the Schlemm channels of the eye in order to improve aqueous outflow without a stent or shunt. Instead of changing or bypassing the natural drainage pathways of aqueous humour, ABiC is designed to restore the natural outflow pathway by addressing all drainage channels (Webeyeclinic 2018).

Assign 90075-00 **[191]** *Other procedures for glaucoma* when GATT or ABiC is performed.

Follow the ACHI Alphabetic Index:

Procedure

- glaucoma NEC 90075-00 **[191]**

See also Coding Rule *Insertion of minimally invasive glaucoma surgery (MIGS) device without concurrent cataract extraction.*

Improvements to ACHI are proposed for Twelfth Edition.

References:

Glaucoma Associates of Texas 2021, *GATT procedure: Gonioscopy-Assisted Transluminal Trabeculotomy*, viewed 15 September 2021, <https://www.glaucomaassociates.com/gonioscopy-assisted-transluminal-trabeculotomy/>.

Webeyeclinic 2018, ABiC Glaucoma Procedure, viewed 15 September 2021, https://www.webeyeclinic.com/glaucoma/abic-glaucoma-procedure

Published 15 December 2021,
for implementation 01 January 2022.

Ref No: TN697 | Published On: 15-Jun-2014 | Status: Retired | Retired On: 1-Jul-2022

Sclerotherapy of lesion of large intestine

Q:

How do you code injection of sclerosing agent into lesion of large intestine?

A:

Sclerotherapy (injection of sclerosing agent) is a type of destruction procedure that involves injection of a chemical irritant into a vein to produce hardening and destruction of the vein. The chemical irritates the lining of the vein, causing it to swell and the blood to clot. Scar tissue is produced, the vein shrinks and blood flow deviates to other healthy blood vessels.

When endoscopic sclerotherapy (injection of sclerosing agent) into lesion of large intestine is performed, assign 90308-00 **[908]** *Endoscopic destruction of lesion of large intestine* by following the index pathway:

Destruction

…

- lesion (tumour)

…

- - intestine, large

- - - endoscopic (closed) 90308-00 **[908]**

Amendments to ACHI Alphabetic Index will be considered for a future edition.

Published 15 June 2014,
for implementation 01 July 2014.

Ref No: Q3062 | Published On: 15-Sep-2017 | Status: Superseded | Superseded On: 1-Jul-2022 | Superseded By: TN1598

Recurrent post procedural wound infection due to mesh

Q:

What code is assigned for a recurrent wound infection due to mesh from a hernia repair?

A:

Deep wound infections due to the mesh used in hernia repair procedures are uncommon, but may occur years after the hernia repair and mesh implantation procedure. If the infection is recurrent, the infected mesh may be removed to eradicate the source of infection (Delikoukos et al. 2007; Maheshwari & Garg 2016).

As per ACS 1904 *Procedural Complications/Sequelae*:

> *A sequela of a complication is a current condition that is the result of a previously occurring procedural complication.*

While the infection is still receiving active treatment it is not classified as a sequela of a procedural complication.

Assign T85.78 *Infection and inflammatory reaction due to other internal prosthetic devices, implants and grafts* by following the Alphabetic Index:

Infection, infected (opportunistic)

- due to or resulting from

- - device, implant or graft NEC *(see also Complication(s)/by site and type)* T85.78

Also assign external cause of injury and place of occurrence codes:

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

and

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

or

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

Reference:

Delikoukos, S, Tzovaras, G, Liakou, P, Mantzos, F & Hatzitheofilou, C 2007, 'Late-onset deep mesh infection after inguinal hernia repair', *The World Journal of Hernia and Abdominal Wall Surgery,* vol. 11, no. 1, pp. 15-17, viewed 21 March 2017, https://www.ncbi.nlm.nih.gov/pubmed/16941077

Maheshwari, J & Garg, KM 2016, 'Mesh Infection after Inguinal Hernia Mesh Repair – Experience of Five Mesh Removal', *Journal of Dental and Medical Sciences*, vol.15, no. 4, pp. 78-80, viewed 21 March 2017, http://www.iosrjournals.org/iosr-jdms/papers/Vol15-Issue%204/Version-12/P1504127880.pdf

Published 15 September 2017,
for implementation 01 October 2017.

Ref No: TN1035 | Published On: 15-Dec-2015 | Status: Retired

Low magnesium

Q:

What is the correct code to assign for a documented low serum magnesium level, confirmed as low on biochemistry, and for which magnesium replacement is given (i.e. Mg 0.42 on admission commenced on Magmin 3 tabs TDS)? Is it correct to follow the advice in the Coding Rule *Use of abbreviations, symbols and test results values* (originally published 15 September 2009 and updated 15 September 2015) and follow the index pathway *Deficiency/magnesium* to assign E61.*2 Magnesium deficiency* as per the example of low potassium cited in this Coding Rule?

A:

The index pathways in ICD-10-AM for low magnesium are not consistent with those for low potassium. For low potassium following the lead terms **Deficiency**, **Depletion**, **Hypokalaemia**, **Hypopotassaemia** or **Syndrome** result in only one code, E87.6 *Hypokalaemia.* However three different codes may be assigned for low magnesium depending on the lead term chosen:

E83.4 *Disorders of magnesium metabolism*

E61.2 *Magnesium deficiency*

R79.0 *Abnormal level of blood mineral*

For low magnesium without further specification use the lead term **Hypomagnesaemia** to assign E83.4 *Disorders of magnesium metabolism* in category E83 *Disorders of mineral metabolism* which is the same block where low potassium is classified (*Metabolic disorders* (E70–E89)).

Do not follow the index pathway ***Deficiency/magnesium*** to assign E61.2 *Magnesium deficiency*, in block E50–E64 *Other nutritional deficiencies*, unless there is documentation to support that the patient has a dietary deficiency.

Codes in category E61 *Deficiency of other nutrient elements* and E83 *Disorders of mineral metabolism* are mutually exclusive as per the *excludes notes* at E61 and E83.

R79.0 *Abnormal level of blood mineral* is also inappropriate, as this is a symptom code in Chapter 18 *Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified* (R00–R99) and is only to be used when a more specific code is not available elsewhere in the classification. R79.0 excludes both disorders of mineral metabolism (E83.-) and nutritional mineral deficiency (E58–E61).

See also Coding Rule *Use of abbreviations, symbols and test results values* (originally published 15 September 2009 and updated 15 September 2015)

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Eleventh Edition FAQs Part 1: ACS 0010 *Clinical documentation and general abstraction guidelines* - Clinician queries

Q:

Does the documentation within an episode of care require updating/amendment following a clinician response to a documentation query?

A:

Many questions were received regarding the revision of ACS 0010 *Clinical documentation and general abstraction guidelines* in relation to whether or not the documentation contained within the episode of care requires updating/amendment following a clinician's response to a documentation query. Specifically, "Does it mean that the doctor has to fix the medical record or is the coding query response sufficient"…for completeness of the episode of care. There is no mention of 'updating the clinical documentation' within an episode of care to reflect the clinician's response to a documentation query in ACS 0010, nor in other introductory sections of the ACS.

The query response is acceptable as an update to the episode of care and to inform accurate clinical coding, as long as the guidelines for generating appropriate queries to clinicians are followed.

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Eleventh Edition FAQs Part 1: ACS 0010 *Clinical documentation and general abstraction guidelines* – Abstraction from outside the episode of care

Q:

When should information located outside the episode of care be used to add further specificity?

A:

There have been a number of questions regarding using information from outside the episode of care to add further detail/specificity to documented conditions.

ACS 0010 *Clinical documentation and general abstraction guidelines* under the section *Roles and responsibilities in the documentation and abstraction process* states:

> Information from the health care record outside of that directly relating to the current episode of care can help to inform code assignment. For example:
>
> • past episodes of care (at current or other health facility)
>
> • referral letters and other correspondence
>
> • emergency notes
>
> • outpatient notes
>
> Such sources can be used to:
>
> • clarify documentation contained within the current episode of care
>
> • gain further specificity on documentation contained within the current episode of care
>
> • determine the reason for admission (eg reviewing outpatient notes and referral letters).

A Clinical Coder should only be looking outside of the current episode of care (eg past episodes, referral letters, emergency and/or outpatient notes) only when conditions documented in the current episode of care require further clarification or specificity, or where the reason for admission is required (eg from outpatient notes or referral letters).

For example, a patient is re-admitted for an intervention on their broken wrist, after presenting to the Emergency Department the day before. The use of the radiology report from the Emergency Department visit to gather specificity on the fracture detail is acceptable.

Another example, is where a patient is admitted for day only chemotherapy for ‘breast cancer’, but has no documentation of the morphology in this episode of care. It is acceptable to use the histopathology result from a previous episode to gather specificity regarding the morphology.

It is not intended that conditions which are not documented in the current episode of care be classified after finding them documented in a previous episode(s) of care.

For example, if there is documentation of a patient being a ‘smoker’ or ‘ex-smoker’ in the current episode of care (with no further detail), but a previous episode of care contained documentation that the patient had chronic obstructive pulmonary disease (COPD) due to harmful use of tobacco, the code for harmful use of tobacco and COPD cannot be assigned in the current episode of care.

In another example, the current episode of care contains documentation that the patient is a Type 2 diabetic without any complications/manifestations listed. Documentation in a previous episode(s) indicates that the patient has complications/manifestations with their Type 2 Diabetes. In this instance it is not acceptable to use the documentation from a previous episode of care to assign the codes for the complications/manifestations in the current episode of care.

Classification instructions in specialty standards (eg ACS 0236 *Neoplasm coding and sequencing* and ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia*) are meant to provide classification guidance to ensure clarity, specificity of the condition(s) and above all consistency when performing the clinical coding function. The guidance provided in the ACS is not intended to classify for severity of a condition. Where severity is required, this is depicted in ICD-10-AM itself (eg stages of pressure injury, stages of chronic kidney disease).

ACS 0010 was revised with the intent to minimise coder burden where there is ambiguous or poor documentation in the current episode of care. Tracking back through episodes of care to establish manifestations of diabetes or metastatic sites of a neoplasm is not expected unless it is for the reasons highlighted above.

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Eleventh Edition FAQs Part 1: Allergens and anaphylaxis

Q:

When assigning codes for anaphylactic reactions, should codes for the individual components of the reaction also be assigned?

A:

Research indicates that anaphylaxis and anaphylactic shock are part of a continuum. Anaphylaxis is a serious and potentially life-threatening reaction to a trigger such as an allergy. The clinical manifestations of mild anaphylaxis may rapidly progress to a more severe anaphylaxis and lead to upper airway obstruction, respiratory failure, and circulatory shock (that is, anaphylactic shock).

ACS 0001 *Principal diagnosis/Codes for symptoms, signs and ill-defined conditions* states:

Codes for symptoms, signs and ill-defined conditions from Chapter 18 *Symptoms signs and abnormal clinical and laboratory findings* are not to be used as principal diagnosis when a related definitive diagnosis has been established.

Therefore, the individual components of the anaphylactic reaction (ie bronchospasm) would not be classified in addition to the anaphylaxis.

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Eleventh Edition FAQs Part 1: Neoplasms

Q:

When a diagnosis is a complication of the neoplasm, or a complication of neoplasm treatment, does the neoplasm itself need to meet ACS 0002 *Additional diagnoses* to be assigned?

A:

ACS 0236 *Neoplasm coding and sequencing* provides the following instructions for clinical coding:

> A primary neoplasm is classified as a current condition if the episode of care is for:
>
> - diagnosis or treatment of the primary neoplasm, in any of the following circumstances:
>   - initial diagnosis of the primary neoplasm
>   - treatment of complications of the primary neoplasm or neoplasm treatment
>
> …

For example, if a patient is admitted for treatment/management of a complication of chemotherapy, ACS 0236 instructs that the neoplasm must also be coded as a current condition. As ACS 0236 is a specialty standard, its instruction overrides ACS 0002 in this instance.

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Eleventh Edition FAQs Part 1: Ophthalmology – cataract with glaucoma intervention

Q:

When coding cataract extraction with insertion of iStent, why is an additional ACHI code assigned for cataract extraction?

A:

ACS 0701 *Cataract* was developed based on DRG logic which has since been superseded. It is acknowledged that consideration be given to a revision/deletion of ACS 0701 in a future edition of the Australian Coding Standards. Updated DRG logic has rendered the sequencing of cataract and glaucoma codes inconsequential.

ACHI code 42705-00 **[200]** *Extraction of crystalline lens with implantation of trans-trabecular drainage device* is a combination code due to the fact that an iStent has not yet been approved by the Therapeutic Goods Administration (TGA) and cannot yet be performed in Australia without a cataract intervention. It is for this reason the code 42705-00 **[200]** is located in the block for cataract interventions (Block **[200]** *Extraction of crystalline lens*) and not in block **[191]** *Procedures for glaucoma*.

The rationale for the *Code first* note is to capture the full clinical concept regarding the cataract intervention (i.e. the mechanism of extraction).

In Eleventh Edition Errata 1 a *Code first* instruction was added at 42705-00 **[200]** to ensure:

- the type of cataract extraction is captured; and
- the cataract is sequenced ahead of the glaucoma procedure (and the insertion of lens).

As an ICD convention or instructional note overrides an ACS, the classification instruction in ACS 0701 *Cataract* which states ‘If treatment for glaucoma and cataract is received during the same operation, sequence the glaucoma before the cataract for the diagnosis and the procedure codes.’ will not be applied for iStent cases.

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Eleventh Edition FAQs Part 1: Sequencing of complications following abortion, ectopic or molar pregnancy

Q:

Are there sequencing instructions for assigning Chapter 15 codes in obstetrics episodes?

A:

There is no sequencing instruction for Chapter 15 *Pregnancy, childbirth and the puerperium* codes within a code string, unless directed by an *Instructional* note/term in the Tabular List or an Australian Coding Standard.

ACS 1544 *Complications following abortion and ectopic and molar pregnancy* states:

> Codes from category O08 *Complications following abortion and ectopic and molar pregnancy* are assigned when a patient is admitted with a complication of an abortion, but the abortion was treated, performed or complete (eg complete spontaneous abortion) prior to the episode of care (ie the 'complication' is the focus of care; also referred to as the 'subsequent episode'):
>
> - Assign a code from category O08 *Complications following abortion and ectopic and molar pregnancy*
> - Assign a code from another chapter, where it adds specificity
> - Sequence codes as per the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*.

Example 5 in ACS 1544 demonstrates when the Chapter 15 code would be assigned as an additional diagnosis not a principal diagnosis (ie it was not the reason for admission).

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Eleventh Edition FAQs Part 1: Delivery and assisted delivery

Q:

If a patient delivers enroute with a McRobert's manoeuvre performed by paramedics and then spontaneously delivers the placenta in the admitted episode of care, is the principal diagnosis coded to O83 or O80?

A:

ACS 1505 *Delivery and assisted delivery codes* states:

> For classification purposes, once an assistance procedure is performed during the delivery episode of care (eg McRoberts manoeuvre, version, breech extraction), the delivery is **not classified as spontaneous**.
>
> …
>
> Delivery is not complete until after expulsion of the placenta, excluding any retained portion(s), expelled or requiring removal post delivery.

For the scenario above, the delivery was not completed until the patient was in the health care facility, therefore the location where the McRoberts manoeuvre was performed is irrelevant.

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Eleventh Edition FAQs Part 1: Wound Management – Vacuum assisted closure (VAC) dressings

Q:

How many times should a VAC dressing be assigned in an episode of care?

A:

From Eleventh Edition onwards, VAC dressings should be coded once per episode, unless a subsequent VAC dressing(s) is undertaken in theatre under cerebral anaesthesia. In such cases the additional VAC dressing(s) would be coded as many times as performed under cerebral anaesthesia.

Q:

Where a VAC dressing is performed with debridement, do we code debridement with a VAC dressing, or just the VAC dressing?

A:

Coders should assign both ACHI codes for debridement with a VAC dressing as there is no *Excludes* note at 90665-01 **[1628]** *Debridement of skin and subcutaneous tissue, not elsewhere classified* to instruct otherwise.

Q:

Where a debridement occurs with a repair, do we code both debridement and repair of the wound?

A:

For Eleventh Edition, both codes for the repair (suture) of the skin and subcutaneous tissue at block **[1635]** and the debridement at block **[1628]** should be assigned.

Eleventh Edition Errata 1 removed an *Excludes* note and included a *Code also* note at the category level at block **[1635]** *Repair of wound and subcutaneous tissue* to code also the debridement 90665-01 **[1628]**.

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Eleventh Edition FAQs Part 1: Diabetes mellitus and pressure injuries

Q:

Do the guidelines in ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* for 'complications' of diabetes mellitus, apply to pressure injury in a patient with diabetes mellitus?

A:

ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia/General classification rules for DM and IH* Rule 3 states:

> The classification includes conditions (often termed '**complications**') which occur commonly **with** DM or IH. These conditions may or may not have been a direct consequence of the metabolic disturbance and are indexed under Diabetes, with or *Hyperglycaemia/intermediate/with*. Always refer to these index entries to classify DM or IH (see examples 2–7).

ACS 1221 *Pressure injury* states that synonymous terms for pressure injury include pressure ulcer, decubitus ulcer, pressure area, plaster ulcer and bedsore.

However, none of the synonyms for pressure injury listed in ACS 1221 are entries in the Alphabetic Index under *Diabetes/with*.

Therefore, the guidelines in ACS 0401 for 'complications' of diabetes mellitus do not apply to pressure injury in a patient with diabetes mellitus, unless the criteria for diabetic foot are met (See also ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia/6. Diabetic foot*).

For Eleventh Edition there was also an *Excludes* note added at E1-.69 *Diabetes mellitus with other specified complication* excluding pressure ulcer not meeting the criteria for diabetic foot (L89.-).

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Eleventh Edition FAQs Part 1: Ongoing anticoagulation therapy

Q:

In episodes of ongoing anticoagulation therapy, when should a code for Z95.2 *Presence of prosthetic heart valve* be assigned? When should the underlying disease code (eg atrial fibrillation) be assigned?

A:

As per ACS 0002 *Additional diagnoses* do not assign an additional diagnosis code for a pre-existing condition requiring administration of ongoing medication. This includes where the ongoing medication is adjusted due to the management of another condition.

An additional diagnosis code can be assigned for a pre-existing condition if a change in the pre-existing condition requires an amendment to its treatment plan.

Assign additional diagnosis codes for a personal or family history of diseases and disorders, or statuses (eg artificial opening, organ transplantation, presence of functional implants, graft or other device, dependence on enabling machines or devices) classified to categories Z80–Z99 *Persons with potential health hazards related to family and personal history and certain conditions influencing health status*, when they are relevant to a condition being managed or an intervention being performed in the current episode of care.

In ACS 0303 *Abnormal coagulation profile due to anticoagulants* Example 3 the intervention of bridging Clexane was required due to the presence of the heart valve replacement, therefore it is relevant to the episode of care.

In ACS 0303 *Abnormal coagulation profile due to anticoagulants* Example 4 the adjustment of the medication was to manage the overwarfarinisation, and not management of the atrial fibrillation.

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Ref No: TN1502 | Published On: 16-Sep-2019 | Status: Retired | Retired On: 1-Jul-2022

Eleventh Edition FAQs Part 2: Wound management

Q:

Can 96255-00 **[1601]** *Wound management NEC* be assigned for management of wounds on the ward (ie not in theatre) when performed by a medical officer, a specialist nurse, or allied health staff (eg podiatrist); or is this code only assigned for wound management performed in theatre under cerebral anaesthesia?

A:

The code 96255-00 **[1601]** *Wound management NEC* is only assigned where it meets the criteria in ACS 0042 *Procedures normally not coded*, that is if:

- cerebral anaesthesia is required in order for the procedure to be performed (see ACS 0031 *Anaesthesia*)
- it is 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)
- another specialty standard directs they should be assigned. In such cases, the specialty standard overrides this list and the stated code is assigned.

Examples in the Eleventh Edition education material that are in contradiction to this standard, have been corrected for implementation 1 October 2019.

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Ref No: TN1502 | Published On: 16-Sep-2019 | Status: Retired | Retired On: 1-Jul-2022

Eleventh Edition FAQs Part 2: Lactation consultation in newborn episode

Q:

Can the new allied health code for lactation consultant be used on a newborn/neonate episode when the lactation consultant sees the neonate and documents in the progress notes, or is it for use in the obstetric (mothers) episode of care only?

A:

The new intervention code 95550-16 **[1916]** *Allied health intervention, lactation consultant* is intended for use on the mother's episode of care, not on the newborn's episode of care (male or female). This is confirmed by the presence of the clinical (sex) edit on this code which prohibits its assignment on the episode of care of a male.

Where a newborn is reviewed for feeding problems by a lactation consultant (eg review of tongue tie), coders should assign a diagnosis code to indicate the neonatal condition causing the breastfeeding (attachment) difficulty, if applicable or a code from category P92 *Feeding problems of newborn*.

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Ref No: TN1502 | Published On: 16-Sep-2019 | Status: Retired | Retired On: 1-Jul-2022

Eleventh Edition FAQs Part 2: Nontraumatic haematoma

Q:

Can a nontraumatic haematoma be assigned where documentation specifies ‘spontaneous’ or ‘due to an unknown cause’? When a haematoma is documented as due to anticoagulants, should the essential modifier of ‘nontraumatic’ be followed?

A:

A spontaneous haematoma can be assumed to be ‘nontraumatic’ and the essential modifier ‘nontraumatic’ followed to assign a code for a spontaneous haematoma.

Similarly, where a haematoma is documented as due to anticoagulants, it can be assumed to be ‘nontraumatic’ and the essential modifier ‘nontraumatic’ followed to assign a code for a spontaneous haematoma. This is supported by the *Code also, if applicable* instruction:

D68.3 *Haemorrhagic disorder due to circulating anticoagulants*

…

Code also, if applicable:

- nontraumatic haematoma of skin and subcutaneous tissue (L98.8)
- nontraumatic haematoma of soft tissue (M79.8-)

However, where a haematoma is documented as due to an unknown cause, without further qualification, a code for a traumatic haematoma is assigned following the alphabetic index where ‘traumatic’ is a nonessential modifier:

Haematoma (skin surface intact) (traumatic) (*see also Contusion*) T14.08

Indexing improvements will be considered for a future edition of ICD-10-AM.

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Eleventh Edition FAQs Part 2: Use of U91 *Syndrome not elsewhere classified*

Q:

When classifying a syndrome classifiable to a single ICD-10-AM code, should U91 *Syndrome, not elsewhere classified* also be assigned?

A:

Where a syndrome is classified to a single code, U91 *Syndrome, not elsewhere classified* is not assigned.

For example, Brugada syndrome is classified to I49.8 *Other specified cardiac arrhythmias*.

The criteria for code assignment of U91 *Syndrome, not elsewhere classified* is specified in ACS 0005 *Syndromes*:

> Where there is no single ICD-10-AM code to classify all the elements of a syndrome, assign:
>
> - codes for the manifestations that are relevant for the patient, and meet the criteria in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*
>
> and
>
> - U91 *Syndrome, not elsewhere classified*, as an additional diagnosis to flag that the manifestations are related to a syndrome.

U91 *Syndrome, not elsewhere classified* is intended to identify rare syndromes that are not classifiable to a single code in ICD-10-AM.

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Eleventh Edition ACS 1904 *Procedural complications* – due to/related to prosthetic devices, implants or grafts

This Coding Rule supersedes the published Coding Rule of the same name, implemented 1 July 2019 (TN1504) to correct the following errors:

- Incorrect principal diagnosis assigned in Example 3
- Incorrect code assignment in Example 5

Procedural complications may be classified to either the body system chapters or block T80–T88 *Complications of surgical and medical care, not elsewhere classified*.

Where a complication is related to a prosthetic device, implant or graft, assign an appropriate code from T82–T85 *Complications of prosthetic devices, implants and grafts*, unless otherwise directed by the Alphabetic Index or not supported by an *Includes* note.

Where a condition is not related to a prosthetic device, implant or graft and:

- it is related to a body system, assign an appropriate code from the body system chapter
- the complication is not related to a body system, assign an appropriate code from T80–T81 or T86–T88

ACS 1904 *Procedural complications/Overview/dot point three*, supports the use of codes in T82–T85 for complications specific to prosthetic devices, implants and grafts including mechanical complication, infection, pain, thrombosis, haemorrhage, mesh erosion and so on.

A causal relationship does not need to be documented to assign a procedural complication when a condition is classified to block T82–T85 unless there is a specific Coding Rule or ACS that indicates otherwise (eg complications related to coronary artery bypass graft).

Example 1: Patient with a history of endovascular aneurysm repair (EVAR) of an abdominal aortic aneurysm (AAA) with a bifurcated endoprosthesis, was readmitted due to intermittent abdominal pain and progressive dyspnoea. Computed tomography (CT) angiogram of the aorta confirmed endoleaks following EVAR.

Assign:

T82.3 *Mechanical complication of other vascular grafts*

External cause codes

Follow the ICD-10-AM Alphabetic Index Section I:

Leak, leakage

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

- - arterial graft NEC T82.3

Example 2: Patient was admitted for a ruptured anterior cruciate ligament (ACL) graft for which the patient underwent revision of a left knee ACL reconstruction.

Assign:

T84.4 *Mechanical complication of other internal orthopaedic devices, implants and grafts*

External cause codes

Follow the ICD-10-AM Alphabetic Index Section I:

Complication(s) (from) (of)

- orthopaedic

- - device, implant or graft *(see also Complication(s)/by site and type)* T84.9

- - - mechanical NEC T84.4

Example 3: A 59-year-old woman was admitted with loss of mobility, and pain in her left leg stump. She had a below knee amputation (BKA) of her left lower limb in 2010. She only intermittently wore her prosthesis over the amputated site, because of persistent touch-evoked pain. Physical examination revealed erythema on the stump with cellulitis. She was diagnosed with cellulitis of the amputation stump due to an ill-fitting prosthetic limb.

Assign:

T88.8 *Other specified complications of surgical and medical care, not elsewhere classified*

L03.13 *Cellulitis of lower limb*

Y84.8 *Other medical procedures*

Place of occurrence code

Z89.5 *Acquired absence of leg at or below knee*

Follow the ICD-10-AM Alphabetic Index Section I:

Complication(s)

- orthopaedic

- - external device or appliance T88.8

Cellulitis (diffuse) (with lymphangitis)

- limb

- - lower L03.13

Absence

- extremity (acquired)

- - lower

- - - below knee (unilateral) Z89.5

Follow the ICD-10-AM Alphabetic Index Section II *External causes of injury*:

Complication(s) (delayed) (medical or surgical procedure) (of or following)

- procedures other than surgical operation NEC (see also Complication(s)/by type of procedure)

- - specified Y84.8

Example 4: Urethral trauma/injury sustained from displacement of an indwelling catheter.

Assign:

T83.0 *Mechanical complication of urinary (indwelling) catheter*

External cause codes

Follow the ICD-10-AM Alphabetic Index Section I:

Displacement, displaced

- device, implant or graft (see also Complication(s)/by site and type/mechanical)
- - catheter NEC
- - - urinary (indwelling) T83.0

It is not necessary to assign an additional code from Chapter 19 (eg S37.3- *Injury of urethra*) to indicate the site of the post-operative complication. The purpose of S codes in Chapter 19 *Injury, poisoning and certain other consequences of external causes* is to classify injures due to trauma (ie an injury not related to an intervention).

If urethral trauma/injury occurs during removal (accidental or intentional) of an indwelling catheter (IDC) by a patient, ACS 1904 is not applicable as the trauma/injury is not a complication of the device (catheter).

Where the urethral trauma/injury meets the criteria in ACS 0002 *Additional diagnoses*, assign:

S37.3- *Injury of urethra*

X58 *Exposure to other specified factors*

Place of occurrence and activity codes

Follow the ICD-10-AM Alphabetic Index Section I:

Injury

- urethra (sphincter) S37.30
- - membranous S37.31
- - penile S37.32
- - prostatic S37.33
- - specified part NEC S37.38

Follow the ICD-10-AM Alphabetic Index Section II *External causes of injury*:

Exposure (to)

- factor(s)
- - specified NEC X58

Example 5: Ureteral stricture due to a procedure.

Ureteral stricture occurring after insertion of prosthetic devices, implants or grafts is classified as a complication of prosthetic devices, implants or grafts.

Assign:

T83.84 *Stenosis following insertion of genitourinary prosthetic devices, implants and grafts*

External cause codes

Follow the ICD-10-AM Alphabetic Index Section I:

Complication(s) (from) (of)

- genitourinary NEC (see also Complication(s)/by site and type)

- - device, implant or graft

- - - stricture (stenosis) T83.84

Ureteral stricture due to a procedure with no involvement of prosthetic devices, implants or grafts is classified to an appropriate code from the end of body system chapter.

Assign:

N99.89 *Other intraoperative and postprocedural disorder of genitourinary system*

N13.5 *Kinking and stricture of ureter without hydronephrosis*

External cause codes

Follow the ICD-10-AM Alphabetic Index Section I:

Complication(s) (from) (of)

- genitourinary NEC *(see also Complication(s)/by site and type*)

- - intraoperative or postprocedural

- - - specified NEC N99.89

Stricture

- ureter (postprocedural) N13.5

N13.5 is assigned as an additional diagnosis to provide further specificity of the condition (ie ureteral stricture).

Example 6: Lymphocele following cannulation of the femoral vein.

Assign:

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

I97.83 *Postprocedural lymphocele, lymphoedema and chylothorax*

External cause codes

Follow the ICD-10-AM Alphabetic Index Section I:

Complication(s) (from) (of)

- vascular

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

- - - infusion catheter

- - - - specified NEC T82.89

Lymphocele I89.8

- postprocedural I97.83

I97.83 is assigned to provide further specificity of the condition (ie postprocedural lymphocele) (Note: there are no *Excludes* notes to prevent assignment of T82.89 and I97.83 together). However, it is not necessary to assign I89.8 *Other specified noninfective disorders of lymphatic vessels and lymph nodes* as it does not provide further specificity of the condition.

This content has been adapted and disaggregated from the Clarification on the application of ACS 1904 *Procedural complications* issued 28 June 2019 for implementation 1 July 2019 (updated for 1 October 2020)

Published 21 September 2020,
for implementation 01 October 2020.

Ref No: TN1504 | Published On: 28-Jun-2019 | Status: Retired | Retired On: 1-Jul-2022

Eleventh Edition ACS 1904 *Procedural complications* – care beyond intraoperative/postoperative care

Some conditions that develop postoperatively are considered as natural or expected events and are not necessarily complications of clinical care (ie they are not considered significant as per the criteria in ACS 0002 *Additional diagnoses*).

These conditions are only assigned as procedural complications when there is documentation of care or management that is significantly beyond routine care.

Care beyond routine may include:

- consultation/treatment by a clinician resulting in a change of management
- application of vacuum dressing or other specialised dressing/device, which was not previously required, to replace a conventional dressing
- unexpected or unplanned return to theatre
- commencement of antibiotics
- treatment that delays discharge

Example 16:

This 58 year old lady with bilateral ovarian cysts underwent bilateral oophorectomy and division of omental adhesions under a general anaesthetic (GA) without any complications. Persistent wound ooze from the abdominal site noted on day 2 postoperatively by wound management team. The dressing from the abdominal wound was removed and a vacuum dressing was applied. Patient remained in hospital until ooze settled down. The patient was discharged home on day 4 as significant ooze was no longer present. Patient instructed to present to the Emergency Department if she has any concerns. Histopathology report – mucinous cystadenoma of ovaries.

Assign:

D27 *Benign neoplasm of ovary*

M8470/0 *Mucinous cystadenoma NOS*

K66.0 *Peritoneal adhesions*

T81.89 *Other complications following a procedure, not elsewhere classified*

with appropriate external cause codes.

Follow the Alphabetic Index:

Complication(s) (from) (of)

- postprocedural

- - specified NEC T81.89

This content has been adapted and disaggregated from the Clarification on the application of ACS 1904 Procedural complications issued 28 June 2019 for implementation 1 July 2019 (updated for 1 October 2019).

Published 28 June 2019,
for implementation 01 July 2019.

Ref No: Q3423 | Published On: 16-Dec-2019 | Status: Superseded | Superseded On: 1-Jul-2022 | Superseded By: Q3685

Adhesions divided during caesarean without labour

Q:

What ICD-10-AM code is assigned for pelvic adhesions, divided during caesarean section?

A:

The ICD-10-AM Alphabetic Index below is inconsistent with other index entries for O65.5 *Labour and deliver affected by abnormality of maternal pelvic organs* that specify conditions complicating 'labour or delivery':

Adhesions, adhesive (postinfective)

- pelvic, pelvis (see also Adhesions/peritoneum)
- peritoneum, peritoneal (male)
- - female pelvic (postpartal) (to uterus)
- - - affecting
- - - - labour and delivery O65.5
- - - - pregnancy O34.8

Classification guidelines in ACS 1506 *Fetal presentation, disproportion and abnormality of maternal pelvic organs* should specify that codes in category O64–O66 may be assigned '**during** labour and/or delivery'.

Therefore, assign O65.5 *Labour and delivery affected by abnormality of maternal pelvic organs* where division of adhesions are required during caesarean section, regardless of when the adhesions are first diagnosed.

ACS 1506 *Fetal presentation, disproportion and abnormality of maternal pelvic organs* and the inconsistent index entry were amended in Eleventh Edition Errata 3.

Published 16 December 2019,
for implementation 01 January 2020.

Ref No: Q3441 | Published On: 22-Jun-2020 | Status: Superseded | Superseded On: 1-Jul-2022 | Superseded By: Q3668

Dilation of ileal stricture via colonoscopy

Q:

What code is assigned for dilation of an ileal stricture performed via colonoscopy?

A:

Endoscopic (balloon) dilation of an ileal stricture is a minimally invasive intervention performed as an alternate to surgical interventions such as strictureplasty or resection (Gustavsson 2012).

As there is currently no ACHI code for endoscopic dilation of an ileal stricture, where this procedure is performed via a colonoscopy, assign 32090-00 **[905]** *Fibreoptic colonoscopy to caecum* alone.

Follow the ACHI Alphabetic Index:

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

Amendments will be considered for a future edition.

References:

Gustavsson, A., Magnuson, A., Blomberg, B., Andersson, M., Halfvarson, J. & Tysk, C. 2012, 'Endoscopic dilation is an efficacious and safe treatment of intestinal strictures in Crohn's disease', *Alimentary Pharmacology and Therapeutics*, vol. 36, issue 2, pp. 151–158, viewed 26 February 2020, https://onlinelibrary.wiley.com/doi/full/10.1111/j.1365-2036.2012.05146.x.

Published 22 June 2020,
for implementation 01 July 2020.

Ref No: Q3339 | Published On: 15-Dec-2018 | Status: Superseded | Superseded On: 1-Jul-2022 | Superseded By: Q3668

Dilation of ileocolic anastomotic stricture

Q:

What ACHI code is assigned for dilation of ileocolic anastomotic stricture?

A:

Ileocolic anastomotic strictures may occur after ileocaecal resection or hemicolectomy for conditions such as malignancy of the gastrointestinal tract or Crohn's disease. Endoscopic balloon dilation or surgical resection are performed to treat the ileocolic anastomotic strictures (Ding et al. 2016; Lian et al. 2017).

For dilation of ileocolic anastomotic stricture, assign 32094-00 **[917]** *Endoscopic dilation of colorectal stricture* as a best fit.

Follow the Alphabetic Index:

Dilation

- stricture

- - anastomotic (endoscopic)

- - - colorectal 32094-00 **[917]**

Amendments may be considered for a future edition.

References:

Ding, NS, Yip, WM, Choi, CH, Saunders, B, Thomas-Gibson, S, Arebi, N, Humphries Hart, A 2016, Endoscopic dilatation of Crohn's anastomotic strictures is effective in the long term, and escalation of medical therapy improves outcomes in the biologic era, *Journal of Crohn's and colitis*, vol. 10, no. 10, pp. 1172-1178, viewed 6 November 2018, https://doi.org/10.1093/ecco-jcc/jjw072

Lian, L, Stocchi, L, Remzi, FH Shen, B 2017, Comparison of Endoscopic Dilation vs Surgery for Anastomotic Stricture in Patients with Crohn's Disease Following Ileocolonic Resection, *Clinical Gastroenterology and Hepatology*, vol. 15, no. 8, pp. 1226-1231, viewed 6 November 2018, https://www.clinicalkey.com.au/#!/content/playContent/1-s2.0-S1542356516310011?returnurl=https:%2F%2Flinkinghub.elsevier.com%2Fretrieve%2Fpii%2FS1542356516310011%3Fshowall%3Dtrue referrer=https:%2F%2Fwww.ncbi.nlm.nih.gov%2F

Published 15 December 2018,
for implementation 01 January 2019.

Ref No: Q3013 | Published On: 15-Jun-2016 | Status: Retired | Retired On: 31-Dec-2019

Cardiac pacemaker and implanted defibrillator status

Q:

When should the pacemaker status code Z95.0 *Presence of cardiac device* be assigned?

A:

Medical equipment and devices which emit electromagnetic interference (EMI) can inhibit pulse generators and pacemakers causing damage to the circuits of the device and placing a patient at risk, so monitoring of the pacemaker function is essential during these procedures. The risk of EMI is high for some procedures, such as monopolar electrocautery.

ACS 0016 *General procedure guidelines states*:

A procedure is defined as “a clinical intervention represented by a code that:

- is surgical in nature, and/or
- ·carries a procedural risk, and/or
- ·carries an anaesthetic risk, and/or
- ·requires specialised training, and/or
- ·requires special facilities or equipment only available in an acute care setting” (METeOR 514040) (Australian Institute of Health and Welfare 2014)

ACS 0936 *Cardiac pacemakers and implanted defibrillators* states:

> Patients with a pacemaker or defibrillator in situ require additional care at the time of procedural interventions, and therefore *Z95.0* Presence of cardiac device should be coded for all procedural cases.

Z95.0 *Presence of cardiac device* is assigned as an additional diagnosis for those patients who have a pacemaker or implanted defibrillator in situ and who undergo a procedure that meets the definition of a procedural intervention as per ACS 0016 *General procedure guidelines*.

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for implementation 01 July 2016.

Ref No: TN1505 | Published On: 28-Jun-2019 | Status: Retired | Retired On: 30-Sep-2019

ACS 0002 / ACS 0010 Revision

Definition of 'clinical significance' or 'transient' in relation to ACS 0002 *Additional diagnoses*:

ACCD sought input from advisory groups to develop a definition for clinical 'significance' and 'insignificance' of a condition to be included in the review of ACS 0002 for Eleventh Edition. No definition was put forward other than agreement on the criteria in ACS 0002 for qualifying a condition that should be assigned (or not assigned) as an additional diagnosis.

For classification purposes, a transient condition (or an insignificant condition), is a temporary condition that can be treated successfully with administration of medication and does not require:

- further clinical consultation as evidenced by documentation of a clinical assessment
- further investigation specifically to establish a diagnosis or provide greater specificity to an established diagnosis
- a care plan specifically developed for the condition (apart from routine clinical care) within an episode care.

With reference to transient conditions and the significance of them, ACS 0002 *Additional diagnoses* in the section regarding the *Commencement, alteration or adjustment of therapeutic treatment* states:

- Do not assign an additional diagnosis code for a condition that is transient and can be treated successfully with administration of medication without the need for further consultation, investigation or a plan of care (eg Mylanta for heartburn; paracetamol for headache; Sominex for insomnia) (see Examples 1, 2 3).
- An additional diagnosis code can be assigned if a condition requires further assessment (ie the condition is no longer considered transient) by a clinician and
- a diagnostic or therapeutic intervention is undertaken, or
- a care plan is prescribed following clinical consultation

Determining that a condition is transient (insignificant) or significant should be done on a case by case basis within the context of the particular episode of care and with respect to the clinical documentation contained within the episode of care.

It is very difficult for a query to be answered without context or reference to the entire episode of care. For the example of '*Hypokalaemia documented by treating team with a plan for stat dose of potassium replacement*'. In this instance, we are assuming that during the episode of care the patient's electrolytes would require further assessment to ensure that their potassium levels return to the normal range. In this instance the hypokalaemia should be coded as an additional diagnosis.

With regard to the example of '*PPH 500 mls documented by midwife with a stat dose of IM Ergometrine administered*', obstetric episodes of care should be classified utilising the ACS in the specialty Chapter 15 *Pregnancy, childbirth and the puerperium*, as well as the general standards for diseases and interventions.

ACS 1500 *Diagnosis sequencing in obstetric episodes of care/ 080-084 Delivery as a principal diagnosis*, the second dot point states:

- Assign additional diagnoses to indicate the reason for any delivery intervention (eg the reason for induction, use of forceps, caesarean section)

Therefore, the administration of IM Ergometrine is recognised as a delivery intervention for the control of postpartum haemorrhage. 'Postpartum haemorrhage' documented within an episode of obstetric care should be coded regardless of the treatment given or the amount of blood loss. It is a complication of delivery and would require further assessment to ensure that the haemorrhage has been resolved.

During the Eleventh Edition ITG process, examples within the revised ACS 0002 were specifically requested by ITG members, and the examples went through various iterations before being accepted with ITG consensus. ACS 0002 contains examples to demonstrate both when to code and when not to code conditions.

It is impossible to cover every given scenario in examples within the ACS. Clinical coders are required to use the ACS as a guide and the decision to assign additional diagnosis codes should be made on a case by case basis with due consideration to ICD-10-AM convention and the ACS.

Application of ACS 0002 in conjunction with specialty standards and conventions

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

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

For example, ACS 0236 *Neoplasm coding and sequencing* provides the following instructions for clinical classification:

A primary neoplasm is classified as a current condition if the episode of care is for:

- diagnosis or treatment of the primary neoplasm, in any of the following circumstances:
  - initial diagnosis of the primary neoplasm
  - treatment of complications of the primary neoplasm or neoplasm treatment
  - operative intervention to remove the primary neoplasm
  - medical care related to the primary neoplasm, including palliative care (see also ACS 2116 *Palliative care*)
  - recurrence of the primary neoplasm previously eradicated from the same organ or tissue (see also ACS 0237 *Recurrence of malignancy*).
- diagnosis or treatment of a secondary (metastatic) malignancy, regardless of when/if the primary site was previously resected. Assign an additional diagnosis code for the primary neoplasm if known, or C80.- *Malignant neoplasm without specification of site* if the site of the primary neoplasm is unknown or unspecified.
- treatment aimed at stopping progression of the neoplasm, such as:
  - pharmacotherapy or radiotherapy (see also ACS 0044 *Pharmacotherapy* and ACS 0229 *Radiotherapy*)
  - subsequent admissions for wider excision (even if there is no residual neoplasm identified on histopathology)

- staged surgery for prophylactic removal of a related organ.

…

In the dot point underlined in the above excerpt from ACS 0236, the primary neoplasm may not meet the criteria for code assignment as per ACS 0002, however as ACS 0236 is a specialty standard, this instruction overrides ACS 0002.

In another example, ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* instructs coders to always code diabetes and its manifestations/complications. In some circumstances, the manifestations will not meet the criteria of ACS 0002, however as ACS 0401 is a specialty standard, its instruction overrides ACS 0002.

Conventions and instructional notes

The ICD employs some special conventions (relating to the use of parentheses, square brackets, colons, etc) as well as use of instructional notes (*Code first, Code also, Use additional code* etc). The conventions and instructional notes of the classification need to be clearly understood both by clinical coders and applied mandatorily.

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Ref No: Q3084 | Published On: 15-Sep-2016 | Status: Retired | Retired On: 31-Dec-2019

Musculoskeletal injury of specified site

Q:

How do you code ‘musculoskeletal injury’ of a specified site?

A:

The musculoskeletal system is comprised of bones, muscles, cartilage, tendons, ligaments, joints and other connective tissue structures. Chapter 13 *Diseases of the musculoskeletal system and connective tissue* includes a list of specific musculoskeletal sites under *Site of Musculoskeletal involvement,* for example:

- Shoulder region (eg clavicle, scapula)
- Upper arm (humerus, elbow joint)
- Forearm (radius, ulna, wrist joint)
- Hand (eg carpus, fingers)
- Pelvic region and thigh (eg femur, pelvis)
- Lower leg (fibula, tibia, knee joint)
- Ankle and foot (eg metatarsus, toes)
- Head/neck/ribs/skull

A ‘musculoskeletal injury’ of a specified site is not a synonymous term for injury of a muscle of that site. The description of an injury as a ‘musculoskeletal injury’ indicates that it is an injury of the musculoskeletal system, rather than another body system (for example soft tissue or skin and subcutaneous tissue).

Chapter 19 *Injury, poisoning and certain other consequences of external causes* classifies injuries of specified body sites to S00-S99.

Where there is documentation of a specified type of injury (eg fracture, sprain, dislocation), refer to the applicable lead term in the Alphabetic Index for the specified injury type (see also the cross reference at *Injury* (*see also specified injury type*)).

Where there is documentation of ‘musculoskeletal injury’ (NOS) of a specified site, assign an appropriate code by following the Alphabetic Index at *Injury/by site*. For example:

Musculoskeletal injury of ankle:

Injury
- ankle
 - specified NEC S99.8

S99.8 *Other specified injuries of ankle and foot*

Musculoskeletal injury of neck:

Injury
- neck
 - specified NEC S19.8

S19.8 *Other specified injuries of neck*

Musculoskeletal injury of shoulder:

Injury

- shoulder

- - specified NEC S49.8

S49.8 *Other specified injuries of shoulder and upper arm*

Also assign appropriate codes for external cause of injury, place of occurrence and activity.

Published 15 September 2016,
for implementation 01 October 2016.

Ref No: Q2905 | Published On: 15-Sep-2015 | Status: Superseded | Superseded On: 21-Sep-2020 | Superseded By: Q3496

Coding of allergic reactions NOS and anaphylactic reactions

Q:

How should allergic reactions not otherwise specified (NOS) and anaphylactic reactions be coded? Should symptom codes be assigned for allergic reactions?

A:

The correct code assignment for allergic reactions NOS and anaphylactic reactions are outlined below.

Allergic reaction NOS:

T78.4 *Allergy, unspecified* following the Alphabetic Index:

Allergy, allergic (reaction) T78.4

Allergic reaction NOS to food:

T78.1 *Other adverse food reactions, not elsewhere classified* following the Alphabetic Index:

Allergy, allergic (reaction)

- food (any) (ingested) NEC T78.1

Anaphylaxis / anaphylactic shock due to food:

T78.0 *Anaphylaxis and anaphylactic shock due to adverse food reaction* following the Alphabetic Index:

Anaphylaxis

- due to

- - food reaction T78.0

When assigning a code classified to category T63 *Toxic effect of contact with venomous animals* additional codes should be assigned for any associated allergic reaction as per the instructional note at this category.

Symptoms such as wheeze, urticaria and swelling should not be coded when a diagnosis of allergic reaction or anaphylaxis has been established unless the symptom is significant in its own right and treated independently of the allergic reaction (*see also Note* at the beginning of Chapter18 *Symptoms, signs and abnormal clinical findings, not elsewhere classified*).

Assign external cause codes from Y37 Exposure to or contact with allergens as appropriate.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

Published 15 September 2015,
for implementation 01 January 2020.

Coding Rules

Retired/Superseded prior to Twelfth Edition

Ref No: Q3376 | Published On: 15-Dec-2018 | Status: Retired | Retired On: 30-Jun-2019

Pregnancy complicated by diseases of the genitourinary system

The ICD-10-AM Alphabetic Index at Pregnancy/complicated by/conditions in/N00-N99 and Pregnancy/complicated by/diseases of genitourinary system has been updated for Eleventh Edition.

In the interim, assign the following for pregnancy complicated by:

- diseases of the genital organs NEC, assign O99.8 *Other specified diseases and conditions in pregnancy, childbirth and the puerperium*
- infection of the genital organs or genitourinary system, assign:
- a code from category O23 *Infections of genitourinary tract in pregnancy* **or**
- O98.0 *Tuberculosis in pregnancy, childbirth and the puerperium* **or**
- O98.1 *Syphilis in pregnancy, childbirth and the puerperium* **or**
- O98.2 *Gonorrhoea in pregnancy, childbirth and the puerperium* **or**
- O98.3 *Other infections with a predominantly sexual mode of transmission in pregnancy, childbirth and the puerperium*
- diseases of the genitourinary system NEC, assign O26.81 *Kidney disorders in pregnancy, childbirth and the puerperium*

See also condition/in pregnancy or Pregnancy/complicated by/abnormal, abnormality/by site:

Pregnancy (single) (uterine) — see also condition/in pregnancy
- complicated by
- - abnormal, abnormality
- - - broad ligament O34.8
- - - cervix O34.4
- - - fallopian tube O34.8
- - - ovary O34.8
- - - pelvic organs or tissues O34.9
- - - - specified NEC O34.8
- - - pelvis, with disproportion (bony) (major) NEC O33.0
- - - perineum O34.7
- - - uterus NEC O34.5
- - - - congenital O34.0
- - - vagina O34.6
- - - vulva O34.7

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for implementation 01 January 2019.

Ref No: Q3285 | Published On: 15-Dec-2018 | Status: Retired | Retired On: 30-Jun-2019

Nonendoscopic replacement of urinary catheter

Q:

What ACHI codes are assigned for nonendoscopic replacement of IDC?

A:

Assign the following codes for nonendoscopic replacement of an indwelling urinary catheter (IDC) following an admission for trial of void (TOV) that was unsuccessful:

92119-00 **[1902]** *Removal of other urinary drainage device*

and

36800-00 **[1090]** *Bladder catheterisation*

Follow the ACHI Alphabetic Index:

Removal — *see also Excision*

- catheter
- - bladder (endoscopic) (indwelling)
- - - nonoperative (nonendoscopic) NEC 92119-00 **[1902]**

Insertion

- catheter
- - bladder, indwelling 36800-00 **[1090]**

Amendments have been undertaken for Eleventh Edition.

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for implementation 01 January 2019.

Ref No: Q3326 | Published On: 15-Dec-2018 | Status: Retired | Retired On: 30-Jun-2019

Anaphylaxis due to latex

Q:

What codes are assigned for anaphylaxis due to latex exposure?

A:

A wide range of commercial and medical equipment products contain natural latex. In people who have developed sensitivity to natural latex proteins, direct contact (eg from wearing latex (rubber) gloves or blowing up balloons) or inhalation (eg via powdered lubricant from latex gloves), may result in minor conditions such as urticaria or allergic rhinitis, or a more severe reaction such as anaphylaxis (ASCIA 2015).

For anaphylaxis due to latex, regardless of the latex source or exposure setting, assign

T78.2 *Anaphylactic shock, unspecified* with X58 *Exposure to other specified factors.*

Follow the Alphabetic Index Section I:

Anaphylaxis T78.2

Follow the External causes of injury Alphabetic Index Section II:

Exposure (to)
- specified factors NEC X58

Also assign place of occurrence and activity codes as appropriate

Amendments have been undertaken for Eleventh Edition.

References:

ASCIA 2015, *Latex allergy*, Australian society of clinical immunology and allergy, viewed 30 July 2018, https://www.allergy.org.au/patients/product-allergy/latex-allergy

Published 15 December 2018,
for implementation 01 January 2019.

Ref No: Q3367 | Published On: 15-Dec-2018 | Status: Retired | Retired On: 30-Jun-2019

Anticoagulants not requiring INR level monitoring.

Q:

Do the guidelines in ACS 0303 *Abnormal coagulation profile due to anticoagulants* apply to Novel/Non-vitamin K Oral Anticoagulants (NOAC) (ie anticoagulants that do not require INR level monitoring)?

A:

The guidelines in ACS 0303 *Abnormal coagulation profile due to anticoagulants* apply to abnormal INR (ie abnormal coagulation profile) due to anticoagulant use; therefore, if INR monitoring is not required, ACS 0303 does not apply to the episode of care.
Note also that antiplatelets are not anticoagulants, and INR monitoring is not required when these agents are administered.
ACS 0303 states:

> Patients taking oral anticoagulants may require bridging anticoagulant therapy prior to a planned procedure. This involves replacing their usual oral anticoagulant (eg warfarin) with a short action agent such as Clexane or heparin until the patient can resume their usual anticoagulant therapy. The intention of bridging therapy is to minimise the risk of developing a thromboembolic event after a procedure.
>
> **CLASSIFICATION**
>
> If patients on long term anticoagulants require anticoagulant level monitoring during an episode of care and the INR level is within the target therapeutic range (ie no supratherapeutic or subtherapeutic INR is documented), assign Z92.1 *Personal history of long term (current) use of anticoagulants* as an additional diagnosis

ACS 0303 has been amended for Eleventh Edition. In the interim, apply the following guidelines to clarify the assignment of Z92.1:

Assign Z92.1 *Personal history of long term (current) use of anticoagulants* as an additional diagnosis if a patient is on long term anticoagulants and:

- bridging anticoagulant therapy is administered prior to or following a planned procedure, or
- anticoagulant therapy is withheld because the patient has a medical condition that contraindicates the continued use of anticoagulants, or
- anticoagulant level monitoring is undertaken during an episode of care and the INR level is within the target therapeutic range (ie no supratherapeutic or subtherapeutic INR is documented)

Published 15 December 2018,
for implementation 01 January 2019.

Ref No: Q3313 | Published On: 15-Dec-2018 | Status: Retired | Retired On: 30-Jun-2019

Dental filling not otherwise specified

Q:

What procedure code is assigned for dental restoration/filling not otherwise specified?

A:

Where there is no documentation on to the type of material used for dental restoration (filling), seek clarification from the treating clinician. When this is not possible, assign:

97511-01 **[465]** *Metallic restoration of tooth, 1 surface, direct* as per the *Inclusion* term in the ACHI Tabular List.

ACCD acknowledges that the above code is not listed as the default in the ACHI Alphabetic Index.

Amendments to this section in ACHI have been undertaken for Eleventh Edition.

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for implementation 01 January 2019.

Ref No: Q3260 | Published On: 15-Sep-2018 | Status: Retired | Retired On: 30-Jun-2019

Spontaneous/nontraumatic perinephric haematoma

Q:

What code is assigned for a spontaneous/nontraumatic perinephric haematoma with no identified cause of bleeding?

A:

The retroperitoneum is divided into anterior pararenal space, perirenal space, posterior pararenal space and the great vessel space containing the aorta and inferior venacava (Hacking & Jones 2017).

For spontaneous/nontraumatic perinephric haematoma (ie no identified cause of bleeding), assign K66.1 *Haemoperitoneum*.

Follow the Alphabetic Index:

Haematoma

- retroperitoneal (nontraumatic) K66.1

Amendments will be considered for a future edition.

References:

Hacking, C & Jones, J 2017, *Retroperitoneum*, Radiopaedia.org, viewed 27 March 2018, https://radiopaedia.org/articles/retroperitoneum

Published 15 September 2018,
for implementation 01 October 2018.

Ref No: Q3298 | Published On: 15-Sep-2018 | Status: Retired | Retired On: 30-Jun-2019

Transcranial magnetic stimulation

Q:

What ACHI code is assigned for transcranial magnetic stimulation (TMS)?

A:

Transcranial magnetic stimulation (TMS) involves stimulation of a small area on the surface of the brain through magnetic fields, generated from a coil placed on the head. TMS is performed using pulses of various intensities or frequencies administered repeatedly, for treatment of major depressive and other mental disorders. A session of TMS typically takes 10-30 minutes and is performed daily.

After a patient has responded to treatment, maintenance TMS may be implemented by gradually reducing the number of treatment sessions to prevent a relapse of depression (Rachid 2018).

Assign 96155-00 **[1880]** *Stimulation therapy, not elsewhere classified*

Follow the Alphabetic Index:

Therapy

- stimulation (using electrophysical agent) NEC 96155-00 **[1880]**

Amendments for the classification of TMS have been made in ACHI Eleventh Edition.

References:

Rachid, F 2018, Maintenance repetitive transcranial magnetic stimulation (rTMS) for relapse prevention in depression: A review, *Psychiatry Research*, vol. 262, pp. 363-372, viewed 15 April 2018, https://www-clinicalkey-com-au.ezproxy1.library.usyd.edu.au/#!/content/journal/1-s2.0-S0165178117304730

Published 15 September 2018,
for implementation 01 October 2018.

Ref No: Q3279 | Published On: 15-Sep-2018 | Status: Retired | Retired On: 30-Jun-2019

Postural Orthostatic Tachycardia Syndrome (POTS)

Q:

What code is assigned for Postural orthostatic tachycardia syndrome?

A:

Postural orthostatic tachycardia syndrome (POTS) is due to dysfunction of the autonomic nervous system that controls the heart rate, blood pressure, gastrointestinal motility and other autonomic functions of the body. Symptoms include headaches, fatigue, lightheadedness, sweating, nausea, fainting, dizziness, gastroparesis or rapid gastric emptying and orthostatic tachycardia.

The current diagnostic criteria for POTS is an increase in heart rate greater than 30 beats per minute from the lying to upright position, or greater than 120 beats per minute within 10 minutes of standing. The cause of POTS is not known (Dysautonomia International 2012; Raj 2013).

Assign G90.8 *Other disorders of autonomic nervous system* for postural orthostatic tachycardia syndrome (POTS).

Follow the Alphabetic Index:

Disorder (of) — *see also Disease*

- autonomic nervous system G90.9

- - specified NEC G90.8

Amendments will be considered for a future edition.

References:

Dysautonomia International 2012, *Postural orthostatic tachycardia syndrome*, Dysautonomia International, viewed 6 July 2018, http://www.dysautonomiainternational.org/page.php?ID=30

Raj, SR 2013, Postural orthostatic tachycardia syndrome, *Circulation: American Heart Association*, vol.127, no. 23, pp. 2336-2342, viewed 6 July 2018, http://circ.ahajournals.org/content/127/23/2336

Published 15 September 2018,
for implementation 01 October 2018.

Ref No: Q3267 | Published On: 15-Sep-2018 | Status: Retired | Retired On: 30-Jun-2019

Brachioplasty

Q:

What is the correct code to assign for brachioplasty?

A:

Brachioplasty, also known as arm lift, is the removal of excess skin and fat from the under surface of the upper arms and contouring the remaining skin resulting in a smooth, toned appearance. It is usually performed for cosmetic reasons, where there is significant skin excess and looseness, after weight loss or due to ageing (Australian Society of Plastic Surgeons 2018).

Assign:

30168-00 **[1666]** *Lipectomy, 1 excision* for unilateral brachioplasty

Or

30171-00 **[1666]** *Lipectomy, 2 or more excisions* for bilateral brachioplasty

Follow the Alphabetic Index:

Lipectomy

- arm

- - 1 excision 30168-00 **[1666]**

- - 2 excisions 30171-00 **[1666]**

Amendments will be considered for a future edition.

References:

Australian Society of Plastic Surgeons 2018, *Arm lift*, Australian Society of Plastic Surgeons, viewed 11 May 2018, https://plasticsurgery.org.au/procedures/surgical-procedures/arm-lift/

Published 15 September 2018,
for implementation 01 October 2018.

Ref No: Q3263 | Published On: 15-Sep-2018 | Status: Retired | Retired On: 30-Jun-2019

Chewing tobacco

Q:

Are codes for ‘current use’, ‘history of’ or ‘tobacco use disorder’ applicable to ‘chewing tobacco’?

A:

Chewing tobacco (a form of smokeless tobacco use) is detrimental to health and can cause a variety of health problems such as nicotine addiction, cancer of the mouth, oesophagus and pancreas, oral leucoplakia and increased risk of early delivery and still birth when used during pregnancy. The level of nicotine absorbed through the tissues of the mouth from chewing tobacco can be equivalent to or greater than that found in cigarette smokers (Centers for Disease Control and Prevention 2016, Product Safety Australia n.d.).

Research has indicated that mental and behavioural disorders (harmful use, dependence) from smoking tobacco can also occur with chewing tobacco.

Therefore, where use of chewing tobacco is documented in the record assign:

Z72.0 *Tobacco use, current*

or

F17.- *Mental and behavioural disorders due to use of tobacco*

or

Z86.43 *Personal history of tobacco use disorder*

Follow the Alphabetic Index:

Tobacco (nicotine)
- dependence F17.2
- harmful use F17.1
- hazardous use Z72.0
- intoxication F17.0
- maternal use, affecting fetus or newborn P04.2
- use NEC Z72.0
- - counselling and surveillance Z71.6
- withdrawal state F17.3

History (of) (personal)
- tobacco use disorder Z86.43

Amendments will be considered for a future edition.

References:

Centers for Disease Control and Prevention 2016, *Smokeless tobacco: health effects*. Office on Smoking and health, National Center for chronic disease prevention and health promotion, viewed 23 April 2018, https://www.cdc.gov/tobacco/data_statistics/fact_sheets/smokeless/health_effects/index.htm

Product Safety Australia n.d. *Smokeless tobacco products*, Australian Competition & Consumer Commission, viewed 7 May 2018, https://www.productsafety.gov.au/products/health-lifestyle/personal/tobacco-related-products/smokeless-tobacco-products

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for implementation 01 October 2018.

Ref No: Q3257 | Published On: 15-Sep-2018 | Status: Retired | Retired On: 30-Jun-2019

Platelet rich plasma injection into joint

Q:

What is the correct procedure code for platelet rich plasma injection into a joint?

A:

Autologous platelet-rich plasma (PRP) is blood plasma enriched with platelets. PRP contains increased concentration of proteins called growth factors that promote wound healing and bone growth. Autologous PRP is used in many fields including sports medicine, orthopaedics, cosmetics, fasciomaxillary and urology.

Intra-articular injection of autologous PRP is performed for conditions such as cartilage degeneration and osteoarthritis. The procedure involves injection of approximately 3 - 8 ml of PRP with a 21–22-gauge needle into the joint. The aim of intra-articular autologous PRP injection is to promote healing of damaged cartilage, tendons, ligaments, muscles and bones to improve joint function (Sanchez et al. 2011; Wilson 2014; Xing et al. 2017).

Assign 50124-01 **[1552]** *Administration of agent into joint or other synovial cavity, not elsewhere classified* for intra-articular PRP injection.

Follow the Alphabetic Index:

Administration

- specified site

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

Note: Interventions classified in block **[1893]** *Administration of blood and blood products* are assigned for transfusion of blood and blood products to improve circulation and replace low or missing blood components.

Amendments will be considered for a future edition.

References:

Sanchez, M, Guadilla, J, Fiz, N, & Andia, I 2012, Ultrasound-guided platelet-rich plasma injections for the treatment of osteoarthritis of the hip, *Rheumatology*, vol. 51, no. 1, pp. 144-150, viewed 28 March 2018, https://academic.oup.com/rheumatology/article/51/1/144/1776016

Wilson, JJ 2014, Platelet-rich plasma injection procedure, Arthritis-*health*, viewed 28 March 2018, https://www.arthritis-health.com/treatment/injections/platelet-rich-plasma-injection-procedure

Xing, D, Wang, B, Zhang, W, Yang, Z, Hou, Y, Chen, Y, & Lin , J, 2017, Intra-articular platelet-rich plasma injections for knee osteoarthritis: An overview of systematic reviews and risk of bias considerations, *International Journal of Rheumatic Diseases*, vol. 20, no.11, pp. 1612-1630, viewed 28 March 2018, https://onlinelibrary.wiley.com/doi/full/10.1111/1756-185X.13233

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Ref No: Q3230 | Published On: 15-Sep-2018 | Status: Retired | Retired On: 30-Jun-2019

Debridement in the oral cavity

Q:

What code is assigned for debridement of tooth, with or without repair of the oral cavity?

A:

Clinical advice confirms that debridement during a tooth extraction involves removing tooth, bone fragments or necrotic tissue in the tooth socket, and is regarded as an inherent part of the procedure; therefore a code for the debridement is not required as per ACS 0016 *General procedure guidelines* which states:

> **Do not** code procedures which are individual components of another procedure. These components would usually be considered a routine or inherent part of the more significant procedure being performed.

Assign a code for debridement of the oral cavity only when it is performed in isolation to treat a specific condition (eg infection of tooth socket).

For oral cavity debridement performed in isolation (ie not in conjunction with another dental procedure), assign 97281-00 **[456]** *Nonsurgical periodontal treatment, not elsewhere classified.*

Follow the Alphabetic Index:

Treatment

- dental

- - periodontal, nonsurgical 97281-00 **[456]**

For debridement and repair of the mucosa of the oral cavity, such as the cheek (buccal mucosa), assign 45676-00 **[406]** *Other repair of mouth.*

Follow the Alphabetic Index:

Repair

- mouth NEC 45676-00 **[406]**

Amendments have been undertaken in regard to dental interventions for Eleventh Edition.

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Ref No: Q3316 | Published On: 15-Jun-2018 | Status: Retired | Retired On: 30-Jun-2019

Chemical peritonitis

Q:

What code is assigned for chemical peritonitis that is not due to a complication of a procedure?

A:

Chemical peritonitis is a type of secondary peritonitis, due to irritants such as bile, blood, or foreign substances in the peritoneal cavity (Blum, n.d.; WebMD n.d.).

Splenic injury is a common result of blunt abdominal trauma. Haemorrhage into the peritoneum (haemoperitoneum) from splenic injury may result in chemical peritonitis.

The indexing and classification of chemical peritonitis to T81.6 *Acute reaction to foreign substance accidentally left during a procedure* originates from ICD-10 WHO. This is inappropriate for chemical peritonitis that is **not** a complication of a procedure.

Assign K65.8 *Other peritonitis* for chemical peritonitis that is not documented as due to a foreign substance accidently left in the peritoneal cavity during a procedure.

Amendments will be considered for a future edition.

References:

Bluhm, E n.d., *Splenic Injury and Hemoperitoneum,* viewed 8 March 2018, http://www.med.unc.edu/medicine/education/residency/files/pdf/hemoperitoneum.pdf

WebMD n.d., *Peritonitis,* viewed 8 March 2018, https://www.webmd.com/digestive-disorders/peritonitis-symptoms-causes-treatments#1-3

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for implementation 01 July 2018.

Ref No: Q3302 | Published On: 15-Jun-2018 | Status: Retired | Retired On: 30-Jun-2019

Transfer in third stage of labour

Q:

What codes are assigned when a patient delivers a baby at one facility, and is transferred to another facility to deliver the placenta?

A:

The third stage of labour is defined as the time between the birth of the baby and delivery of the placenta (and membranes), and is usually 10 to 30 minutes in duration. A third stage longer than 30–60 minutes is generally considered prolonged, and is associated with a significant risk of postpartum haemorrhage. Prolonged third stage may be due to a complication such as retained or adherent placenta, requiring manual or surgical removal of the placenta. (Arulkumaran S, n.d; National Institute for Health and Care Excellence 2017; Women and Newborn Health Service, King Edward Memorial Hospital 2017).

Delivery of a baby at one facility, with delivery of the placenta at another facility is **not usual practice**, due to the limited time between these two events (unless there is a condition that delays delivery of the placenta). ACCD acknowledges that in this unusual scenario, the intent was to complete the delivery at the first facility, but this was not possible due to unforeseen circumstances. Assigning delivery codes (O80-O84) at both facilities is not supported by ACCD.

Therefore, if a baby and placenta are delivered **at different facilities**:

First facility – where the baby is delivered, assign:

- a code for the delivery (O80-O84) (see also ACS 1500 *Diagnosis sequencing in delivery episodes of care*)
- a code from category Z37 *Outcome of delivery*
- Z75.3 *Unavailability and inaccessibility of health-care facilities*, if applicable
- an ACHI code for the delivery procedure

Second facility – where the placenta is delivered, assign:

- as principal diagnosis, a code for the condition that necessitated the patient's transfer (eg retained/adherent placenta)

OR

if there is no condition documented as the reason for transfer, assign O63.9 *Long labour, unspecified*

- Z39.01 Postpartum care after hospital delivery as an additional diagnosis
- an appropriate ACHI code (eg from block **[1345]** Postpartum evacuation of uterus), if applicable. Do not assign an ACHI delivery procedure code (**[1336]**–**[1340]** Delivery procedures).

Amendments to the ACS Chapter 15 Pregnancy, childbirth and the puerperium are in progress for Eleventh Edition.

References:

Arulkumaran, S n.d. The active management of the third stage of labor. The Foundation for The Global Library of Women's Medicine (GLOWM), The Safer Motherhood, Knowledge Transfer Program, London, United Kingdom, https://www.glowm.com/pdf/AMTSL_Wallchart_Single_FINAL.pdf

National Institute for Health and Care Excellence 2017, Intrapartum care pathway, Care in third stage of labour, viewed 15 January 2018, https://pathways.nice.org.uk/pathways/intrapartum.../care-in-third-stage-of-labour.pdf

Women and Newborn Health Service, King Edward Memorial Hospital, Department of Health, Government of Western Australia 2017, Clinical guidelines, Obstetrics and midwifery, Intrapartum care, Third stage of labour management, Retained placenta, B 5.10, viewed 15 January 2018, http://www.kemh.health.wa.gov.au/development/manuals/O&G_guidelines/sectionb/5/5437.pdf

Women and Newborn Health Service, King Edward Memorial Hospital, North Metropolitan Health Service, Government of Western Australia 2017, Clinical practice guideline, Labour: third stage, viewed 15 January 2018, http://www.kemh.health.wa.gov.au/development/manuals/O&G_guidelines/sectionb/5/b5.10.1.pdf

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for implementation 01 July 2018.

Ref No: Q3294 | Published On: 15-Jun-2018 | Status: Retired | Retired On: 30-Jun-2019

Administration of misoprostol

Q:

What code is assigned for administration of misoprostol to induce abortion/terminate pregnancy?

A:

Misoprostol is a prostaglandin E1 synthetic analogue that may be administered to induce abortion/terminate pregnancy. It is usually administered orally (eg buccally) following ingestion of mifespristone. Misoprostol causes softening and opening of the cervix, and uterine contractions (ie it induces labour) (Alfirevic, Aflaifel & Weeks 2014, NPS Medicinewise 2017; The Royal Hospital for Women 2013).

ACS 1511 *Termination of pregnancy* states:

> **PROCEDURES FOR TERMINATION OF PREGNANCY**
>
> Termination of pregnancy may be performed by:
>
> - extraction (eg dilation and curettage/evacuation (D&C/D&E) or suction curettage). Assign an appropriate code from **[1265]** *Curettage and evacuation of uterus.*
> - induction of labour. Assign a code from block **[1334]** *Medical or surgical induction of labour* regardless of the duration of pregnancy and outcome
> - other methods (eg insertion of prostaglandin suppository). Code specific procedure(s) performed (see ACHI Alphabetic Index).

Therefore, where Misoprostol is administered to induce labour for abortion/termination of pregnancy, assign 90465-01 **[1334]** *Medical induction of labour, prostaglandin* by following the Alphabetic Index:

Induction

- labour

- - medical (administration of pharmacological agent)

- - - prostaglandin 90465-01 **[1334]**

Amendments to ACHI Obstetric interventions are in progress for Eleventh Edition.

References:

Alfirevic, Z, Aflaifel, N & Weeks, A 2014, Oral misoprostol for induction of labour, The Cochrane Collaboration, viewed 21 March 2018, http://www.cochrane.org/CD001338/PREG_oral-misoprostol-for-induction-of-labour

NPS Medicinewise 2017, Mifepristone (Mifepristone Linepharma) followed by misoprostol (GyMiso) for terminating early pregnancy, viewed 17 January 2018, https://www.nps.org.au/medical-info/clinical-topics/news/mifepristone-mifepristone-linepharma-followed-by-misoprostol-gymiso-for-terminating-early-pregnancy

The Royal Hospital for Women 2013, *Misoprostol and mifepristone for medical termination of pregnancy and or fetal death,* viewed 17 January 2018, https://www.seslhd.health.nsw.gov.au/rhw/manuals/documents/Terminations/Misoprostol%20and%20Mifepristone%20for%20Medical%20Termination%20of%20Pregnancy%20and%20or%20Fetal%20Death.pdf

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Ref No: Q3269 | Published On: 15-Jun-2018 | Status: Retired | Retired On: 30-Jun-2019

Discharge home, or transfer in labour for administrative purposes

Q:

If a patient with a pregnancy complication is discharged home or transferred in labour for administrative purposes, is a code from Chapter 15 *Pregnancy, childbirth and the puerperium* assigned OR a code from category Z34 *Supervision of normal pregnancy*?

A:

A patient in the early stages of labour, may be discharged home to await more established labour before being readmitted for the delivery episode. Alternatively, a patient in the first stage of labour may be transferred to another facility for administrative reasons.

Guidelines regarding *discharge home/transfer in labour for administrative purposes* are included in ACS 1550 *Discharge/transfer in labour*. Although not explicit, the current guidelines are intended for 'uncomplicated' cases (that is, where there is no 'complication of pregnancy' code assigned from Chapter 15 *Pregnancy, childbirth and the puerperium*).

ACS 1550 *Discharge/transfer in labour* is under review for Eleventh Edition. In the interim, apply the following guidelines:

Where a patient in labour is discharged home or transferred to another facility for administrative reasons in the first stage of labour, and is ≥37 completed weeks of gestation, assign as principal diagnosis:

- a code from category Z34 **only** if there is no code from Chapter 15 assigned for the episode of care

OR

- a code from Chapter 15 for any documented complication of pregnancy.

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for implementation 01 July 2018.

Ref No: Q3244 | Published On: 15-Jun-2018 | Status: Retired | Retired On: 30-Jun-2019

Debridement of wound outside of theatre

Q:

When non viable skin is debrided outside of theatre, is it considered excisional or nonexcisional debridement?

A:

ACCD acknowledges ACS1203 *Debridement* is ambiguous for classification of debridement and wound management outside of theatre, with regard to the debridement being classified as excisional or nonexcisional.

Clinical coders cannot assume the debridement is either excisional or nonexcisional based upon the use of a sharp surgical instrument, as this does not necessarily indicate the debridement is excisional if only loose fragments of tissue were removed (Chand 2014).

Clinical coders should always be guided by clinical documentation. Follow the guidelines in ACS 1203 *Debridement* which states:

…

- **most** debridements are excisional
- check with the clinician if unsure
- use the nonexcisional code if documentation/clinical advice supports its use

Note: a review of the ACHI debridement codes and the relevant ACS are in progress for Eleventh Edition.

In the interim:

- where the term ‘excisional’ is documented by a clinician (eg specialist nurse or medical professional) for the debridement outside of theatre, assign a code for excisional debridement.
- where wound debridement is performed in an operating theatre using cerebral anaesthesia, assign 90665-00 **[1628]** *Excisional debridement of skin and subcutaneous tissue* if there is no documentation or clinical advice to the contrary.
- where documentation is unclear, seek clinical clarification to determine if the debridement is excisional or nonexcisional. Assign a code for nonexcisional debridement if documentation or clinical advice supports its use.

Note: Amendment made, however this coding advice remains effective as at July 1, 2018

References:

Chand, D 2014, *‘Excisional versus non-excisional debridement’*, Akron Children’s Hospital, Akron, viewed 23 November 2017, http://doctors.akronchildrens.org/2014/09/cdi-team-excisional-versus-non-excisional-debridement/

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Ref No: Q3265 | Published On: 15-Mar-2018 | Status: Retired | Retired On: 30-Jun-2019

Additional diagnoses in delivery episodes of care

Q:

Do the guidelines in ACS 1521 *Conditions and injuries in pregnancy* apply to complications of labour and delivery?

A:

ACS 1521 *Conditions and injuries in pregnancy* was updated for Tenth Edition to provide comprehensive guidelines for nonobstetric conditions complicating pregnancy. The Tenth Edition amendments to ACS 1521 built upon the logic contained in previous versions of the ACS (previously titled *Conditions complicating pregnancy*).

The guidelines in ACS 1521 have never been applied to labour and delivery episodes of care.

The *Conventions used in the Tabular List of Diseases/Multiple condition coding* state:

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

ACS 1500 *Diagnosis sequencing in delivery episodes of care/Other additional diagnoses in delivery episodes of care* states:

> Assign codes for other conditions/complications (pregnancy, childbirth, puerperal or nonobstetric) that meet the criteria for an additional diagnosis in ACS 0002 *Additional diagnoses*.

For example, to classify *maternal exhaustion complicating labour*, if the exhaustion meets the criteria in ACS 0002, follow the Alphabetic Index:

Exhaustion (physical) NEC R53

- maternal, complicating delivery O75.8

Assign:

O75.8 *Other specified complications of labour and delivery*

R53 *Malaise and fatigue*

This is consistent with coding practice in previous editions of ICD-10-AM.

Amendments to the classification and ACS for obstetrics are continuing for Eleventh Edition.

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for implementation 01 April 2018.

Ref No: Q3262 | Published On: 15-Mar-2018 | Status: Retired | Retired On: 30-Jun-2019

Genital herpes in pregnancy

Q:

What codes are assigned for genital herpes in pregnancy?

A:

Genital herpes is a common sexually transmitted infection (STI).

Assign the following codes for genital herpes in pregnancy:

O98.3 *Other infections with a predominantly sexual mode of transmission in pregnancy, childbirth and the puerperium*

A60.0 *Herpesviral infection of genitalia and urogenital tract*

N77.0* *Ulceration of vulva in infectious and parasitic diseases classified elsewhere*

OR

N77.1* *Vaginitis, vulvitis and vulvovaginitis in infectious and parasitic diseases classified elsewhere*

Follow the Alphabetic Index:

Pregnancy (single) (uterine) — *see also condition/in pregnancy*
- complicated by
- - conditions in
- - - A55–A64 O98.3

Herpes, herpetic

…
- genital, genitalis
- - female A60.0† N77.-*

See also the *Inclusion* term at A60.0 *Herpesviral infection of genitalia and urogenital tract.*

Amendments are being considered for ICD-10-AM Eleventh Edition.

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for implementation 01 April 2018.

Ref No: Q3258 | Published On: 15-Mar-2018 | Status: Retired | Retired On: 30-Jun-2019

Ligament pain in pregnancy

Q:

What code is assigned for ligament pain (eg broad ligament, round ligament) in pregnancy?

A:

Ligament (eg broad ligament, round ligament) pain is common in pregnancy, usually due to stretching as the uterus expands.

Where there is documentation of ‘broad ligament pain’, ‘round ligament pain’, or ‘ligament pain’ NOS (not otherwise specified) in pregnancy, meeting the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses,* assign O34.8 *Maternal care for other abnormalities of pelvic organs.*

Follow the Alphabetic Index:

Pregnancy (single) (uterine)

- complicated by

- - abnormal, abnormality

- - - pelvic organs or tissues

- - - - specified NEC O34.8

Amendments are being considered for ICD-10-AM Eleventh Edition.

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for implementation 01 April 2018.

Ref No: Q3252 | Published On: 15-Mar-2018 | Status: Retired | Retired On: 30-Jun-2019

Benign juvenile granulosa cell tumour (JGCT) of the testis

Q:

What codes are assigned for benign juvenile granulosa cell tumour (JGCT) of the testis?

A:

Granulosa cell tumours are types of stromal cell tumours. There are two types of granulosa cell tumours; adult or juvenile. Juvenile granulosa cell tumours (JGCT) of the testis are rare, benign tumours that present most commonly in the perinatal period (Bulotta et al 2012; Rane 2017).

ICD-10-AM Appendix A *Morphology of neoplasms* contains a table correlating behaviour codes with Chapter 2 *Neoplasms* categories. As indicated by the table, /1 behaviour codes are usually assigned with D37-D48 *Neoplasms of uncertain or unknown behaviour.* There are, however, exceptions where behaviour codes are assigned that do not correlate with the listed Chapter 2 topography codes (see *Note* at D45 *Polycythaemia vera*, D46 *Myelodysplastic syndromes* and D47 *Other neoplasms of uncertain or unknown behaviour of lymphoid, haematopoietic and related tissue*).

Juvenile granulosa cell tumours are classified as per ICD-O Third Edition with behaviour code /1 *Uncertain whether benign or malignant*. ICD-10-AM does not list a morphology code for JGCT with benign behaviour. Therefore, assign as a best fit for benign JGCT of the testis:

D29.2 *(Benign neoplasm of) Testis*

M8622/1 *Granulosa cell tumour, juvenile*

Follow the Alphabetic Index:

Neoplasm, neoplastic

- testis (Benign) D29.2

Tumour

- granulosa cell

- - juvenile (M8622/1)

Amendments will be considered for a future edition.

References:

Bulotta, A, Molinaro, F, Angotti, R, Ferrara, F, Di Maggio, G, Bindi, E & Messina, M 2012, 'Juvenile granulosa cell tumor of the testis: prenatal diagnosis and prescrotal approach', Italian Journal of Pediatrics, 2012; 38: 67, viewed 18 September 2017, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3585781/

Rane, SU 2017, *Testis and epididymis*. Sex cord stromal tumors. Juvenile granulosa cell tumor, PathologyOutlines.com Inc, viewed 18 September 2017, http://www.pathologyoutlines.com/topic/testisgranulosajuvenile.html

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for implementation 01 April 2018.


IHACPA

Ref No: Q3246 | Published On: 15-Mar-2018 | Status: Retired | Retired On: 30-Jun-2019

Non-malignant stromal endometriosis

Q:

What code is assigned for non-malignant stromal endometriosis?

A:

Stromal endometriosis, presenting usually in the form of superficial nodules or plaques, is a relatively common form of endometriosis. It typically occurs in association with classic endometriosis but occasionally occurs on its own (Boyle & McCluggage, 2009).

Where there is documentation of stromal endometriosis with no evidence of malignancy, follow the Alphabetic Index at the lead term *Endometriosis* and select a subterm for the *specific site*.

For example:

Peritoneal biopsy of endometriosis deposits.

Histopathology report states: stromal endometriosis; no atypia or evidence of malignancy seen.

Assign: N80.3 *Endometriosis of pelvic peritoneum*

Follow the Alphabetic Index:

Endometriosis

- peritoneal (pelvic) N80.3

Amendments will be considered for a future edition.

References:

Boyle D & McCluggage, W 2009, Peritoneal stromal endometriosis: A detailed morphological analysis of a large series of cases of a common and under-recognised form of endometriosis, Journal of Clinical Pathology, 2009; 62: 530-533, viewed 18 September 2017, https://www.researchgate.net/publication/23803087_Peritoneal_stromal_endometriosis_A_detailed_morphological_analysis_of_a_large_series_of_cases_of_a_common_and_under-recognised_form_of_endometriosis

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Ref No: Q3233 | Published On: 15-Mar-2018 | Status: Retired | Retired On: 30-Jun-2019

Cerebral infarction with haemorrhagic transformation

Q:

What code is assigned for cerebral infarction with haemorrhagic transformation?

A:

Cerebral (ischaemic) infarction may be complicated by haemorrhagic transformation (HT) (also known as haemorrhagic conversion). There are two main types of HT:

- haemorrhagic infarction (HI); petechial haemorrhages at the infarct margins or throughout the infarct, without mass effect. HI occurs commonly in the natural evolution of an acute embolic stroke and is usually asymptomatic.
- parenchymal haematoma (PH); (secondary) intracerebral haematoma with mass effect (ie. ischaemic infarct with superimposed cerebral haemorrhage). PH is less common, but is symptomatic due to extension and mass effect beyond the original infarct territory.

Haemorrhagic transformation may occur spontaneously, or as a complication of anticoagulant/thrombolytic therapy (Gaillard 2017; The Internet Stroke Center 2017; Zhang et al. 2014).

In the absence of a precoordinated code for *cerebral infarction with haemorrhagic transformation*, assign codes from categories I63 *Cerebral infarction* and I61 *Intracerebral haemorrhage* as per the guidelines in the *Conventions used in the Tabular List of Diseases/Multiple condition coding*:

In Australia, multiple condition coding (meaning that multiple conditions may be assigned in an episode of care) is used to provide the necessary specificity to fully describe the episode of care.

Follow the Alphabetic Index and select an appropriate code from the subterms:

Infarct, infarction (of)
- cerebral I63.9
- - due to
- - - cerebral venous thrombosis, nonpyogenic I63.6
- - - embolism
- - - - cerebral arteries I63.4
- - - - precerebral arteries I63.1
- - - occlusion NEC
- - - - cerebral arteries I63.5
- - - - precerebral arteries I63.2
- - - stenosis NEC
- - - - cerebral arteries I63.5
- - - - precerebral arteries I63.2
- - - thrombosis

- - - - cerebral arteries I63.3

- - - - precerebral arteries I63.0
- - specified NEC I63.8

Haemorrhage, haemorrhagic

- cerebellar, cerebellum (nontraumatic) I61.4
- cerebral, cerebrum *(see also Haemorrhage/intracerebral)* I61.9
- - lobe I61.1
- intracerebral (nontraumatic) I61.9
- - deep I61.0
- - in
- - - brain stem I61.3
- - - cerebellum I61.4
- - - hemisphere I61.2
- - - - cortical I61.1
- - - - subcortical I61.0
- - intraventricular I61.5
- - multiple localised I61.6
- - specified NEC I61.8
- - superficial I61.1

See also ACS 0303 *Abnormal coagulation profile due to anticoagulants* and ACS 1902 *Adverse effects.*

Amendments will be considered for a future edition.

References:

Dove, H.G, Schneider, K.C & Wallace, J.D 1984, 'Evaluating and predicting outcome of acute cerebral vascular accident', *Stroke. Journal of the American Heart Association,* 1984;15:858-864, viewed 27 July 2017, http://stroke.ahajournals.org/content/strokeaha/15/5/858.full.pdf

Gaillard, F 2017, *Haemorrhagic transformation of an ischaemic infarct,* Radiopaedia.org viewed 27 July 2017, https://radiopaedia.org/articles/haemorrhagic-transformation-of-an-ischaemic-infarct

The Internet Stroke Center 2017, 'Hemorrhagic conversion', Genentech, Inc. viewed 27 July 2017, http://www.strokecenter.org/professionals/brain-anatomy/cerebral-embolism-formation/hemorrhagic-conversion/

Zhang, J, Yang, Y, Sun, H & Xing, Y 2014, 'Hemorrhagic transformation after cerebral infarction: current concepts and challenges', *Annals of Translational medicine,* 2014 Aug; 2(8): 81, viewed 27 July 2017, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4200641/

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Ref No: Q3226 | Published On: 15-Mar-2018 | Status: Retired | Retired On: 30-Jun-2019

Corneal collagen cross-linking (CXL) for keratoconus

Q:

What code is assigned for corneal collagen cross-linking (CXL), performed for keratoconus?

A:

Keratoconus or conical cornea is thinning of the central zone of the cornea. As the disease progresses, normal eye pressure causes the round shape of the cornea to distort developing an irregular cone-like bulge, resulting in significant visual impairment.

Corneal collagen cross-linking, also known as corneal crosslinking (CXL), is a relatively new procedure that slows or halts progression in keratoconus. It achieves this through a chemical reaction using a combination of riboflavin (vitamin B_2) and ultraviolet (UVA) light to strengthen the crosslinks between the collagen fibres within the stroma layer of the cornea.

There are two protocols of CXL, the epithelium-off and epithelium-on methods. In the epithelium-off protocol, the outer most layer (epithelium) of the cornea is removed and the eye is soaked in riboflavin drops for 30 minutes. The cornea is then irradiated with ultraviolet A (UVA) light for 30 minutes with riboflavin drops inserted regularly during this stage. The epithelium-on method leaves the epithelium intact to lower the risk of infection and reduce the post-operative pain and healing period for the patient (Keratoconus Australia n.d., MSAC 2017).

Assign 90066-00 **[174]** *Other repair of cornea* for corneal collagen cross-linking.

Follow the Alphabetic Index:

Repair

- cornea, corneal (laceration) NEC 90066-00 **[174]**

Amendments will be considered for a future edition.

References:

Keratoconus Australia n.d., Corneal crosslinking, viewed 26 November 2017, https://www.keratoconus.org.au/treatments/corneal-collagen-crosslinking/

Medical services advisory committee 2017, Corneal Collagen Cross Linking as early intervention in progressive keratoconus, viewed 26 November 2017, http://www.msac.gov.au/internet/msac/publishing.nsf/content/1392-public

Published 15 March 2018,
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Ref No: Q3237 | Published On: 15-Dec-2017 | Status: Retired | Retired On: 30-Jun-2019

Pressure injury with diabetes mellitus

Q:

Is a pressure injury classified as a complication of diabetes mellitus?

A:

ACS 1221 *Pressure injury* states that synonymous terms for pressure injury include pressure ulcer, decubitus ulcer, pressure area, plaster ulcer and bedsore.

ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia/General classification rules for DM and IH* states:

> **Rule 3.**
>
> The classification includes conditions (often termed 'complications') which occur commonly with DM or IH. These conditions may or may not have been a direct consequence of the metabolic disturbance and are indexed under *Diabetes, with* or *Hyperglycaemia/intermediate/with*. Always refer to these index entries to classify DM or IH (see examples 2-7).

None of the synonyms listed above for pressure injury are listed in the Alphabetic Index under *Diabetes, with.* Therefore, the guidelines in ACS 0401 for 'complications' of diabetes mellitus do not apply to pressure injury in a patient with diabetes mellitus, unless the criteria for diabetic foot are met.

See also ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia/6. Diabetic foot.*

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Pathology and other test results reproduced or copied into electronic documents

Q:

Can pathology and other test results reproduced or copied into electronic documents be used for code assignment?

A:

ACS 0010 General abstraction guidelines/Test results states:

> …
>
> Before coding any diagnosis/procedure recorded, the clinical coder must verify information recorded on the front sheet and/or the discharge summary by reviewing pertinent documents in the body of the clinical record.
>
> …
>
> Laboratory, x-ray, pathological and other diagnostic results should be coded where they clearly add specificity to already documented conditions that meet the criteria for a principal diagnosis (see ACS 0001 Principal diagnosis) or an additional diagnosis (see ACS 0002 Additional diagnoses).

The Introduction of the Australian Coding Standards states:

> …
>
> coding decisions are not made solely based on information provided on clinical record front sheet and/or the discharge summary (or a copy of the same) but that analysis of the entire clinical record is performed before code assignment. …
>
> and
>
> …
>
> When a diagnosis is recorded for which there is no supporting documentation in the body of the clinical record, it may be necessary to consult with the clinician before assigning a code.

The access to or inclusion of test results in an electronic medical record is no different to a printed result within a paper-based record. Therefore, apply the above guidelines where test results are included in an electronic medical record.

See also ACS 0010 General abstraction guidelines and Coding Rule: Coding from test results and findings on radiological reports.

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Preparatory care for dialysis code

Q:

Is supplementary code U87.1 *Chronic kidney disease, stage 3–5* or N18.*5 Chronic kidney disease, stage 5* assigned when a patient is admitted for creation of an AV fistula for haemodialysis?

A:

ACS 1438 Chronic kidney disease/Classification states:

> Chronic kidney disease (N18.-) must be assigned in all episodes of care when a diagnosis of chronic kidney disease (or chronic renal failure) is documented and meets the criteria for an additional diagnosis (see ACS 0002 Additional diagnoses).

When a patient with chronic kidney disease (CKD) is admitted for creation of an AV fistula for haemodialysis, do not assign a code for CKD unless it meets the criteria in ACS 0002 Additional diagnoses. Note that creation of the AV fistula is to obtain vascular access for haemodialysis, and is not a therapeutic treatment for CKD, and thus cannot be used as a criterion for assignment of CKD as per ACS 0002.

In this scenario assign:

Z49.0 *Preparatory care for dialysis*

U87.1 *Chronic kidney disease, stage 3–5*

Assign ACHI codes as appropriate.

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Placental site nodule

Q:

What code is assigned for placental site nodule?

A:

A placental site nodule (PSN) is a rare, benign, nonmolar nonneoplastic lesion that may be identified months or years following delivery. Patients present with abnormal vaginal bleeding (eg menorrhagia, intermenstrual bleeding) or an abnormal Pap smear. PSN is usually a histological finding, not a clinical diagnosis (Jacob & Mohapatra 2009; Pramanick et al 2014). Because of their small size and circumscription, they are usually completely removed by the surgical procedure (eg dilation and curettage) that led to their discovery (Shih, 2009).

Assign O90.8 *Other complications of the puerperium, not elsewhere classified* for placental site nodules meeting the criteria in ACS 0002 *Additional diagnoses* (except for same-day endoscopy – see below).

Follow the Alphabetic Index:

Puerperal, puerperium

- complications

- - specified NEC O90.8

ACS 0051 *Same-day endoscopy – Diagnostic/Classification* states:

> **1. Symptom/condition documented as the indication for endoscopy:**
>
> **1.1 If a causal link is documented** between the indication/symptom and any of the findings, that is, either the clinician documents the link, or the classification directs clinical coders to assume a link:

- assign as principal diagnosis a code for the finding identified as the cause of the indication and do not assign a code for the indication/symptom (see also *Note* at the beginning of Chapter 18 *Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified*)
- assign codes for all other findings as additional diagnoses (note these findings do not need to meet the criteria in ACS 0002 *Additional diagnoses*).

> **1.2 If no causal link is documented** between the indication/symptom and any of the findings:
>
> - assign a code for the indication/symptom as the principal diagnosis
> - assign codes for all findings as additional diagnoses.

Therefore, assign O90.8 for a histological finding of placental site nodule following same-day endoscopy (ie hysteroscopy), and sequence as per the above guidelines.

Do not assign Z39.0- *Postpartum care and examination immediately after delivery* unless the episode of care is within the puerperal period (see ACS 1548 *Puerperal/postpartum condition or complication/ Postpartum care and examination immediately after delivery*).

Amendments will be considered for a future edition.

References:

Jacob, S & Mohapatra, D 2009, 'Placental site nodule: a tumor-like trophoblastic lesion', *Indian Journal of Pathology and Microbiology*, 2009 Apr-Jun;52(2):240-1, viewed 6 June 2017, https://www.ncbi.nlm.nih.gov/pubmed/19332926

Pramanick, A, Hwang, W, & Mathur, M 2014, 'Case report. Placental site nodule (PSN): an uncommon diagnosis with a common presentation', *BMJ Case Reports*, 2014; doi:10.1136/bcr-2013-203086, viewed 6 June 2017, http://casereports.bmj.com/content/2014/bcr-2013-203086.full

Shih, I-M 2009, *Gynecologic Pathology: A Volume in the Series: Foundations in Diagnostic Pathology,* viewed 19 July 2017, https://www-clinicalkey-com-au.ezproxy1.library.usyd.edu.au/#!/content/book/3-s2.0-B9780443069208500201

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Ref No: Q3205 | Published On: 15-Dec-2017 | Status: Retired | Retired On: 30-Jun-2019

Acute kidney injury with chronic kidney disease (stage 3-5)

Q:

When a patient is admitted with acute kidney injury (AKI) on a background of chronic kidney disease (CKD) stage 3-5, but only the AKI is actively managed, is U87.1 *Chronic kidney disease, stage 3-5* or N18.3-N18.5 *Chronic kidney disease* assigned with the AKI code?

A:

ACS 0001 *Principal diagnosis*/Acute and chronic conditions states:

> If a condition is described as both acute (subacute) and chronic **and separate subterms exist in the Alphabetic Index at the same indentation level**, code both and sequence the acute (subacute) code first.

Therefore, where a patient is admitted with acute kidney injury (AKI) on a background of chronic kidney disease (CKD), assign codes for both conditions.

Follow the Alphabetic Index:

Injury

- kidney

- - nontraumatic — see Failure/kidney

Failure, failed

- kidney N19

- - acute N17.9

- - - with

- - - - cortical necrosis N17.1

- - - - medullary necrosis N17.2

- - - - tubular necrosis N17.0

- - - puerperal, postpartum O90.4

- - - specified NEC N17.8

- - chronic — see Disease/kidney/chronic

- - - end-stage (CKD stage 5) N18.5

- - - hypertensive (see also Hypertension/kidney) I12.0

See also ACS 1438 *Chronic kidney disease.*

References:

National Institutes of Health 2014, Acute kidney injury, chronic kidney disease each a risk of the other, NIH, Bethesda, viewed 16 August 2017, https://www.nih.gov/news-events/news-releases/acute-kidney-injury-chronic-kidney-disease-each-risk-other

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Ref No: Q3241 | Published On: 15-Dec-2017 | Status: Retired | Retired On: 30-Jun-2019

HELLP syndrome

Q:

When both pre-eclampsia and HELLP syndrome are documented in the clinical record, are two codes assigned?

A:

In ICD-10-AM HELLP syndrome is classified as a type of pre-eclampsia, as per ICD-10. The codes listed in category O14 *Pre-eclampsia* represent a continuum of pre-eclampsia severity; mild/moderate, severe, and HELLP syndrome. This is highlighted in a number of other international classifications:

- ICD-11 (Beta) describes HELLP syndrome as: Severe preeclampsia associated with hemolysis, elevated liver enzymes, or low platelets
- ICD-10-CM (USA) lists an *Inclusion* term at O14.2 *HELLP syndrome*: Severe pre-eclampsia with hemolysis, elevated liver enzymes and low platelet count
- SNOMED CT lists HELLP syndrome as a subclassification of severe pre-eclampsia (disorder)

Therefore, for classification purposes (severe) pre-eclampsia is inherent in O14.2 *HELLP syndrome.*

Amendments will be considered for a future edition.

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Ref No: Q3203 | Published On: 15-Dec-2017 | Status: Retired | Retired On: 30-Jun-2019

MonaLisa™ Touch procedure

Q:

What code is assigned for MonaLisa™ Touch procedure?

A:

MonaLisa Touch™ is a new treatment for vaginal atrophy (and its symptoms such as vaginal dryness, irritation and fissures). MonaLisa Touch™ uses a carbon dioxide laser to deliver a precise amount of heat to the vaginal wall, stimulating regeneration of the vaginal tissue, promoting proliferation of the cells, and restoration of vaginal wall strength and blood supply. This action causes micro-lesions, triggering the process of collagen reproduction, which in turn re-balances vaginal mucosa, and re-establishes the correct vaginal pH (High Tech Laser Australia 2017; MonaLisa Touch™ 2017).

Assign 35539-01 **[1281]** *Laser destruction of lesion of vagina* for MonaLisa Touch™ by following the Alphabetic Index:

Laser therapy

- vagina 35539-01 **[1281]**

Amendments will be considered for a future edition.

References:

High Tech Laser Australia 2013, *Mona Lisa Touch*, viewed 19 June 2017, http://www.monalisatouch.com.au/about-monalisa-touch-vaginal-atrophy-treatment.php

Mona Lisa Touch 2015, *Mona Lisa Touch – The new laser therapy*, Italy, viewed 19 June 2017, http://www.monalisatouch.com/monalisatouch-the-laser-therapy/

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Ref No: Q3200 | Published On: 15-Dec-2017 | Status: Retired | Retired On: 30-Jun-2019

Immunisation in a delivery episode of care

Q:

Is a code required when a patient receives immunisation during a delivery episode of care?

A:

Immunisation is not routinely provided to all patients following delivery. Women who are under immunised (that is, have a suboptimal level of immunisation) against certain infectious diseases during pregnancy, may receive immunisation in the postpartum period (Australian Government Department of Health 2016; Farlex, Inc 2017).

ACS 1500 *Diagnosis sequencing in delivery episodes of care* states:

> Assign codes for other conditions/complications (pregnancy, childbirth, puerperal or nonobstetric) that meet the criteria for an additional diagnosis in ACS 0002 *Additional diagnoses*.

Where there is documentation identifying that a patient requires, and is provided with immunisation in the delivery episode, assign an appropriate code for *Need for immunisation…* by following the Alphabetic Index at the lead term *Vaccination,* by type of vaccination.

Assign an ACHI code by following the Alphabetic Index at the lead term *Vaccination/by type.*

For example, if a patient is immunised with measles-mumps-rubella (MMR) vaccine in the delivery episode, assign Z27.4 *Need for immunisation against measles-mumps-rubella [MMR]* and 92156-00 **[1882]** *Administration of measles-mumps-rubella vaccine* by following the Alphabetic Indexes:

ICD-10-AM Alphabetic Index

Vaccination

- prophylactic (against)

- - measles-mumps-rubella (MMR) Z27.4

ACHI Alphabetic Index

Vaccination (against) (prophylactic)

- measles

- - with mumps and rubella combined 92156-00 **[1882]**

Amendments will be considered for a future edition.

References:

Australian Government Department of Health 2016, Immunisation and pregnancy, viewed 24 May 2017, http://www.pregnancybirthbaby.org.au/immunisation-and-pregnancy

Farlex, Inc 2017, Underimmunization, The free dictionary, viewed 24 May 2017 http://medical-dictionary.thefreedictionary.com/underimmunization

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Ref No: Q3193 | Published On: 15-Dec-2017 | Status: Retired | Retired On: 30-Jun-2019

Replacement of cochlear implant magnet

Q:

What code is assigned for replacement of a cochlear implant magnet?

A:

Cochlear implants contain internal and external magnets. The external (sound processor) magnet maintains the position of the sound processor (the device component that receives sound) over the internal (implant) magnet. The main component of the device is implanted into the inner ear (cochlear).

Internal magnets may require temporary removal in order for an MRI (magnetic resonance imaging) to be performed; the magnet is reinserted following the MRI. Internal magnets may also be replaced due to a complication (for example, dislodgement) (Cochlear Ltd 2017).

ACHI contains codes for implantation and removal of cochlear prosthetic devices in block **[329]** *Application, insertion or removal procedures on inner ear*:

41617-00 **[329]** *Implantation of cochlear prosthetic device*

41617-01 **[329]** *Removal of cochlear prosthetic device*

Assign both of the above codes for replacement of the entire cochlear implant device (that is, both the magnets and the cochlear component). It is not appropriate to assign these codes for replacement of the internal magnet alone.

Block **[1870]** *Interventions involving assistive or adaptive device, aid or equipment* includes auditory aid [cochlear implant] [hearing aid]. Therefore, where a cochlear implant magnet is replaced, assign 96092-00 **[1870]** *Application, fitting, adjustment or replacement of other assistive or adaptive device, aid or equipment* as a best fit by following the Alphabetic Index:

Replacement

- assistive or adaptive device, aid or equipment NEC 96092-00 **[1870]**

Amendments will be considered for a future edition.

References:

Cochlear Ltd 2017, *Baha® Bone Conduction Implants,* viewed 10 May 2017, http://www.cochlear.com/wps/wcm/connect/uk/home/discover/baha-bone-conduction-implants

Cochlear Ltd 2017, *Magnetic connection,* viewed 10 May 2017, http://www.cochlear.com/wps/wcm/connect/uk/home/support/baha-system/connections/sp-magnet

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Ref No: Q3191 | Published On: 15-Dec-2017 | Status: Retired | Retired On: 30-Jun-2019

Deroofing of a blister

Q:

What code is assigned for deroofing of a blister?

A:

Deroofing a blister involves removing the top layer of skin from the blister. This is performed for a number of reasons including to remove non-viable tissue, to assess the wound bed, to ease the pain of the blister, and to reduce the risk of infection (North Bristol NHS 2016).

Deroofing of blisters is often undertaken with a dressing change or debridement, and may be performed on the ward with no anaesthesia. In this case the blister deroofing is an inherent component of the dressing or debridement, and is not coded as per ACS 0016 *General Procedure Guidelines, Procedure Component.*

Where blister 'deroofing' is performed in an operating theatre under anaesthesia without any other intervention for the blister site (ie changing of dressing or debridement), assign 90665-00 **[1628]** *Excisional debridement of skin and subcutaneous tissue* by following the Alphabetic Index:

Debridement

- skin

- - excisional 90665-00 **[1628]**

As blisters may be nontraumatic or due to an external cause such as burns, see also ACS 1203 *Debridement* and ACS 1911 *Burns/Dressing/debridement of burns*, if applicable.

See also Coding Rule: *Debridement of burn performed with change of dressing* and

Coding Rule: *Wound debridement.*

Improvements to the classification of wound management is currently under review for Eleventh Edition.

References:

North Bristol NHS Trust 2016, *The de-roofing of burns blisters*, United Kingdom, viewed 19 June 2017, https://www.nbt.nhs.uk/sites/default/files/attachments/The%20De-roofing%20of%20Burns%20Blisters_NBT002996.pdf

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Ref No: Q3180 | Published On: 15-Dec-2017 | Status: Retired | Retired On: 30-Jun-2019

Acanthoma

Q:

What codes are assigned for an acanthoma of the skin, with no evidence of malignancy?

A:

Acanthomas are benign tumours of epidermal keratinocytes (Le Boit et al, 2016).

Malignant clear cell acanthomas, which are rare, are classified morphologically to M8070/3 *Squamous cell carcinoma NOS* as per the Alphabetic Index.

Where there is documentation of acanthoma of the skin with no evidence of malignancy, assign as a best fit:

D23.- *Other benign neoplasm of skin*

M8000/0 *Neoplasm, benign*

Follow the Alphabetic Index:

Neoplasm, neoplastic

- skin (nonmelantoic)/by site/benign

and

Tumour

- benign (unclassified) (M8000/0) — *see Neoplasm/benign*

Amendments will be considered for a future edition.

Reference:

LeBoit P.E., Burg G., Weedon D, Sarasain A. (Eds.) 2006 World Health Organization Classification of Tumours: Pathology and Genetics of Skin Tumours, IARC Press Lyon, France.

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Ref No: Q3178 | Published On: 15-Dec-2017 | Status: Retired | Retired On: 30-Jun-2019

Radiofrequency ablation of the nasal turbinates

Q:

What code is assigned for radiofrequency ablation (RFA) of the nasal turbinates?

A:

Radiofrequency ablation is a minimally invasive destruction technique using radiofrequency energy, rather than electrical energy used in diathermy, to heat the soft tissue to a temperature that induces cell death. It is used in patients with hypertrophy of the nasal turbinates to reduce the bulk of the nasal turbinates and reduce nasal obstruction (HealthPACT, 2016).

Assign 41674-00 **[374]** *Cauterisation or diathermy of nasal turbinates* as a best fit for radiofrequency ablation of the nasal turbinates by following the Alphabetic Index:

Diathermy

- nose, nasal

- - turbinates 41674-00 **[374]**

Amendments will be considered for a future edition.

References:

Health Policy Advisory Committee on Technology (HealthPACT), 2016, *Technology Brief Radiofrequency Ablation for Hypertrophy of the Inferior Nasal Turbinates*, viewed 11 May 2017, https://www.health.qld.gov.au/__data/assets/pdf_file/0020/427016/wp215.pdf

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Assigning multiple manifestation (asterisk) codes paired with the same aetiology (dagger) code

Q:

Can multiple manifestation (asterisk) codes be assigned when paired with the same aetiology (dagger) code?

A:

Where multiple manifestation (asterisk) codes are paired with the same aetiology (dagger) code, assign the aetiology code once only, as per the guidelines in ACS 0025 *Double coding.*

Example 1:

Systemic lupus erythematosus with nephritis, pleuritis and pericarditis

Assign:

M32.1† *Systemic lupus erythematosus with organ or system involvement*

J99.1* *Respiratory disorders in other diffuse connective tissue disorders*

N08.5* *Glomerular disorders in systemic connective tissue disorders*

I32.8* *Pericarditis in other diseases classified elsewhere*

Example 2:

Lewy body disease with dementia and Parkinson's disease

Assign:

G31.3† *Lewy body disease*

F02.8* *Dementia in other specified diseases classified elsewhere*

G22* *Parkinsonism in diseases classified elsewhere*

Assign and sequence codes as per the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*.

Amendments will be considered for a future edition.

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Transarterial chemoembolisation of the liver

Q:

What is the correct code to assign for a transarterial chemoembolisation (TACE) of the liver?

A:

Transarterial chemoembolisation (TACE) is a combination of chemotherapy (pharmacotherapy) and embolisation.

Embolisation involves injecting soft, gelatinous sponges, or tiny plastic beads into a blood vessel via a catheter. This material blocks or slows down the blood supply to an organ, causing any tumours within to shrink and/or die.

Chemoembolisation involves administration of chemotherapeutic agents within the beads used in the embolisation procedure (Canadian Cancer Society 2017, Cancer Council NSW 2016).

For transarterial chemoembolisation (TACE) of the liver (ie the chemotherapeutic agent is administered locally) assign:

35321-05 **[768]** *Transcatheter embolisation of blood vessels, abdomen*

and

35317-02 **[741]** *Peripheral arterial or venous catheterisation with administration of other therapeutic agent*

Follow the Alphabetic Index:

Embolisation

- blood vessel, transcatheter

- - liver 35321-05 **[768]**

and

Chemotherapy

- for local effect (open) (percutaneous) (via peripheral arterial or venous catheterisation) 35317-02 **[741]**

References:

Canadian Cancer Registry, Transarterial chemoembolization (TACE) for liver cancer 2017, Canadian Cancer Registry, Toronto, viewed 11 April 2017, http://www.cancer.ca/en/cancer-information/cancer-type/liver/treatment/transarterial-chemoembolization/?region=on

Cancer Council NSW, Transarterial chemoembolisation (TACE) 2016, Cancer Council NSW, Woolloomooloo, viewed 11 April 2017, https://www.cancercouncil.com.au/liver-cancer/treatment/tace/

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Respiratory epithelial adenomatoid hamartoma (REAH)

Q:

What codes are assigned for a respiratory epithelial adenomatoid hamartoma?

A:

A hamartoma is a benign neoplasm that results from overgrowth of glands indigenous to a particular site. Hamartomas tend to originate from the lung, liver, spleen, kidney, intestine and the upper aerodigestive tract.

Respiratory epithelial adenomatoid hamartoma (REAH) (also referred to as glandular hamartoma and seromucinous hamartoma), is a benign lesion of the nasal cavity, paranasal sinuses and nasopharynx. They often arise in the context of inflammatory polyps within the nasal cavity and are usually diagnosed on pathology in patients undergoing endoscopic sinus surgery (Barnes et al. 2005; Davison et al. 2016; Fitzhugh & Mirani 2008).

Assign a topography (site) code for benign neoplasm from the subterms listed at *Neoplasm, neoplastic* (eg nasal cavity, paranasal sinus or nasopharynx).

ICD-10-AM does not list a morphology code for epithelial adenomatoid hamartoma. Assign M8010/0 *Epithelial tumour, benign* as a best fit by following the Alphabetic Index:

Tumour

- epithelial

- - benign (M8010/0)

Amendments will be considered for a future edition.

References:

Barnes, L, Eveson, JW, Reichart, P & Sidransky, D (eds) 2005, World Health Organization Classification of Tumours: Pathology and Genetics of Head and Neck Tumours, IARC Press, Lyon.

Davison, WL, Pearlman, AN, Donatelli, LA & Conley, LM 2016, 'Respiratory epithelial adenomatoid hamartomas: An increasingly common diagnosis in the setting of nasal polyps', American Journal of Rhinology & Allergy, vol. 30, no. 4, pp. 139-46, viewed 26 March 2017 https://www.ncbi.nlm.nih.gov/pubmed/27456590

Fitzhugh VA & Mirani N 2008, 'Respiratory Epithelial Adenomatoid Hamartoma: A Review', Head and Neck Journal, vol. 2, no. 3, pp. 203-208, viewed 26 March 2017 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2807563/

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SVD in multiple delivery by combination of methods

Q:

Can an ACHI code for spontaneous vertex delivery (SVD) be assigned in a multiple delivery, if one (or more) of the infants is delivered by SVD but the remaining infants are delivered following an assistance procedure?

A:

Advice was published in September 2017 as part of the Tenth Edition Q&As:

> As per the table in ACS 1505 *Delivery and assisted delivery codes*, codes for spontaneous delivery (90467-00 **[1336]** *Spontaneous vertex delivery* and 90470-00 **[1339]** *Spontaneous breech delivery*) are assigned with O80 *Single spontaneous delivery* or O84.0 *Multiple delivery, all spontaneous.*
>
> **Note that for classification purposes, once a delivery is 'assisted' it is no longer 'spontaneous'**.

In addition to the above advice, the ACHI codes for spontaneous delivery may be assigned with

O84.82 *Multiple delivery by combination of methods,* when at least one of the infants is delivered vaginally without assistance (ie spontaneously).

For example:

Twin 1 delivered by spontaneous vertex delivery. Twin 2 delivered vaginally following breech extraction. Assign:

O84.82 *Multiple delivery by combination of methods*

O30.0 *Twin pregnancy*

O64.1 *Labour and delivery affected by breech presentation*

Z37.2 *Twins, both liveborn*

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

90470-03 **[1339]** *Breech extraction*

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DVT of the iliofemoral vein

Q:

What code is assigned for a DVT of the iliofemoral vein?

A:

Tenth Edition FAQs Part 1: *Deep Venous Thrombosis (DVT)* provides advice with regard to documentation of DVT at multiple levels:

> There is nothing to preclude assignment of multiple codes from category I80 *Phlebitis and thrombophlebitis*, as there is no hierarchy within the category.

Therefore, for a DVT of the iliofemoral vein, assign:

I80.21 *Phlebitis and thrombophlebitis of iliac vein*

I80.1 *Phlebitis and thrombophlebitis of femoral vein*

The following amendments to the Alphabetic Index are included in Errata 3 to Tenth Edition, for implementation 1 January 2018:

Phlebitis (infective) (pyaemic) (septic) (suppurative) (ulcerative) NEC

- iliofemoral — *see Phlebitis/lower extremity/femoral AND Phlebitis/lower extremity/iliac*

- lower extremity (vessels) NEC I80.3

- - femoral I80.1

- - iliac I80.21

Thrombophlebitis

- iliofemoral — *see Thrombophlebitis/lower extremity/femoral AND Thrombophlebitis/lower extremity/iliac*

- lower extremity (vessels) NEC I80.3

- - femoral I80.1

- - iliac I80.21

Thrombosis, thrombotic (multiple) (progressive) (septic) (vein) (vessel)

- iliofemoral — see Thrombosis, thrombotic/lower extremity/femoral AND Thrombosis, thrombotic/lower extremity/iliac

- lower extremity NEC I80.3

- - femoral I80.1

- - iliac I80.21

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Z38 Liveborn infants according to place of birth

Q:

In ACS 1607 *Newborn/neonate,* what is the definition of '**immediately post delivery'** in regards to admission of babies born outside the hospital?

A:

ACS 1607 *Newborn/neonate* defines a neonate as "*a liveborn who is less than 28 days old*". Therefore, neonate (newborn) is synonymous with liveborn infant.

The Classification points in ACS 1607 provide (sequencing) guidelines regarding assignment of codes from category Z38 *Liveborn infants according to place of birth*:

> 1. A code from category Z38 *Liveborn infants according to place of birth* should be sequenced as the principal diagnosis **only** when the newborn is completely well (including those babies who have had a circumcision performed). This category includes babies born:
>
> • in hospital
>
> • outside the hospital and admitted immediately post delivery.
>
> …
>
> 2. Any morbid condition arising during the birth episode should be sequenced before Z38 *Liveborn infants according to place of birth*.
>
> …
>
> 3. A code from category Z38 *Liveborn infants according to place of birth* is not required when coding second or subsequent admissions.

ACCD acknowledges that there are no criteria for "immediately post delivery" with regards to neonates. Applying the above definition and guidelines in ACS 1607, assign a code from category Z38 for **an infant less than 28 days old** (ie a newborn/neonate) who is admitted to hospital **for the first time** after birth outside of hospital.

Follow the Alphabetic Index:

Newborn (infant) (liveborn) (singleton)

- born

- - outside hospital Z38.1

- multiple (delivery)

- - born

- - - outside hospital Z38.7

- twin

- - born

- - - outside hospital Z38.4

It should be noted that classification advice is provided independent of admitted patient care types, unless specifically stated otherwise.

See also Coding Rule: Assigning Z38.- as the principal diagnosis.

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Tenth Edition FAQs Part 3: Obstetrics

Q:

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

A:

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

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

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

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

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

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Tenth Edition FAQs Part 3: Same-day endoscopy

Q:

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

A:

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

Q:

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

A:

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

Q:

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

A:

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

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

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

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Tenth Edition FAQs Part 2: Same-day endoscopy

Q:

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

A:

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

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Tenth Edition FAQs Part 2: Procedural complications

Q:

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

A:

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

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

Scenario 1:

Lymphocele following radical prostatectomy

Assign:

I97.83 *Postprocedural lymphocele, lymphoedema and chylothorax*

Scenario 2:

Lymphocele due to cannulation of the femoral vein

Assign:

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

I97.83 *Postprocedural lymphocele, lymphoedema and chylothorax*

Q:

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

A:

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

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

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

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

K65.- *Peritonitis*

Y84.1 *Kidney dialysis*

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

or

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

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

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

Q:

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

A:

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

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

Scenario 1:

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

Assign:

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

(external cause codes as appropriate)

Scenario 2:

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

Assign:

T84.0 *Mechanical complication of internal joint prosthesis*

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

R52. 2 *Chronic pain*

(external cause codes as appropriate)

Q:

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

A:

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

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

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

Haemorrhage

- due to **or associated with**

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

Scenario:

A tracheoesophageal fistula formed following tracheostomy

Assign:

J95.04 *Tracheo-oesophageal fistula following tracheostomy*

Scenario:

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

Assign:

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

D62 *Acute posthaemorrhagic anaemia*

(external cause codes as appropriate)

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

Q:

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

A:

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

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

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

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

Scenario 1:

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

Assign:

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

Scenario 2:

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

Assign:

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

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

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

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Tenth Edition FAQs Part 2: Obstetrics

Q:

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

A:

ACS 1505 *Delivery and assisted delivery codes* states:

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

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

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

Q:

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

A:

ACS 1505 *Delivery and assisted delivery codes* states:

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

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

That is:

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

Scenario: Healthy twins both delivered by spontaneous vertex delivery.

Assign:

O84.0 *Multiple delivery, all spontaneous*

O30.0 *Twin pregnancy*

Z37.2 *Twins, both liveborn*

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

(anaesthesia code if applicable)

Q:

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

A:

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

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

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

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

Assign:

O83 *Other assisted delivery*

Z37.0 *Single live birth*

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

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

Q:

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

A:

ACS 1511 *Termination of pregnancy* states:

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

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

Assign:

O02.1 *Missed abortion*

O09.2 *14–19 completed weeks*

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

Follow the Alphabetic Index:

Death

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

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

Induction

- labour

- - medical (administration of pharmacological agent)

- - - prostaglandin 90465-01 **[1334]**

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

Q:

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

A:

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

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

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

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

Assign:

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

E11.9 *Type 2 diabetes mellitus without complication*

Q:

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

A:

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

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

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

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

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

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

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

Q:

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

A:

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

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

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

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

Assign:

O72.2 *Delayed and secondary postpartum haemorrhage*

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

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

(anaesthesia code)

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

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Admission for induction following termination of pregnancy at another facility.

Q:

What abortion code is assigned when a patient is admitted following intra-amniotic injection for termination of pregnancy (TOP) at another facility?

A:

Historically, patients were admitted to a facility for a medical abortion (termination of pregnancy (TOP)), and the procedure completed within the episode of care. A change of practice means that some patients present to one facility for intra-amniotic TOP (as outpatients), and are admitted to another facility the following day for induction to expel the dead fetus.

Assign codes for *medical abortion* for the admitted episode of care, as per the guidelines in ACS 1511 *Termination of pregnancy*.

Amendments will be considered for a future edition.

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Breast carcinoma no specific/special type (NST)

Q:

What is the correct morphology code to assign where there is documentation of breast carcinoma of no specific/special type (NST)?

A:

Breast carcinoma of no specific/special type (NST), also known as ductal carcinoma NST, is an invasive (infiltrating) breast tumour where the cells are not able to be identified as a specific histological type.

Where there is documentation of breast carcinoma NST, assign M8500/3 *Infiltrating duct carcinoma NOS* or M8500/6 *Infiltrating duct carcinoma NOS, metastatic* as appropriate.

Amendments to the Alphabetic Index will be considered for a future edition.

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Administration of Albumex or plasma with plasmapheresis

Q.

Is a code for administration of albumin (Albumex) or (fresh frozen) plasma assigned in addition to 13750-00 **[1892]** *Therapeutic plasmapheresis*?

A.

'Plasmapheresis' refers to a range of procedures in which extracorporeal separation of blood components results in a filtered plasma product. In therapeutic plasmapheresis, filtered plasma is discarded and red blood cells with donor plasma or albumin are returned to the patient (Stieglitz 2016).

ACS 0016 *General procedure guidelines/Procedure components* states:

> Do not code procedures which are individual components of another procedure. These components would usually be considered a routine or inherent part of the more significant procedure being performed.

Therefore, an additional ACHI code is not required for the administration of Albumex (albumin) or plasma, as it is a component of therapeutic plasmapheresis.

Reference:

Stieglitz E 2016, 'Plasmapheresis', Medscape, viewed 12 December 2016, http://emedicine.medscape.com/article/1895577-overview

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Tenth Edition FAQs Part 1: Obesity and BMI

Q:

What code is assigned for obesity without a BMI documented?

A:

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

Follow the Alphabetic Index:

Obesity (morbid) (simple) E66.9-

Assign a fifth character by referring to the Tabular List:

E66 Obesity and overweight

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

Excludes: adiposogenital dystrophy (E23.6)
lipomatosis:
• dolorosa [Dercum] (E88.2)
• NOS (E88.2)
Prader-Willi syndrome (Q87.14)

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

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

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

0 body mass index [BMI] not elsewhere classified

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

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

3 body mass index [BMI] >= 40 kg/m^2
Clinically severe obesity
Extreme obesity
Obese class III

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

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

Q:

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

A:

As per the ICD-10-AM Alphabetic index:

BMI (body mass index)

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

- >= 30 kg/m^2 — *see Obesity*

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

Q:

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

A:

There are no index entries for increased BMI:

BMI (body mass index)

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

- >= 30 kg/m^2 — *see Obesity*

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

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

Q:

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

A:

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

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

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

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

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Tenth Edition FAQs Part 1: Passive smoking

Q:

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

A:

ACS 2118 *Exposure to tobacco smoke* states:

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

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

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

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

Q:

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

A:

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

I80.22 *Phlebitis and thrombophlebitis of popliteal vein*

and

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

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Tenth Edition FAQs Part 1: Adoption

Q:

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

A:

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

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Tenth Edition FAQs Part 1: Application of ACS 0001 and ACS 0002 in conjunction with specialty standards

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

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

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

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Ref No: TN1248 | Published On: 15-Sep-2017 | Status: Retired | Retired On: 30-Jun-2019

Tenth Edition FAQs Part 1: Mental health interventions

Q:

Are mental health intervention codes mandatory?

A:

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

> For admitted episodes of care **it is not mandatory** to assign code(s) for mental health care interventions with the exception of electroconvulsive therapy.

However, their use is encouraged in specialist mental health care facilities and units to better represent care provided to these patients. It should also be noted that these interventions are not exclusive to mental health and may be assigned outside of this context.

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

> For inpatient coding it is only necessary to assign the general code(s) from block **[1916]** *Generalised allied health interventions*.

However, clinical coders are encouraged to use the more specific codes for allied health interventions to better represent the interventions performed.

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Tenth Edition FAQs Part 1: ACS deleted for Tenth Edition

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

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

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

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

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

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

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

Q:

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

A:

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

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

Administration

- specified site

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

…

- type of agent

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

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Tenth Edition FAQs Part 1: Multiple condition coding convention

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

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

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

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

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Tenth Edition FAQs Part 1: Chronic pain

Q:

Will there be amendments to chronic pain in Errata 2?

A:

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

Q:

What codes are assigned for chronic pain with underlying conditions?

A:

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

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

ACS 1807 *Acute and chronic pain* states:

> To classify chronic pain with a documented underlying cause and/or site:
>
> - code first the underlying cause and/or site and,
> - assign R52.2 *Chronic pain* as an additional diagnosis
> - *Note*: the amendments made to ACS 1807 in Errata 2 are included in the text above

Scenario:

Chronic low back pain due to bone metastases

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

M54.5 *Low back pain* (ie the site of the chronic pain)

R52.2 *Chronic pain* (ie to identify the chronicity)

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

R52.2 Chronic pain may be assigned as a principal diagnosis if there is no documentation of an underlying cause or site.

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

Q:

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

A:

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

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

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

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

Scenario:

Pain due to osteoarthritis of the hip.

Assign: M16.1 *Other primary* coxarthrosis

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

Q:

What codes are assigned for chronic pain with external causes?

A:

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

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Tenth Edition FAQs Part 1: ACS mutual exclusivity

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

- Apply first the general standards for diseases and interventions.

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

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

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

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

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

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Tenth Edition FAQs Part 1: Use of definitional information

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

This information is provided for coder education only.

For example:

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

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

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

Q:

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

A:

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

Q:

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

A:

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

If patients on long term anticoagulants require anticoagulant level monitoring during an episode of care and the INR level is within the target therapeutic range (ie no supratherapeutic or subtherapeutic INR is documented), assign Z92.1 *Personal history of long term (current) use of anticoagulants* as an additional diagnosis

If the INR value is outside the patient's normal/usual therapeutic range (eg supratherapeutic or subtherapeutic INR is documented) but no bleeding occurs, assign R79.83 *Abnormal coagulation profile* together with appropriate external cause codes to indicate that the abnormal coagulation profile is related to the administration of an anticoagulant.

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

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

Key points

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

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

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

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

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

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

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

Problems and Underlying conditions

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

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

Scenario:

Neurogenic bladder due to cauda equina syndrome

Assign:

N31.9 *Neuromuscular dysfunction of bladder, unspecified*

G83.4 *Cauda equina syndrome*

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

Note:

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

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

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Tenth Edition FAQs Part 1: Difficult intubation

Q:

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

A:

Assign:

T88.42 *Difficult intubation*

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

Y92.24 *Health service area, this facility*

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Ref No: Q3181 | Published On: 15-Jun-2017 | Status: Retired | Retired On: 30-Jun-2019

Laparoscopic biopsy of uterine serosa

Q:

What code is assigned for laparoscopic biopsy of lesion (eg granulation or cyst) of uterine serosa?

A:

There are three uterine layers; endometrium (inner layer), myometrium (middle/muscle layer), and perimetrium/serosa (outer layer that covers the uterus).

For laparoscopic biopsy of uterine serosa, assign 90452-00 **[1266]** *Excision of other lesion of uterus* as a best fit, by following the Alphabetic Index:

Excision — *see also Removal*

- lesion(s) — *see also Excision/tumour AND Excision/cyst AND Excision/polyp*

- - uterus 90452-00 **[1266]**

Assign 30390-00 **[984]** *Laparoscopy* as per the guidelines in ACS 0023 *Laparoscopic/arthroscopic/endoscopic surgery.*

Amendments to ACHI will be considered for a future edition.

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Ref No: Q3173 | Published On: 15-Jun-2017 | Status: Retired | Retired On: 30-Jun-2019

Carrier of drug resistant microorganisms

Q:

What codes are assigned for carrier of/colonisation with drug resistant microorganisms such as Vancomycin Resistant *Enterococcus* (VRE) or Methicillin Resistant *Staphylococcus aureus* (MRSA), without current infection?

A:

Where a patient is a carrier of a drug resistant microorganism, and it meets the criteria in ACS 0002 *Additional diagnoses,* assign a code from Z22 *Carrier of infectious disease* and apply the *Instructional note* (*Use additional code to identify resistance to antimicrobial drugs* (Z06.5- –Z06.7-)).

For example:

- For carrier of Vancomycin Resistant *Enterococcus* (VRE), such as a patient with VRE positive urine without documentation of a urinary tract infection (UTI), requiring full contact precautions and reviews by the Infection Control team, assign:

  Z22.3 *Carrier of other specified bacterial diseases*

  and

  Z06.61 *Resistance to vancomycin*.

- For carrier of Methicillin Resistant *Staphylococcus aureus* (MRSA), such as a patient with a groin swab positive for MRSA, requiring full contact precautions and isolation, assign:

  Z22.3 *Carrier of other specified bacterial diseases*

  and

  Z06.52 *Resistance to methicillin*

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Ref No: Q3128 | Published On: 15-Jun-2017 | Status: Retired | Retired On: 30-Jun-2019

Unintentional event (misadventure) code for ‘failed intubation’

Q:

What is the external cause code (unintentional event/misadventure) for failed intubation?

A:

It is acknowledged that the indexing and classification of *unintentional event/misadventure due to endotracheal tube* is inconsistent and confusing.

Documentation of ‘failed intubation’ indicates that the external cause is due to complication/unintentional event (misadventure) due to endotracheal intubation. The absence of an endotracheal tube during general anaesthesia is equivalent to ‘failure to intubate/failure to introduce an endotracheal tube’

The indexing and classification of Y65.3 and Y65.4 is based on ICD-10. Both codes are listed in the same rubric; Y65.3 is a more specific option:

Y65.3 ***Endotracheal tube*** *wrongly placed during anaesthetic procedure*

Y65.4 *Failure to introduce or to remove* ***other tube*** *or instrument*

‘Failure to introduce endotracheal tube (failed intubation) during anaesthetic procedure’ is classified to Y65.3, as indicated by the NEM in the Alphabetic Index:

Failure

- to

- - introduce tube or instrument (except endotracheal tube during anaesthesia) Y65.4

...

- - remove tube or instrument (except endotracheal tube during anaesthesia) Y65.4

Therefore, when:

- ‘failed intubation during anaesthetic procedure’ is documented, assign Y65.3 *Endotracheal tube wrongly placed during anaesthetic procedure* as the external cause
- ‘failed intubation’ is documented, but it is not during an anaesthetic procedure, assign Y65.4 *Failure to introduce or to remove other tube or instrument* as the external cause.

Amendments to ICD-10-AM will be considered for a future edition.

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Ref No: Q3125 | Published On: 15-Jun-2017 | Status: Retired | Retired On: 30-Jun-2019

Fetal scalp blood sampling (for lactate or pH)

Q:

What code is assigned for fetal scalp lactate or fetal scalp pH?

A:

Fetal scalp lactate is a blood sample taken from the fetal scalp vessels during labour to measure lactate levels. Blood lactate levels are used to predict intrapartum fetal hypoxia (hypoxic ischaemic encephalopathy (HIE)) in conjunction with electronic fetal monitoring.

Fetal blood sampling may also be performed to measure blood pH levels.

Assign 16606-00 **[1330]** *Fetal blood sampling* by following the Alphabetic Index:

Sampling

- fetal blood 16606-00 **[1330]**

Amendments to ACHI will be considered for a future edition.

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Ref No: Q3066 | Published On: 15-Jun-2017 | Status: Retired | Retired On: 30-Jun-2019

T-cell therapy

Q:

How do you code T-cell therapy?

A:

T-cells are a type of white blood cell that play an essential role in cell-mediated immunity.

T-cell therapy, also known as chimeric antigen receptor (CAR) T-cell therapy or adoptive cell transfer (ACT) immunotherapy, involves collecting T-cells via apheresis and genetically modifying them in a laboratory to produce chimeric antigen receptors (CARs) on their surface. CARs are proteins that allow T-cells to recognise a specific protein (antigen) on tumour cells.

When infused back into the patient's bloodstream, the reengineered CAR T-cells destroy tumour cells that contain the antigen on their surfaces. CAR T-cells may remain in the body long after the infusion has been completed, and may protect the patient against cancer recurrence, resulting in long-term remissions.

For collection of T-cells via apheresis, assign 13750-01 **[1892]** *Therapeutic leukopheresis* by following the Alphabetic Index:

Leukopheresis, therapeutic (leukocytapheresis) 13750-01 **[1892]**

For infusion of the reengineered CAR T-cells (T-cell therapy), assign 13706-04 **[1893]** *Administration of leukocytes* by following the Alphabetic Index:

Administration (around) (into) (local) (of) (therapeutic agent)

- type of agent

- - white cells (donor leukocytes) 13706-04 **[1893]**

Amendments to ACHI will be considered for a future edition.

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Ref No: Q3058 | Published On: 15-Jun-2017 | Status: Retired | Retired On: 30-Jun-2019

Hepatic encephalopathy and alcoholic hepatic encephalopathy

Q:

What codes are assigned for hepatic encephalopathy and alcoholic hepatic encephalopathy?

A:

Hepatic encephalopathy is a complication of severe hepatic failure or cirrhosis where the liver can no longer adequately remove toxins from the blood resulting in a build-up of toxins in the bloodstream that may lead to confusion, strange behaviours or mood changes and in severe cases leads to brain damage.

Alcoholic hepatic encephalopathy is the above condition due to alcohol use/abuse.

Note also that **alcoholic encephalopathy** (classified to G31.2 *Degeneration of nervous system due to alcohol)* is encephalopathy caused by alcohol toxicity, or thiamine deficiency due to the effects of alcohol, but without liver disease (Canadian Liver Foundation 2016, Wolf 2017).

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

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

Therefore:

- for **hepatic encephalopathy** not otherwise specified (NOS) assign:

  G93.4 *Encephalopathy, unspecified*

  and

  K72.9 *Hepatic failure, unspecified*

- for **alcoholic hepatic encephalopathy**, follow the cross reference in the Alphabetic Index:

  Encephalopathy G93.4
  - hepatic *(see also Failure/hepatic)*

  Failure, failed
  - hepatic
  - - alcoholic (acute) (chronic) (subacute) (with or without hepatic coma) K70.4

  assign:

  G93.4 *Encephalopathy, unspecified*

  and

K70.4 *Alcoholic hepatic failure*

Amendments to ICD-10-AM will be considered for a future edition.

References:

Canadian Liver Foundation, Hepatic Encephalopathy 2016, liver.ca, Markham, viewed 9 June 2016
http://www.liver.ca/liver-disease/types/cirrhosis/hepatic-encephalopathy.aspx

Wolf, DC 2017, *'Hepatic encephalopathy'*, Medscape, New York, viewed 26 March 2017
http://emedicine.medscape.com/article/186101-overview

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Ref No: Q3058 | Published On: 15-Jun-2017 | Status: Retired | Retired On: 30-Jun-2019

Alcoholic cirrhosis of liver and alcoholic liver failure

Q:

Can K70.3 *Alcoholic cirrhosis of liver* and K70.4 *Alcoholic hepatic failure* be assigned together in an episode of care?

A:

K70.3 *Alcoholic cirrhosis of liver* and K70.4 *Alcoholic hepatic failure* are not mutually exclusive. Therefore, both codes can be assigned for these conditions if they meet the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses.*

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Ref No: Q3165 | Published On: 15-Jun-2017 | Status: Retired | Retired On: 30-Jun-2019

Total laparoscopic abdominal hysterectomy with removal of adnexa, and pelvic lymph node dissection

Q:

What codes are assigned for total laparoscopic abdominal hysterectomy with removal of adnexa (fallopian tube(s) and/or ovary(ies)), and pelvic lymph node dissection?

A:

Where total laparoscopic abdominal hysterectomy with removal of adnexa (fallopian tube(s) and/or ovary(ies)) and pelvic lymph node dissection is documented, assign:

35670-00 **[1268]** *Abdominal hysterectomy with radical excision of pelvic lymph nodes*

30390-00 **[984]** *Laparoscopy*

Follow the Alphabetic Index:

Hysterectomy

- abdominal (total)

- - with

- - - dissection of pelvic lymph nodes 35670-00 **[1268]**

Assign the code for laparoscopy as per the guidelines in ACS 0023 *Laparoscopic/arthroscopic/endoscopic surgery*.

Amendments are in progress for ACHI Eleventh Edition.

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Ref No: Q3151 | Published On: 15-Mar-2017 | Status: Retired | Retired On: 30-Jun-2019

Place of occurrence, water NOS

Q:

What place of occurrence code is assigned for water NOS?

A:

Place of occurrence codes for specific types of water are located in Y92.8 *Other specified place of occurrence*:

Y92.80 *Area of still water*

Y92.81 *Stream of water*

Y92.82 *Large area of water*

Y92.83 *Beach*

Assign Y92.88 *Other specified place of occurrence* for water NOS by following the External Causes of Injury Alphabetic Index:

Place of occurrence of external cause Y92.9

- specified NEC Y92.88

Amendments will be considered for a future edition of ICD-10-AM.

Published 15 March 2017,
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Ref No: Q3139 | Published On: 15-Mar-2017 | Status: Retired | Retired On: 30-Jun-2019

Goldilocks mastectomy

Q:

How do you code Goldilocks mastectomy?

A:

Goldilocks mastectomy is a procedure that uses autologous cutaneous mastectomy tissue to form a mound, negating the need for an additional flap or insertion of an implant.

Assign a code for subcutaneous mastectomy as a best fit by following the Alphabetic Index:

Mastectomy

- subcutaneous (unilateral) 31524-00 **[1747]**

- - bilateral 31524-01 **[1747]**

31524-00 **[1747]** *Subcutaneous mastectomy, unilateral*

31524-01 **[1747]** *Subcutaneous mastectomy, bilateral*

Amendments to ACHI will be considered for a future edition.

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Ref No: Q3124 | Published On: 15-Mar-2017 | Status: Retired | Retired On: 30-Jun-2019

Gestational diabetes mellitus with hypoglycaemia

Q:

How do you code gestational diabetes mellitus with hypoglycaemia?

A:

The guidelines in ACS 0401 Diabetes mellitus and intermediate hyperglycaemia/Gestational diabetes mellitus (GDM) indicate that GDM is classified to O24.4- *Diabetes mellitus* arising during pregnancy. Follow the Alphabetic Index:

Hypoglycaemia (spontaneous) E16.2

- with diabetes (mellitus) — see Diabetes, diabetic

Diabetes, diabetic

- gestational O24.4-

OR

Pregnancy

- complicated by

- - diabetes (mellitus)

- - - gestational O24.4-

There is no subcategory for GDM with hypoglycaemia as there is for diabetes mellitus type 1, type 2, other, and unspecified (E1-.64 **diabetes mellitus with hypoglycaemia*), therefore assign:

O24.4- *Diabetes mellitus arising during pregnancy*

E16.2 *Hypoglycaemia, unspecified*

Amendments to ICD-10-AM Alphabetic Index will be considered for a future edition.

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Ref No: Q3111 | Published On: 15-Mar-2017 | Status: Retired | Retired On: 30-Jun-2019

Socket moulding

Q:

What code is assigned for socket moulding post enucleation of the eye?

A:

Socket moulding is an impression of the eye socket taken to create a permanent artificial eye following enucleation of the eyeball. The mould is used to match the colour, appearance, shape and thickness of the other eye. Socket moulding may be performed at a clinic or in the hospital, and general anaesthesia is usually required when performed for children.

Assign 96091-00 **[1870]** *Manufacture of assistive or adaptive device, aid or equipment*, following the Alphabetic Index:

Casting

- assistive or adaptive device, aid or equipment 96091-00 **[1870]**

Amendments to ACHI will be considered for a future edition.

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for implementation 01 April 2017.

Ref No: Q3067 | Published On: 15-Mar-2017 | Status: Retired | Retired On: 01-Jul-2017

Postprocedural sepsis

Q:

How do you code postprocedural sepsis?

A:

Postprocedural wound sepsis is classified to T81.4 *Wound infection following a procedure, not elsewhere classified* by following the Alphabetic Index:

Complications (from) (of)

- postprocedural

…

- - wound infection T81.4

Infection, infected (opportunistic) (*see also Infestation*)

…

- postprocedural wound T81.4

Assign an additional code to identify sepsis as per the *Instructional* note at T81.4:

> *Use additional code (Chapter 1, P36–P37) to identify sepsis, if applicable — see Alphabetic Index/Sepsis*

Postprocedural sepsis due to a prosthetic device, implant or graft is classified to T85.78 *Infection and inflammatory reaction due to other internal prosthetic devices, implants and grafts* following the Alphabetic Index:

Sepsis (generalised) (*see also Infection*)

…

- due to

- - device, implant or graft (*see also Complications/by site and type/infection or inflammation*) T85.78

Assign an additional code to identify sepsis as per the *Instructional* note at relevant codes (T82.6–T82.7, T83.5–T83.6, T84.5–T84.7 and T85.7):

> *Use additional code (Chapter 1, P36–P37) to identify sepsis, if applicable — see Alphabetic Index/Sepsis*

Sepsis in the postoperative period not documented as being due to a wound infection or due to a prosthetic device, implant or graft is not classified as a procedural complication, as the cause of the sepsis may be multifactorial.

Assign a code for sepsis (Chapter 1, P36–P37) as per the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*.

Major amendments to the classification of procedural complications have been made for ICD-10-AM Tenth Edition.

Published 15 March 2017,
for implementation 01 April 2017.

Ref No: Q3081 | Published On: 15-Mar-2017 | Status: Retired | Retired On: 01-Jul-2017

Procedural complications

Q:

How do you know if a condition documented during a procedure (intraoperative) or in the postoperative period is a procedural complication?

A:

Extensive amendments have been made to ACS 1904 *Procedural complications* for Tenth Edition. Until these amendments are implemented, the current guidelines/definition in ACS 1904 must be followed to determine if a condition that occurs intraoperatively or in the postoperative period is classified as a procedural complication:

> Qualifying terms such as 'intraoperative', 'postoperative' or 'postprocedural' may be documented in the clinical record to describe these conditions, however they should be assigned procedural complication codes only if they meet the following definition:
>
> **A condition or injury which is directly related to a surgical/procedural intervention.**
>
> Therefore, the terms 'postprocedural' or 'complication' should only be referred to in ICD-10-AM Alphabetic Index when the condition being coded meets this definition of a procedural complication.
>
> **If it cannot be determined whether a condition meets the definition of a procedural complication, it should not be coded as such. In these cases, assign a code(s) for the condition in accordance with ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*.**

However, the following should be noted with regard to procedural complications:

- 'Procedural complication' does not have to be documented to assign a procedural complication code
- The causes of many conditions arising in the postoperative period are multifactorial (eg vomiting, hypothermia). That is, they are not necessarily caused by the procedure performed, but may be related to a complex interaction between the disease process and the procedure. Therefore, conditions are not classified as procedural complications unless a causal relationship is clearly documented

When the relationship is inherent in the diagnosis (eg acute blood loss anaemia during a procedure or from a surgical wound), a causal relationship does not have to be documented to assign a procedural complication code. Assign:

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

D62 *Acute posthaemorrhagic anaemia*

Follow the Alphabetic Index:

Complications

- postprocedural

- - haemorrhage or haematoma T81.0

Anaemia

- due to

- - haemorrhage

- - - acute D62

Published 15 March 2017,
for implementation 01 April 2017.

Ref No: Q3107 | Published On: 15-Mar-2017 | Status: Retired | Retired On: 01-Jul-2017

Complications of prosthetic devices, implants and grafts/haematoma following cardiac catheterisation.

Q:

How do you code haematoma following cardiac catheterisation? Is code assignment different if a device (eg stent) has been inserted via cardiac catheterisation?

A:

For post procedural groin haematoma following cardiac catheterisation, assign:

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

Y84.0 *Cardiac catheterisation* (as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure)

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

For post procedural groin haematoma following cardiac catheterisation with insertion of cardiac stent, assign:

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

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

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

The following should also be noted:

- There is a difference between cardiac catheterisation as operative approach for insertion of a device and as a diagnostic procedure (see also Coding Rule (Q3070): *External cause code for complication of percutaneous angioplasty with stenting of coronary arteries*)
- Haemorrhage/haematoma is classified similar to complications such as embolism, fibrosis etc, and as per the guidelines in ACS 1904 *Procedural complications*
- Assign T82-T85 *Complications of prosthetic devices, implants and grafts* regardless of whether a cause and effect relationship is stated between the complication and the prosthetic device, implant or graft. However, where documentation specifies that a complication is related to a specific cause, assign codes for complications of the documented cause not the prosthetic device, implant or graft. For example:

  - shoulder pain from laparoscopy gas following insertion of Filshie clips; code the pain as a complication of the laparoscopy, not a complication of the Filshie clips

  - bleeding from endotracheal (ET) tube post general anaesthetic for joint replacement; code the bleeding as a complication of the endotracheal tube, not the joint replacement.

(See also Coding Rule (Q2736): *Conventions used in the Tabular List of Diseases*).

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Ref No: Q3110 | Published On: 15-Dec-2016 | Status: Retired | Retired On: 30-Jun-2019

Single delivery assisted by forceps and McRoberts manoeuvre

Q:

How do you code a single delivery where forceps and McRoberts manoeuvre are used to assist the delivery? For example, forceps delivery of head followed by delivery of shoulder and arm via McRoberts manoeuvre.

A:

The following is of note when selecting an appropriate code from O80-O84 *Delivery*:

- Each of the above categories are mutually exclusive
- O80 *Single spontaneous delivery* is never assigned if a delivery assistance procedure has been performed
- O81 *Single delivery by forceps and vacuum extractor* is assigned if delivery is completed using forceps or vacuum extractor. The exception is where forceps are used to rotate the fetal head only, but delivery is not completed using forceps
- O82 *Single delivery by caesarean section* is assigned if delivery is completed by caesarean section, regardless of whether forceps or a vacuum extraction has been attempted, or any other assistance procedure has been performed
- O83 *Other assisted single delivery* is assigned if delivery is assisted by any method other than by forceps or vacuum extractor (assign O81) or caesarean section (assign O82). This includes where forceps are used but fail, or are used to rotate the fetal head only, but delivery is not completed using forceps.

In the cited scenario (forceps delivery of head followed by delivery of shoulder and arm via McRoberts manoeuvre) the delivery was assisted using forceps.

Assign O81 Single delivery by forceps and vacuum extractor by following the ICD-10-AM Alphabetic Index:

Delivery

- assisted

- - by

- - - forceps or vacuum extractor O81

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for implementation 01 January 2017.

Ref No: Q3118 | Published On: 15-Dec-2016 | Status: Retired | Retired On: 30-Jun-2019

Removal of a bone anchored hearing aid (BAHA) implant

Q:

What is the correct ACHI code to assign for the removal of BAHA titanium implants?

A:

The removal of bone anchored hearing aids (BAHA) is usually performed due to skin reactions, for example flap necrosis, granulation or hyperplasia of skin around the implant site, or infection.

Assign 92202-00 **[1908]** *Removal of therapeutic device, not elsewhere classified* as a best fit, by following the Alphabetic Index:

Removal — *see also Excision*

- device

- - therapeutic NEC 92202-00 **[1908]**

A review of the classification of BAHA will be considered for a future edition of ACHI.

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for implementation 01 January 2017.

Ref No: Q3093 | Published On: 15-Dec-2016 | Status: Retired | Retired On: 30-Jun-2019

TransPyloric Shuttle insertion

Q:

What procedure code is assigned for TransPyloric Shuttle insertion?

A:

The TransPyloric Shuttle (TPS®) is a device used to treat obesity. The device is inserted endoscopically into the stomach and consists of a large spherical bulb connected by a silicone tether that passes through the pylorus to a smaller cylindrical bulb in the duodenum. The large bulb prevents the device from migrating out of the stomach, and intermittently creates a seal at the pylorus to delay partially digested food and gastric juices from flowing into the duodenum. This device causes the stomach to fill up faster, and prolongs appetite satiety which reduces the overall calorie intake resulting in weight loss.

Assign 90950-02 **[889]** *Endoscopic insertion of device into stomach* for the endoscopic insertion of a TransPyloric Shuttle for the treatment of obesity by following the Alphabetic Index:

Insertion

- device

- - stomach, for obesity (endoscopic) *(see also Banding/gastric, for obesity)* 90950-02 **[889]**

Amendments to ACHI will be considered for a future edition.

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for implementation 01 January 2017.

Ref No: Q3069 | Published On: 15-Dec-2016 | Status: Retired | Retired On: 30-Jun-2019

Stretta procedure

Q:

What code is assigned for Stretta procedure?

A:

Stretta procedure is performed for the treatment of gastro-oesophageal reflux disease (GORD). It involves radiofrequency (thermal) ablation of the lower oesophageal sphincter (LOS) and gastric cardia, via endoscopy. The thermal energy creates a lesion in the oesophagus, causing the treated area to swell and stiffen as it heals, resulting in an increased thickening of the LOS. The altered LOS, when closed, prevents stomach acid and contents from flowing back up to the oesophagus, thus eliminating GORD symptoms.

Assign 30478-22 **[856]** *Endoscopic destruction of lesion or tissue of oesophagus* for Stretta procedure by following the Alphabetic Index:

Oesophagoscopy

- with

- - radiofrequency (Halo) ablation 30478-22 **[856]**

Amendments to ICD-10-AM ACHI will be considered for a future edition.

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for implementation 01 January 2017.

Ref No: Q3068 | Published On: 15-Dec-2016 | Status: Retired | Retired On: 30-Jun-2019

Drainage of parapharyngeal abscess

Q:

What is the correct code to assign for drainage of parapharyngeal abscess?

A:

In the absence of a specific code or index entries for *drainage of parapharyngeal abscess*, clinical advice supports the assignment of either of the following codes (as appropriate) as a best fit:

31409-00 **[421]** *Excision of parapharyngeal lesion by cervical approach*

31412-00 **[421]** *Excision of recurrent or persistent parapharyngeal lesion by cervical approach*

Amendments to ACHI will be considered for a future edition.

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for implementation 01 January 2017.

Ref No: Q3023 | Published On: 15-Dec-2016 | Status: Retired | Retired On: 30-Jun-2019

Respiratory Distress, unspecified

Q:

Does the statement in ACS 1614 *Respiratory distress syndrome/hyaline membrane disease/surfactant deficiency* regarding unspecified respiratory distress mean that P22.9 *Respiratory distress of newborn, unspecified* should never be assigned?

A:

Respiratory distress in newborns may have many causes including transient tachypnoea of the newborn, respiratory distress syndrome (RSD)/hyaline membrane disease, meconium aspiration syndrome, infections or underlying congenital heart defects.

ACS 1614 *Respiratory distress syndrome/hyaline membrane disease/surfactant deficiency* states*:*

> *The term 'respiratory distress unspecified' should not be coded as such, as it is considered a symptom not a diagnosis. Further information regarding a definitive diagnosis should be sought from the clinician.*

That is, where documentation or clinical advice is available to identify the cause of the symptom 'respiratory distress', assign a code for the underlying cause (see examples above). Where there is no confirmation of an underlying cause, assign P22.9 *Respiratory distress of newborn, unspecified* as a last resort by following the Alphabetic Index:

Distress

- respiratory

- - newborn P22.9

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for implementation 01 January 2017.

Ref No: Q3084 | Published On: 15-Sep-2016 | Status: Retired | Retired On: 31-Dec-2019

Musculoskeletal injury of specified site

Q:

How do you code ‘musculoskeletal injury’ of a specified site?

A:

The musculoskeletal system is comprised of bones, muscles, cartilage, tendons, ligaments, joints and other connective tissue structures. Chapter 13 *Diseases of the musculoskeletal system and connective tissue* includes a list of specific musculoskeletal sites under *Site of Musculoskeletal involvement,* for example:

- Shoulder region (eg clavicle, scapula)
- Upper arm (humerus, elbow joint)
- Forearm (radius, ulna, wrist joint)
- Hand (eg carpus, fingers)
- Pelvic region and thigh (eg femur, pelvis)
- Lower leg (fibula, tibia, knee joint)
- Ankle and foot (eg metatarsus, toes)
- Head/neck/ribs/skull

A ‘musculoskeletal injury’ of a specified site is not a synonymous term for injury of a muscle of that site. The description of an injury as a ‘musculoskeletal injury’ indicates that it is an injury of the musculoskeletal system, rather than another body system (for example soft tissue or skin and subcutaneous tissue).

Chapter 19 *Injury, poisoning and certain other consequences of external causes* classifies injuries of specified body sites to S00-S99.

Where there is documentation of a specified type of injury (eg fracture, sprain, dislocation), refer to the applicable lead term in the Alphabetic Index for the specified injury type (see also the cross reference at *Injury* (*see also specified injury type*)).

Where there is documentation of ‘musculoskeletal injury’ (NOS) of a specified site, assign an appropriate code by following the Alphabetic Index at *Injury/by site*. For example:

Musculoskeletal injury of ankle:

Injury

- ankle

- specified NEC S99.8

S99.8 *Other specified injuries of ankle and foot*

Musculoskeletal injury of neck:

Injury

- neck

- specified NEC S19.8

S19.8 *Other specified injuries of neck*

Musculoskeletal injury of shoulder:

Injury

- shoulder

- - specified NEC S49.8

S49.8 *Other specified injuries of shoulder and upper arm*

Also assign appropriate codes for external cause of injury, place of occurrence and activity.

Published 15 September 2016,
for implementation 01 October 2016.

Ref No: Q3101 | Published On: 15-Sep-2016 | Status: Retired | Retired On: 30-Jun-2019

Coronary angiogram following failed initial access

Q:

What codes are assigned for a coronary angiogram where initial arterial access is abandoned and another artery must be used to complete the procedure?

A:

There are a number of vascular access options for coronary angiography (eg femoral, radial, brachial arteries). Right transfemoral approach is often utilised due to the large diameter of the artery. An alternative to the selected approach is necessary if difficulties with access are encountered.

Failure of one access site and hence use of an alternative site (eg failure to advance the guidewire following needle puncture of the right femoral artery with subsequent successful performance of the procedure via the left femoral artery) is considered routine practice for percutaneous coronary interventions (see ACS 0016 *General procedure guidelines/Procedure components*).

In the above scenario, it is not the angiogram that is abandoned, just the approach. Therefore, ACS 0019 *Procedure not completed or interrupted* does not apply.

Assign ACHI codes only for the successful procedure performed.

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for implementation 01 October 2016.

Ref No: Q3004 | Published On: 15-Sep-2016 | Status: Retired | Retired On: 30-Jun-2019

Check cystoscopy for transitional cell carcinoma (TCC) of the bladder

Q:

What codes are assigned where a different site of the bladder or a different morphological behaviour of TCC in the bladder is found at check cystoscopy?

A:

Transitional cell carcinoma (TCC) of the bladder is a cancer that forms in the lining or urothelium of the bladder. The tumours are commonly superficial with a tendency to recur anywhere in the bladder; therefore surveillance of the bladder (check cystoscopy) is performed regularly after the initial diagnosis.

Follow the guidelines in:

ACS 0052 *Same-dayendoscopy – Surveillance:*

Assign as principal diagnosis:

- the condition under surveillance(follow-up/screening) if detected at screening

and

ACS 0237 *Recurrence of malignancy*:

> *If the primary malignancy previously eradicated has recurred, assign a code for the original primary site using the appropriate code from C00-C75.*

Therefore, where a check cystoscopy is performed for previous TCC (M8120/3) of the bladder, and a TCC with the same morphology (M8120/3), but of a different site of the bladder is found, assign as principal diagnosis TCC of the original primary site, with morphology M8120/3.

For example:

TCC of dome of bladder diagnosed six months ago. TCC of bladder wall found at check cystoscopy. Assign:

C67.1 *Malignant neoplasm of dome of bladder*

M8120/3 *Transitional cell carcinoma NOS*

Where a check cystoscopy is performed for previous TCC (M8120/3) of the bladder, and an in situ TCC (M8120/2) of (any site within) the bladder is found, this is also considered a recurrence of the malignancy (that is, the morphology is the same, only the behaviour is different). Therefore, assign as principal diagnosis TCC of the original primary site, with morphology M8120/3.

For example:

TCC of dome of bladder diagnosed six months ago. In situ TCC of bladder wall found at check cystoscopy. Assign:

C67.1 *Malignant neoplasm of dome of bladder*

M8120/3 *Transitional cell carcinoma NOS*

Note: if a neoplasm is found at check cystoscopy with a different histological type/morphology (eg. previous TCC (M8120/3) with a papillary in situ TCC (M8130/2) found at follow-up), this is **not** considered a recurrence of the original neoplasm. In this scenario assign the appropriate in situ codes.

The classification and sequencing of neoplasms will be reviewed for a future edition.

See also, Coding Rule, *Recurrence of transitional cell carcinoma (TCC) of the bladder*, published 15 December, 2011 - note 'recurrence' does not need to be specifically documented to follow the advice in this Coding Rule.

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for implementation 01 October 2016.

Ref No: Q3095 | Published On: 15-Sep-2016 | Status: Retired | Retired On: 30-Jun-2019

Candidiasis of vulva and/or vagina complicating pregnancy

Q:

What is the correct code to assign from Chapter 15 *Pregnancy, childbirth and the puerperium* for candidiasis of vulva and/or vagina complicating pregnancy?

A:

Assign the following codes for candidiasis of vulva or vagina:

O23.5 *Infections of the genital tract in pregnancy*

B37.3† *Candidiasis of vulva and vagina*

N77.1* *Vaginitis, vulvitis and vulvovaginitis in infectious and parasitic diseases classified elsewhere*

as per the Alphabetic Index:

Pregnancy (single) (uterine)

…

- complicated by

- - infection(s)

- - - genital organ or tract O23.5

Candidiasis, candidal B37.9

…

- vagina B37.3† N77.1*

- vulva B37.3† N77.1*

- vulvovaginitis B37.3† N77.1*

This advice has a minor modification to correspond with an update in a subsequent edition ofICD-10-AM/ACHI/ACS.

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for implementation 01 October 2016.

Ref No: Q2971 | Published On: 15-Sep-2016 | Status: Retired | Retired On: 01-Jul-2017

Revision arthroplasty of the knee

Q:

Where ‘revision TKR’ (total knee replacement) is documented, and the operation report details replacement of a hemiarthroplasty with a total arthroplasty of the knee, is this classified as a revision procedure?

A:

In ACHI, replacement of a partial knee replacement with another partial knee replacement is classified as 49517-00 **[1518]** *Hemiarthroplasty of knee* by following the Alphabetic Index:

Revision (partial) (total)

- joint replacement (prosthesis)

- - knee, total (with removal of prosthesis)

- - - partial 49517-00 **[1518]**

(***Note***: There is an inconsistency in the ACHI Alphabetic Index. The essential modifier for ‘total’ in the above indexing should be a nonessential modifier. As there are no further errata for Ninth Edition, the error will be amended for Tenth Edition).

Where documentation in the operation report indicates ‘revision TKR’, assign codes for revision of total knee replacement, even if the in situ device is a partial knee replacement. Assign codes for revision of total arthroplasty of knee by following the Alphabetic Index:

Revision (partial) (total)

- joint replacement (prosthesis)

- - knee, total (with removal of prosthesis) 49527-00 **[1524]**

- - - with

- - - - anatomic specific allograft 49554-00 **[1523]**

- - - - bone graft

- - - - - anatomic specific allograft 49554-00 **[1523]**

- - - - - femur 49530-00 **[1523]**

- - - - - - and tibia 49533-00 **[1523]**

- - - - - tibia 49530-01 **[1523]**

- - - - - - and femur 49533-00 **[1523]**

Removal of the previously implanted prosthesis is inherent in the above codes.

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for implementation 01 October 2016.

Ref No: Q3007 | Published On: 15-Sep-2016 | Status: Retired | Retired On: 01-Jul-2017

Liver cirrhosis and endoscopic screening/surveillance for varices

Q:

What is the principal diagnosis to assign for liver cirrhosis patients admitted for endoscopy?

A:

Liver cirrhosis is a precursor for the development of oesophageal and gastric varices and may require regular endoscopic surveillance to screen for varices.

Note: the term surveillance is used interchangeably to mean follow-up of a previously treated disease, screening for a disease in patients at risk (eg family or personal history of disease, or a disease that places an individual at risk for other conditions) and/or ongoing management of a chronic disease.

Where a patient with liver cirrhosis is admitted for endoscopy, and:

- there is no documentation of screening/surveillance/? varices as the indication for endoscopy, assign a code for the liver cirrhosis as the principal diagnosis. Assign as an additional diagnosis an appropriate code for varices if found at endoscopy and meeting the criteria in ACS 0002 *Additional diagnoses*.
- documentation states screening/surveillance/? varices as the indication for endoscopy, follow the guidelines in ACS 2111 *Screening for specific disorders*. Do not follow ACS 0046 *Diagnosis selection for same-day endoscopy* which does not apply to screening episodes of care.

  For example, where documentation states admission for screening/surveillance/? varices in a patient with liver cirrhosis, but no varices are found at endoscopy, follow the guidelines in ACS 2111 and assign Z13.83 *Special screening examination for digestive tract disorder* as principal diagnosis.

Amendments are being made to the Australian Coding Standards for Tenth Edition in this area.

Published 15 September 2016,
for implementation 01 October 2016.

Ref No: Q3106 | Published On: 15-Sep-2016 | Status: Retired | Retired On: 01-Jul-2017

Failed back syndrome

Q:

What is the correct code assignment for ‘failed back syndrome’?

A:

Failed back syndrome is a synonym for postlaminectomy syndrome. The correct code to assign for failed back syndrome is M96.1 *Postlaminectomy syndrome, not elsewhere classified* following the Alphabetic Index:

Postlaminectomy syndrome NEC M96.1

Updates to the classification have been made for ICD-10-AM Tenth Edition.

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for implementation 01 October 2016.

Ref No: Q3013 | Published On: 15-Jun-2016 | Status: Retired | Retired On: 31-Dec-2019

Cardiac pacemaker and implanted defibrillator status

Q:

When should the pacemaker status code Z95.0 *Presence of cardiac device* be assigned?

A:

Medical equipment and devices which emit electromagnetic interference (EMI) can inhibit pulse generators and pacemakers causing damage to the circuits of the device and placing a patient at risk, so monitoring of the pacemaker function is essential during these procedures. The risk of EMI is high for some procedures, such as monopolar electrocautery.

ACS 0016 *General procedure guidelines states*:

A procedure is defined as “a clinical intervention represented by a code that:

- is surgical in nature, and/or
- carries a procedural risk, and/or
- carries an anaesthetic risk, and/or
- requires specialised training, and/or
- requires special facilities or equipment only available in an acute care setting” (METeOR 514040) (Australian Institute of Health and Welfare 2014)

ACS 0936 *Cardiac pacemakers and implanted defibrillators* states:

> Patients with a pacemaker or defibrillator in situ require additional care at the time of procedural interventions, and therefore *Z95.0* Presence of cardiac device should be coded for all procedural cases.

Z95.0 *Presence of cardiac device* is assigned as an additional diagnosis for those patients who have a pacemaker or implanted defibrillator in situ and who undergo a procedure that meets the definition of a procedural intervention as per ACS 0016 *General procedure guidelines*.

Published 15 June 2016,
for implementation 01 July 2016.

Ref No: Q3051 | Published On: 15-Jun-2016 | Status: Retired | Retired On: 30-Jun-2019

Endometrial Scratch

Q:

What is the correct code to assign for an endometrial scratch?

A:

Research suggests that by 'scratching' the endometrium the chemical conditions in the endometrium are more beneficial to an implanting embryo. It is thought that a repair process begins and this allows the release of a group of chemicals called growth factors in the endometrium, and it is these chemicals that increase the chances of a pregnancy (Woodhead 2014).

Assign 13215-03 **[1297]** *Other reproductive medicine procedure* for *endometrial scratch* by following the Alphabetic index:

Procedure

- for

- - reproductive medicine (in vitro fertilisation) NEC 13215-03 **[1297]**

Amendments to ACHI will be considered for a future edition.

References:

Woodhead C 2014, '*Endometrial scratch'* Alana healthcare for Women, viewed 25 February 2016, http://www.alanahealthcare.com.au/endometrial-scratch/

Published 15 June 2016,
for implementation 01 July 2016.

Ref No: Q3050 | Published On: 15-Jun-2016 | Status: Retired | Retired On: 30-Jun-2019

Lipiodol (poppy seed oil) tubal flushing

Q:

What procedure code should be assigned for Lipiodol flush?

A:

Lipiodol tubal flushing is a procedure that bathes the fallopian tubes (and uterus) in Lipiodol (poppy seed oil) (Repromed 2016).

Several theories exist on how Lipiodol is thought to enhance pregnancy rates, including flushing of non-occlusive but pregnancy-hindering debris from fallopian tubes; positively influencing the intraperitoneal environment; improving either the environment in which eggs mature or the sperm-egg interaction; or by enhancing implantation through a direct effect on the endometrium (Reilly & Johnson 2010).

The correct code to assign for Lipiodol tubal flushing is 35703-01 **[1248]** *Therapeutic hydrotubation* by following the Alphabetic Index:

Hydrotubation

- fallopian tube

- - therapeutic 35703-01 **[1248]**

If Lipiodol flushing is conducted with other gynaecology procedures eg hysteroscopy, code other procedures as appropriate.

Improvements will be considered for a future edition of ACHI.

References:

Repromed information sheet '*lipiodol flushing procedure*', viewed 25 February 2016, http://202.169.196.26/LinkClick.aspx?fileticket=_1nKGumnC9c%3D&tabid=1953

Reilly S & Johnson N 2010, *Fertility-enhancing effects of Lipiodol and the IVF-LUBE Study A multi-centre randomised trial*' O&G Magazine, vol. 12, no. 3 viewed 25 February 2016, http://www.ranzcog.edu.au/editions/doc_view/321-32-fertility-enhancing-effects-of-lipiodol-and-the-ivf-lube-study.html

Published 15 June 2016,
for implementation 01 July 2016.

Ref No: Q3042 | Published On: 15-Jun-2016 | Status: Retired | Retired On: 30-Jun-2019

Excision of umbilicus

Q:

What is the correct code to assign for excision of the umbilicus?

A:

As ACHI classifies other procedures on the umbilicus to the *Abdomen, Peritoneum and Omentum* assign 90331-00 **[1004]** *Other procedures on abdomen, peritoneum or omentum* following the Alphabetic Index:

Procedure

- abdomen NEC 90331-00 **[1004]**

Amendments for excision of umbilicus will be considered for a future edition of ACHI.

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for implementation 01 July 2016.

Ref No: Q3035 | Published On: 15-Jun-2016 | Status: Retired | Retired On: 30-Jun-2019

Turbinoplasty

Q:

What is the correct code to assign for a turbinoplasty?

A:

During a turbinoplasty, the turbinates are reshaped either by outfracturing or submucosal resection or a combination of the two methods. Both involve removal of turbinate tissue (ie a partial turbinectomy) via different mechanisms.

ACHI does not have a specific code for turbinoplasty, therefore assign code(s) according to the documentation within the operation report:

- 41692-00 **[376]** *Submucous resection of turbinate, unilateral*
- 41692-01 **[376]** *Submucous resection of turbinate, bilateral*
- 41686-00 **[381]** *Surgical fracture of nasal turbinates, unilateral*
- 41686-01 **[381]** *Surgical fracture of nasal turbinates, bilateral*
- 41689-00 **[376]** *Partial turbinectomy, unilateral*
- 41689-01 **[376]** *Partial turbinectomy, bilateral*

If outfracturing (surgical fracture) or submucous resection is not specified assign 41689-00 **[376]** *Partial turbinectomy, unilateral* or 41689-01 **[376]** *Partial turbinectomy, bilateral* following the Alphabetic Index:

Turbinectomy

- partial (unilateral) 41689-00 **[376]**

- - bilateral 41689-01 **[376]**

However, if a turbinoplasty (by any method) is performed in conjunction with a septoplasty assign 41671-02 **[379]** *Septoplasty* or 41671-03 **[379]** *Septoplasty with submucous resection of nasal septum*; as turbinectomy is included within these codes as per the *Includes* notes.

Amendments to ACHI will be considered for a future edition.

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for implementation 01 July 2016.

Ref No: Q3000 | Published On: 15-Jun-2016 | Status: Retired | Retired On: 30-Jun-2019

Endotracheal administration of surfactant

Q:

Should endotracheal intubation be assigned when surfactants, such as Curosurf, are administered via an endotracheal tube?

A:

Curosurf is a natural surfactant, prepared from porcine lungs and used in the treatment of respiratory distress syndrome (RDS) in premature babies. Surfactants are wetting agents that coat the surface of the air sacs (alveoli) and reduce surface tension in the lungs which assists the air sacs to inflate and expand during breathing and stops them sticking together. Administration of surfactants helps premature neonates breathe until their lungs have developed enough to produce their own surfactant.

Surfactants, such as Curosurf, may be given directly into the lungs via an endotracheal tube in a ventilated neonate, or administered prophylactically through an endotracheal tube without ventilation.

ACS 1614 *Respiratory distress syndrome/hyaline membrane disease/surfactant deficiency* states:

> Surfactant is administered routinely for the treatment of respiratory distress syndrome of the newborn and should not be coded (see ACS 0042 *Procedures normally not coded, point 8*).

Endotracheal intubation as the route of administration for a surfactant is not coded unless it proceeds to ventilation.

Published 15 June 2016,
for implementation 01 July 2016.

Ref No: Q2999 | Published On: 15-Jun-2016 | Status: Retired | Retired On: 30-Jun-2019

Implantation of bone conduction hearing devices

Q:

What codes should be assigned for implantation of bone conduction hearing devices?

A:

A bone conduction hearing aid consists of a hearing aid worn behind the ear coupled with an electromagnetic bone conductor/vibrator. These devices are not bone anchored.

Bone conduction aids may be the best option for children who cannot wear a conventional aid due to the following:

- ear/s have not developed normally and parts of the outer or middle ear are missing or too small to fit the device,
- constantly discharging ears,
- severe irritation or inflammation in the external canal.

A bone conduction hearing aid is classified to 41557-02 **[321]** *Implantation of electromagnetic hearing device* by following the Alphabetic Index:

Insertion

- hearing device

- - bone conduction 41557-02 **[321]**

…

- - electromagnetic 41557-02 **[321]**

The bone anchored hearing aid or 'BAHA' system utilises a titanium implant which is placed in the skull bone behind the non-functioning ear. An abutment connects the sound processor with the implant in the bone. This creates direct (percutaneous) bone conduction.

BAHA may be performed as a one stage or two stage surgery. This decision is based on several factors including the thickness and quality of the cortical bone as well as the patient's age. Generally, for patients with good bone quality and thickness greater than 3 mm, surgery in a single operative episode is recommended. However, in patients with compromised or soft bone, irradiated bone, bone thickness less than 3 mm, special needs patients (eg mentally or physically compromised) or in conjunction with other surgery (eg acoustic neuroma removal) two stages is generally recommended.

As per ACS 1220 *Extraoral osseointegrated implants*:

Stage one BAHA surgery is classified to 45794-00 **[1698]** *Osseointegration procedure, implantation of titanium fixture for attachment of bone anchored hearing aid [BAHA]* by following the Alphabetic Index:

Osseointegration

- extraoral

- - implantation of titanium fixture (1st stage)

- - - for

- - - - attachment of

- - - - - bone anchored hearing aid (BAHA) 45794-00 **[1698]**

Stage two BAHA surgery is classified to 45797-00 **[1697]** *Osseointegration procedure, fixation of transcutaneous abutment for attachment of bone anchored hearing aid [BAHA]* by following the Alphabetic Index:

Osseointegration

- extraoral

- - fixation of transcutaneous abutment (2nd stage)

- - - for attachment of

- - - - bone anchored hearing aid (BAHA) 45797-00 **[1697]**

Where both 'stages' of the BAHA are completed in one operative visit assign both codes. Do not assign 41557-02 **[321]** *Implantation of electromagnetic hearing device* with BAHA surgery.

Clinical coders should be guided by the entire operation report, not abbreviations or brand names.

Improvements to the classification of bone conduction and bone anchored hearing aids will be considered for a future edition of ACHI.

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Ref No: Q3030 | Published On: 15-Jun-2016 | Status: Retired | Retired On: 30-Jun-2019

Intra-tympanic dexamethasone (IT dexa)

Q:

What is the appropriate code for intra-tympanic administration of dexamethasone or other pharmacological agent?

A:

Intra-tympanic (IT) administration of pharmacological agents such as dexamethasone and gentamicin are used in the treatment of inner ear disorders such as Meniere's disease and autoimmune or sensorineural hearing loss.

Administration is a simple injection via myringotomy, tympanostomy tube or microwick, which delivers the pharmacological agent directly to the middle ear (round window membrane).

For IT administration of pharmacological agents to the middle ear (round window membrane) assign 90114-00 **[316]** *Other procedures on eardrum or middle ear* following the Alphabetic Index:

Procedure

- ear

- - middle NEC 90114-00 **[316]**

Amendments to ACHI will be considered for a future edition.

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Ref No: Q3052 | Published On: 15-Jun-2016 | Status: Retired | Retired On: 01-Jul-2017

Organ and Tissue Procurement (ACS 0030)

Q:

ACS 0030 *Organ and tissue procurement and transplantation, point 2b. Donation following brain death in hospital* states:

> In the procurement episode after the initial episode and following brain death, assign as principal diagnosis the appropriate code from Z52.- *Donors of organs and tissues* and the relevant procedure code(s). It is not necessary to assign diagnoses from the initial episode or cause of death as these will already have been coded in the initial episode. Only code patients who actually proceed to organ donation.

Do these guidelines apply if the harvested organs are not used for donation?

A:

The instruction in ACS 0030 *Organ procurement and transplantation* cited in the query applies to those patients who have a posthumous procurement episode of care where organs are harvested irrespective of whether or not the organs are used for donation; even if they are returned to the donor.

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for implementation 01 July 2016.

Ref No: Q2992 | Published On: 15-Jun-2016 | Status: Retired | Retired On: 01-Jul-2017

Leg ulcer due to venous insufficiency

Q:

Index entries for leg ulcer due to venous insufficiency lead to I87.2 *Venous insufficiency,* which does not reflect that the patient has a leg ulcer.

Can an appropriate code from category L97 *Ulcer of lower limb, not elsewhere classified* also be assigned to reflect the episode of care?

A:

The indexing for leg ulcer due to venous insufficiency is from ICD-10 and supports mortality coding ie coding of the underlying cause (aetiology). However, for the purpose of morbidity coding, apply ACS 0001 *Principal diagnosis, problems and underlying conditions, point 2. Coding the problem as the principal diagnosis* which supports the assignment of the problem (limb ulcer) **and** underlying cause (venous insufficiency).

Therefore, to classify a leg ulcer (without further specification) due to venous insufficiency, assign L97.9 *Ulcer of lower limb, unspecified* **and** I87.2 *Venous insufficiency (chronic) (peripheral)* as per ACS 0001 *Principal diagnosis, problems and underlying conditions, point 2*.

Note: This advice should not be used as a precedent to ignore other index entries without confirmation from ACCD.

Amendments to ICD-10-AM Alphabetic Index will be considered for a future edition.

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for implementation 01 July 2016.

Ref No: Q3019 | Published On: 15-Jun-2016 | Status: Retired | Retired On: 01-Jul-2017

Neuropathic pain

Q:

What is the correct code to assign for neuropathic pain?

A:

Neuropathic pain is a type of chronic pain caused by a lesion or disorder of the nervous system (eg multiple sclerosis). It typically presents as generalised pain.

ICD-10-AM does not have a specific code or Alphabetic Index entry for neuropathic pain.

It is incorrect to follow the Alphabetic Index Pain/nerve NEC to assign M79.2- *Neuralgia and neuritis, unspecified* or Neuropathy, neuropathic to assign G62.9 *Polyneuropathy, unspecified*.

Where neuropathic pain is documented assign R52.2 *Other chronic pain* following the Alphabetic Index:

Pain(s)

- chronic

- - specified R52.2

If neuropathic pain is documented as localised eg neuropathic pain of leg, follow the guidelines in ACS 1807 *Pain diagnoses and pain management procedures, Chronic/intractable pain* and code the site of the pain.

The classification of chronic pain is currently under review for ICD-10-AM Tenth Edition.

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for implementation 01 July 2016.

Ref No: Q3046 | Published On: 15-Jun-2016 | Status: Retired | Retired On: 01-Jul-2017

Kennedy terminal ulcer

Q:

How should Kennedy terminal ulcer (Kennedy ulcer) be coded? Should it be classified as a pressure injury or as an ulcer?

A:

A Kennedy terminal ulcer (KTU), or Kennedy ulcer, is a type of pressure injury (ulcer) that occurs in patients in the terminal stage of life. Although a Kennedy ulcer may have a different shape to other pressure ulcers and may progress rapidly from superficial to deep, their management is the same as any other pressure injury (ulcer).

Where clinical documentation identifies a Kennedy terminal ulcer, assign an appropriate code from category L89 *Pressure injury*.

Improvements to the classification will be considered for a future edition.

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for implementation 01 July 2016.

Ref No: Q3048 | Published On: 15-Jun-2016 | Status: Retired | Retired On: 01-Jul-2017

Facetectomy

Q:

What is the correct code to assign for facetectomy, eg lumbar 4/5 medial facetectomy?

A:

Medial facetectomy is a procedure that partially removes one or both facet joints of the vertebrae. The procedure decompresses the spinal nerves being pinched by degenerated facet joints (Philips, 2016).

While there is no index entry for facetectomy in ACHI the correct code to assign is 40330-00 **[49]** *Spinal rhizolysis* following the Alphabetic Index:

Decompression

- spinal

- - nerve roots (rhizolysis) 40330-00 **[49]**

Amendments to the ACHI Alphabetic Index will be considered for a future edition.

References:

Philips M 2016, The Brain and Spine Center, Southcoast Hospitals Group, Dartmouth, Massachusetts, *"Medial Facetectomy'*, viewed 25 February 2016, http://www.spines.com/procedures/medial-facetectomy

Published 15 June 2016,
for implementation 01 July 2016.

Ref No: Q3043 | Published On: 15-Mar-2016 | Status: Retired | Retired On: 30-Jun-2019

Chondroplasty of wrist

Q:

What is the correct code to assign for chondroplasty of the wrist?

A:

There is no specific code in ACHI for chondroplasty of the wrist, however ACHI classifies chondroplasty of other sites to blocks for ‘other repair procedures’.

Therefore assign 90542-00 **[1468]** *Other repair of wrist* following the index pathway:

Repair

- wrist NEC 90542-00 **[1468]**

Where chondroplasty of the wrist is performed arthroscopically, also assign 49218-00 **[1443]** *Arthroscopy of wrist*, as per ACS 0023 *Laparoscopic/arthroscopic/endoscopic surgery*.

Amendments to ACHI Alphabetic Index will be considered for a future edition of ACHI

Published 15 March 2016,
for implementation 01 April 2016.

Ref No: Q3017 | Published On: 15-Mar-2016 | Status: Retired | Retired On: 30-Jun-2019

ACS 0002 *Additional diagnoses* and alteration to treatment - Part 2

Q:

Should a condition be assigned as an additional diagnosis whenever medication is altered or only when the medication is altered for management of that condition (ie not management of a side effect). The Coding Rules Anticoagulation monitoring (15 June 2010) and ACS 0002 *Additional diagnoses* and alteration to treatment (15 June 2015) appear to contradict.

A:

The advice published 15 June 2010, Anticoagulation monitoring, is still current and should be followed ie assign Z92.1 *Personal history of long term (current) use of anticoagulants* to reflect alteration to anticoagulants as detailed in the Coding Rule. However, the advice is specific to anticoagulants and should not be applied to other conditions or scenarios. Changes to the classification of anticoagulation therapy are being implemented for Tenth Edition when this advice will be retired.

Where medication to treat a specific condition is altered during an episode of care, assign an additional diagnosis code for the condition by following the criteria in ACS 0002 *Additional diagnoses*, dot point 1, which states:

> *For coding purposes, additional diagnoses should be interpreted as conditions that affect patient management in terms of requiring any of the following:*
>
> - *commencement, alteration or adjustment of therapeutic treatment*

Although alteration to medication may be related to management of a side effect of the medication, the therapeutic treatment of the condition is still being altered and so meets the criterion above to be assigned as an additional diagnosis.

A review of the criteria for assignment of additional diagnoses in ACS 0002 is planned for the future, following analysis of the *Supplementary codes for chronic conditions* (U codes) data.

Published 15 March 2016,
for implementation 01 April 2016.

Ref No: Q2972 | Published On: 15-Mar-2016 | Status: Retired | Retired On: 30-Jun-2019

Traumatic neuroma due to surgery

Q:

What is the correct diagnosis code to assign for a traumatic neuroma due to surgery?

For example, a patient was admitted post brow lift with wound swelling. The wound was excised and the histopathology report found traumatic neuroma.

A:

The correct code to assign for traumatic neuroma due to surgery in the scenario cited is G97.8 *Other intraoperative and postprocedural disorders of the nervous system* following the index pathway:

Complication(s)

- nervous system

- - intraoperative or postprocedural

- - - specified NEC G97.8

ACS 1904 *Procedural complications* states:

An additional code from Chapters 1 to 19 should be assigned where it provides further specificity.

In the scenario cited, no additional code provides further specificity and thus no additional code is assigned.

This advice has a minor modification to correspond with an update in a subsequent edition ofICD-10-AM/ACHI/ACS.

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for implementation 01 April 2016.

Ref No: Q3026 | Published On: 15-Mar-2016 | Status: Retired | Retired On: 30-Jun-2019

Wound debridement

Q:

Can a debridement of a wound in theatre be coded as a soft tissue debridement?

A:

ACS 1203 *Debridement*, states:

- ***most** debridements are excisional*
- *check with the clinician if unsure*
- *use the nonexcisional code if documentation/clinical advice supports its use*

Therefore, a wound taken to theatre for debridement is assumed to be excisional unless there is documentation or clinical advice that supports assignment of a code for nonexcisional debridement. The advice in ACS 1203 effectively defaults classification of wound debridement to excisional. However, there is no default position as to whether the excisional debridement is of soft tissue or skin and subcutaneous tissue.

ACS 1916 *Superficial and soft tissue injuries* defines soft tissue (deep tissue) as tissue that:

> *connects, supports or surrounds other structures and organs of the body. Soft tissue includes muscles, nerves, tendons, fat, blood or lymph vessels, fasciae and tissue around joints (synovial tissue) (that is, all tissue excluding skin, subcutaneous tissue, cartilage and bone).*

Where documentation in the clinical record, in particular the operation report, states that debridement was of 'soft tissue', 'deep tissue' or soft tissue structures assign 30023-00 **[1566]** *Excisional debridement of soft tissue* by following the Alphabetic Index:

Debridement

- soft tissue, excisional NEC 30023-00 **[1566]**

In the absence of documentation to support that any deep or soft tissue structures have been debrided, or if only subcutaneous tissues are documented as having been debrided (and there is no indication it is nonexcisional), assign 90665-00 **[1628]** *Excisional debridement of skin and subcutaneous tissue* by following the index pathway:

Debridement

- skin

- - excisional 90665-00 **[1628]**

This advice has a minor modification to correspond with an update in a subsequent edition ofICD-10-AM/ACHI/ACS.

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for implementation 01 April 2016.

Ref No: TN1033 | Published On: 15-Mar-2016 | Status: Retired | Retired On: 01-Jul-2017

Admission for donor apheresis

Q:

Can Z51.81 *Apheresis* be assigned for a patient admitted to donate their cells via apheresis?

A:

Apheresis (haemapheresis) is the process of removing whole blood, extracting a specific component from the blood and then reinfusing into the donor. A number of terms may be used to describe the specific cells being extracted, for example:

- plasmapheresis – extraction of plasma
- leukapheresis – extraction of leukocytes (white blood cells)
- plateletpheresis – extraction of platelets

Allogeneic donor apheresis is a healthy donor admitted to donate cells for infusion into another person. The target cells are harvested and the unused portion of the blood is reinfused into the donor. Assign as principal diagnosis:

Z51.81 *Apheresis*

Autologous donor apheresis is when a patient with a known disease such as a malignancy is admitted to donate their own cells for therapeutic reinfusion at a later stage. Assign as principal diagnosis the condition that will be treated by the donated cells.

Do not assign Z51.81 in this scenario; the apheresis will be identified by the assignment of an appropriate ACHI code from block **[1892]** *Apheresis.*

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for implementation 01 April 2016.

Ref No: Q2966 | Published On: 15-Mar-2016 | Status: Retired | Retired On: 01-Jul-2017

Postprocedural wound dehiscence

Q:

What is the correct code to assign for a wound dehiscence following insertion of a prosthetic device, implant or graft?

A:

Assign T81.3 *Disruption of operation wound, not elsewhere classified*, for postprocedural wound dehiscence, following the index pathway:

Dehiscence

- postprocedural NEC T81.3

Disregard the *Excludes* note at T81 *Complications of procedures, not elsewhere* classified which excludes

complications of prosthetic devices, implants and grafts (T82–T85)

in this instance as T81.3 provides more specificity than a residual code at T82-T85 *Complications of prosthetic devices, implants and grafts*.

The classification of procedural complications is currently under review.

Published 15 March 2016,
for implementation 01 April 2016.

Ref No: Q3024 | Published On: 15-Mar-2016 | Status: Retired | Retired On: 01-Jul-2017

Endoscopic pilonidal sinus treatment (EPSiT)

Q:

How do you code endoscopic pilonidal sinus treatment (EPSiT)?

A:

Endoscopic pilonidal sinus treatment (EPSiT) is a video-assisted minimally invasive treatment for pilonidal sinus. The aim of EPSiT is to clean and ablate an infected sinus tract, to promote healing and prevent recurrence.

EPSiT is performed by incising a small circular area around the external opening of the pilonidal sinus. Insertion of a 'fistuloscope' (an endoscopic instrument inserted into the fistula/sinus) provides visualization. Hair particles and debris within the sinus are removed using forceps. Sinus granulation tissue is ablated (cauterised) using a monopolar electrode connected to an electrosurgical knife. A continuous infusion of glycine/mannitol solution is used to assist with removal of the ablated/cauterised tissue. Necrotic material may also be removed using an endobrush via the fistuloscope (or Volkmann spoon for superficial waste). Mesh and a fibrin sealant may be sutured at the sinus opening prior to application of an external dressing.

For classification of endoscopic pilonidal sinus treatment (EPSiT), assign:

30676-00 **[1659]** *Incision of pilonidal sinus or cyst*

by following the index pathway:

Incision

- pilonidal sinus (cyst) 30676-00 **[1659]**

Additional codes for the various components of the procedure (eg endoscopy/fistuloscopy, insertion of mesh/fibrin sealant, ablation of pilonidal fistula tissue) are not assigned:

- as per the guidelines in ACS 0016 *General procedure guidelines/procedure components*

and

- as there is no code for fistuloscopy in ACHI.

Enhancements to ACHI will be considered for a future edition.

Published 15 March 2016,
for implementation 01 April 2016.

Ref No: Q3006 | Published On: 15-Mar-2016 | Status: Retired | Retired On: 01-Jul-2017

Diabetes mellitus in pregnancy

Q:

Does diabetes mellitus have to be documented as complicating the pregnancy before assigning a code from O24 *Diabetes mellitus in pregnancy*?

A:

When a pregnant patient is admitted with diabetes mellitus, assign an appropriate code from O24 *Diabetes mellitus in pregnancy;* there does not need to be documentation that the diabetes mellitus is complicating the pregnancy.

See ACS 0001 *Principal diagnosis/Obstetrics* for guidelines regarding sequencing in antepartum and delivery episodes.

The classification of *complications of pregnancy* is being reviewed for Tenth Edition.

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for implementation 01 April 2016.

Ref No: Q2983 | Published On: 15-Mar-2016 | Status: Retired | Retired On: 01-Jul-2017

Tobacco dependence

Q:

What is the correct code to assign for documentation of tobacco dependence (without the term syndrome documented) and does the advice also apply to alcohol and other drugs?

A:

ACS 0503 *Drug, Alcohol and Tobacco Use Disorders* states:

> *Importantly, it should be noted that documentation such as 'on patches' or 'trying to quit' are not justification to classify to the dependence syndrome. The dependence syndrome is defined as a cluster of phenomena … and therefore it is important that a clinical decision to classify a case to this code is made based on that evidence and not because society in general regards all smokers as dependent*.

Dependence, *addiction* **or** *dependence syndrome* must be documented before F10-F19 with fourth character .2 can be assigned. F17.*2 Tobacco dependence syndrome* is assigned following index pathways:

Dependence

- due to

- - nicotine F17.2

- - tobacco F17.2

- syndrome — *code to F10–F19 with fourth character .2*

This rationale also applies to alcohol and other drugs ie *dependence, addiction* or *dependence syndrome* must be documented before assigning an appropriate code from F10-F19 with fourth character code *.2 dependence syndrome*.

The misleading statement above Example 8 in ACS 0503 *Drug, alcohol and tobacco use disorders* will be revised as part of errata 4 to Ninth Edition as follows:

F17.2 Tobacco dependence syndrome

Assign this code if the patient is diagnosed as having tobacco dependence (syndrome).

ACS 0503 *Drug, Alcohol and Tobacco Use Disorders* is currently under review for ICD-10-AM Tenth Edition.

Published 15 March 2016,
for implementation 01 April 2016.

Ref No: Q3027 | Published On: 15-Mar-2016 | Status: Retired | Retired On: 01-Jul-2017

E-cigarettes and waterpipes

Q:

Should the use of alternative smoking devices such as e-cigarettes and shisha be coded to Z72.0 *Tobacco use, current* when their use meets the definition of 'current use'? Do they also qualify for assignment of codes from category F17 *Mental and behavioural disorders due to use of tobacco*?

A:

Electronic cigarettes (e-cigarettes, green cig, e-shisha, vape-pipes) and waterpipes (hookah, narghile, shisha) are increasingly popular alternatives to cigarette smoking.

Electronic cigarettes are an electronic nicotine delivery system (ENDS). The device includes a replaceable cartridge containing nicotine. They also contain tobacco-derived substances but tobacco is not necessary for their operation. This allows the consumer to inhale a mixture of air and vapours from the device into the lungs (WHO, 2009).

Alternatively, waterpipes are a way of smoking tobacco, sometimes mixed with fruit or molasses sugar, through a bowl and hose or tube. Waterpipes can also be tobacco-based or come in 'herbal' forms. Although many consider this type of smoking safer, it carries many of the same toxins and health risks as cigarettes (CDC, 2015).

While nicotine causes the dependence on cigarettes, it is the tobacco which causes the majority of the damage to health (Sweanor, 2000).

Therefore, Z72.0 *Tobacco use, current*:

- **is** assigned where use of waterpipes is documented, as they are a form of tobacco smoking
- is **not** assigned for use of electronic cigarettes, as these devices do not deliver tobacco.

The smoking of both e-cigarettes and waterpipes also qualify for assignment of codes from category F17 *Mental and behavioural disorders due to use of tobacco* (which includes use of nicotine) where supported in the documentation.

References:

Centre for Disease Control and Prevention (CDC) 2015, *Smoking & Tobacco use: Hookas*, viewed 11 February 2016 http://www.cdc.gov/tobacco/data_statistics/fact_sheets/tobacco_industry/hookahs/

Sweanor, D 2000, 'Is it the nicotine or the tobacco?', *Bulletin of the World Health Organization*, volume 78 no.7, viewed 12 February 2016 http://www.who.int/bulletin/archives/78(7)943.pdf

World Health Organization (WHO) 2009, *WHO Technical Report Series 955, WHO Study Group on tobacco product regulation: a report on the scientific basis of tobacco product regulation: third report of a WHO study group*, viewed 12 February 2016 http://apps.who.int/iris/bitstream/10665/44213/1/9789241209557_eng.pdf

Published 15 March 2016,
for implementation 01 April 2016.

Ref No: Q3011 | Published On: 15-Mar-2016 | Status: Retired | Retired On: 01-Jul-2017

ACS 0503 *Drug, Alcohol and Tobacco Use Disorders* and the application instructions for harmful use

Q:

A patient is admitted with UTI. In the medical history it has been documented that the patient has smoking related COPD; now an exsmoker.

Should F17.1*Mental and behavioural disorders due to use of tobacco, harmful use* or Z86.43 *Personal history of tobacco use disorder* be assigned?

Should COPD be assigned if it does not meet ACS 0002 *Additional diagnoses*?

A:

The guidelines in ACS 0503 *Drug, Alcohol and Tobacco Use Disorders*/*Classification/General* (below) state:

> *Where the clinician has clearly documented a relationship between a particular condition(s) and alcohol/drug use, assign a code for the specific condition (see Alphabetic Index), with the appropriate code from F10–F19. Such documentation includes qualifying statements such as 'alcohol-induced' or 'drug-related', or 'CAL/smoker' indicating evidence that the substance use was responsible for (or substantially contributed to) physical or psychological harm. Sequencing should be determined by following the classification guidelines in ACS 0001 Principal diagnosis and ACS 0002 Additional diagnoses.*

There is no explicit 'always code' instruction within ACS 0503, and as such the condition itself must meet the criteria in ACS 0002 *Additional diagnoses* in order to be assigned in conjunction with an appropriate code from F10-F19.

Irrespective of whether or not the condition itself meets the criteria in ACS 0002 *Additional diagnoses* for code assignment, F17.1 *Mental and behavioural disorders due to use of tobacco, harmful use* is the correct code to assign for the scenario cited.

Z86.43 *Personal history of tobacco use disorder* is not to be assigned in addition to F17.1 *Mental and behavioural disorders due to use of tobacco, harmful use* as per the *Excludes* note at Z86.43 *Personal history of tobacco use disorder*.

ACS 0503 *Drug, Alcohol and Tobacco Use Disorders* is being reviewed for ICD-10-AM Tenth Edition.

Published 15 March 2016,
for implementation 01 April 2016.

Ref No: Q3039 | Published On: 15-Mar-2016 | Status: Retired | Retired On: 01-Jul-2017

Insertion, removal and exchange of silicone oil with repair of retinal detachment

Q:

Should insertion, removal or exchange of silicone oil be coded separately when repair of retinal detachment is performed?

A:

The insertion of silicone oil, variously described as fluid exchange or replacement of vitreous, is a component of most retinal detachment repair procedures, and therefore is not to be assigned a separate ACHI code as per ACS 0016 *General procedure guidelines/procedure components*.

Removal of the silicone oil is usually performed three to six months after retinal repair as an independent procedure and is classified to 42815-00 **[205]** *Removal of silicone oil*.

Ophthalmic intervention codes in ACHI are currently under review.

Published 15 March 2016,
for implementation 01 April 2016.

Ref No: Q3038 | Published On: 15-Mar-2016 | Status: Retired | Retired On: 01-Jul-2017

Ptosis of eyebrow

Q:

What code should be assigned for ptosis of the eyebrow?

A:

The index default at the lead term *Ptosis* is H02.4 *Ptosis of eyelid* and there is no subterm for 'eyebrow'. This default is not correct for 'ptosis of eyebrow'. Ptosis (also known as sagging) of the eyebrow is a condition separate to ptosis (or sagging) of the eyelid.

The correct ICD-10-AM code to assign for ptosis of the eyebrow is L98.7 *Excessive and redundant skin and subcutaneous tissue* (which has an inclusion term for sagging skin).

Follow the Alphabetic Index pathway:

Excess, excessive, excessively

- skin (following weight loss) L98.7

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

Published 15 March 2016,
for implementation 01 April 2016.

Ref No: Q3031 | Published On: 15-Mar-2016 | Status: Retired | Retired On: 01-Jul-2017

Adjustment of gastric balloon

Q:

What code is assigned for adjustment of a gastric balloon?

A:

Adjustment of a gastric balloon is an endoscopic procedure, requiring the administration of sedation and preoperative preparation (liquid diet for a number of days prior and fasting the night before the procedure). The position of the gastric balloon is identified using the endoscope and saline is inserted (to further inflate) or aspirated (to partially deflate) the gastric balloon.

While there are codes for insertion and removal of a gastric balloon in ACHI Ninth Edition, there is no code to classify *adjustment* of a gastric balloon.

Where adjustment of gastric balloon is performed, assign:

90943-02 **[889]** *Other endoscopic procedures for obesity*

by following the index pathway:

Procedure

- for

- - obesity NEC

- - - endoscopic 90943-02 **[889]**

Creation of a code for *endoscopic adjustment of device in stomach* will be considered for a future edition of ACHI.

Published 15 March 2016,
for implementation 01 April 2016.

Ref No: Q2993 | Published On: 15-Dec-2015 | Status: Retired | Retired On: 30-Jun-2019

Use of the subterms in (due to) in ICD-10-AM Alphabetic Index

Q:

Should conditions documented together, but without a stated causal relationship documented, both be coded when they are indexed with the terms *in (due to)*?

A:

Even though ‘in’ is a preposition, it is not one of the prepositional subterms listed in the convention for prepositional terms in the *General arrangement of the alphabetic index of diseases*.

The indexing of a condition with the subterm ***in (due to)*** in ICD-10-AM Alphabetic Index implies a cause and effect relationship between two conditions.

The following index entries assign a single code that describes a cause and effect relationship between two conditions:

Encephalopathy (acute)

- in (due to)

- - birth trauma P11.1

P11.1 *Other specified brain damage* ***due to*** *birth trauma*

Myelopathy (spinal cord)

- in (due to)

- - degeneration or displacement, intervertebral disc NEC M51.0

M51.0 *Lumbar and other intervertebral disc disorders* ***with*** *myelopathy*

Other index entries with the subterm in (due to) assign two codes; that is, a dagger and asterisk pair to describe the cause and effect relationship between two conditions as in the following example:

Pyelonephritis *(see also Nephritis/tubulo-interstitial)*

- in (due to)

- - sepsis NEC A41.-† N16.0*

A41 *Other sepsis*

N16.0* *Renal tubulo-interstitial disorders in infectious and parasitic diseases classified elsewhere*

Where the ICD-10-AM Alphabetic Index has linked two conditions using the subterms *in (due to)*, this index entry should be followed except where a specific cause for the condition has been otherwise indicated in the clinical record.

For example, if the patient has pyelonephritis and sepsis during the same episode of care as per the above example, unless documentation identifies that the pyelonephritis is definitively due to another cause, the index pathway should be followed to inform code assignment. The causal relationship between pyelonephritis and sepsis is assumed unless otherwise indicated.

The classification of diabetes mellitus is governed by the specific guidelines in ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* – see *General classification rules for DM and IH* and in particular *Rule 3.*

ACCD will consider adding explanatory text in the conventions for the use of the subterm *in (due to)* in ICD-10-AM Alphabetic Index, in a future edition.

Published 15 December 2015,
for implementation 01 January 2016.

Ref No: TN1028 | Published On: 15-Dec-2015 | Status: Retired | Retired On: 30-Jun-2019

Coding from findings on medical imaging (radiological) reports

Q:

How do you decide when a finding on a radiological report should be used to inform coding?

A:

ACS 0010 *General abstraction guidelines, test results* differentiates between results/findings:

- that clearly add specificity to a documented condition which may be used to inform code assignment
- where the relationship between test results and a documented condition is unclear, test results are not to be used to inform code assignment without clinical confirmation.

Examples:

- Conditions/manifestations (where the classification assumes a causal link), that are listed in test results and not documented or confirmed by the clinician, are not to be used to inform code assignment. For example:
  - Patient with documented diabetes mellitus has a finding of fatty liver on an ultrasound report; do not use the fatty liver to assign E1-.72 **diabetes mellitus with features of insulin resistance*.
  - Although the classification links pneumonia and COPD, both conditions must be documented or confirmed by the clinician before applying the guidelines in ACS 1008 *Chronic obstructive pulmonary disease (COPD)*
  - Although the classification links ureteric calculus and hydronephrosis, both conditions must be documented or confirmed by the clinician to inform code assignment
- Metastases/secondary neoplasms that are identified in medical imaging reports but not documented or confirmed by the clinician are not to be used to inform code assignment.

Where clinical advice is unavailable to clarify the significance of a test result or imaging finding and a documented condition, clinical coders should not use the test result to inform code assignment.

Q:

Can radiological findings be used to identify all injuries in a multiple injury case?

A:

ACS 1907 *Multiple injuries* has been amended for Ninth Edition to incorporate previously published advice:

> When coding the **initial** admission of a multiple trauma, all injuries documented must be coded to represent the totality of multiple trauma.

ACS 1907 and the previous Coding Rule which informed the Ninth Edition update applies to multiple trauma where there is documentation of multiple injuries ranging from severe and life threatening to less severe eg contusions and grazes. The ACS specifies all documented injuries including contusions and grazes (unless associated with a more severe injury of the same site) must be coded to represent the totality of trauma.

In addition, the guidelines must be applied in conjunction with ACS 0010 *General abstraction guidelines, test results.* Therefore, radiological findings may be used to provide specificity to a documented condition (such as the site of a fracture). Do not code conditions identified on test results that are not documented in the clinical record or confirmed by the clinician.

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Injection of markers into lesions of the gastrointestinal tract

Q:

What is the correct procedure code for injection of markers such as lipoidol/ histoacryl markers into gastrointestinal tract lesions?

A:

Endoscopic tattooing or marking is a commonly used method for marking lesions of the gastrointestinal tract (oesophageal, gastric, colonic).

There are different types of markers used for different purposes:

- Radiolucent markers such as carbon particles (SPOT) or India ink, are primarily used to mark a lesion to facilitate location of the lesion in subsequent surgery or follow up.
    - Radio-opaque markers such as Lipoidol, are used to demarcate lesion margins for precise delivery of image guided radiotherapy. Demarcation of the lesion in the gastrointestinal tract is usually performed endoscopically. Markers are injected into the normal mucosa around the circumference of the lesion, outlining its margin.

For injection of tattooing markers (of any type) into lesions of the oesophagus, stomach or intestine, assign an appropriate code for the type of endoscopy with injection/administration of tattooing agent using the following index pathways as appropriate:

Oesophagoscopy (flexible)
- with
- - administration of tattooing agent 30473-07 **[1005]**

OR

Administration
- C

Appropriate codes are:

30473-07 **[1005]** *Panendoscopy to duodenum with administration of tattooing agent*

30473-08 **[1005]** *Panendoscopy to ileum with administration of tattooing agent*

32084-02 **[905]** *Fibreoptic colonoscopy to hepatic flexure with administration of tattooing agent*

32090-02 **[905]** *Fibreoptic colonoscopy to caecum with administration of tattooing agent*

Improvements to ACHI will be considered for a future edition.

Reference:

Australian New Zealand Clinical Trials Registry (ANZCTR) n.d., Phase II Feasibility Study of Lipidiol Markers for Radiation Therapy Localisation and Response Assessment in the Multi-Disciplinary Team Management of Oesophageal-Gastric Cancer, viewed 12, Oct 2015, https://www.anzctr.org.au/Trial/Registration/TrialReview.aspx?ACTRN=12613000239763

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Debridement of burn performed with change of dressing

Q:

Should debridement, trimming of skin and de-roofing of blisters performed with change of burn dressings be coded?

A:

ACCD considers the statement in ACS 1203 *Debridement*, 'most debridements are excisional' refers to debridements performed in an operating room, as per the reference to 'surgeon'. ACS 1911 *Burns/Dressing/debridement of burns* refers to these procedures being performed in the 'operative episode' and refers clinical coders to the excisional debridement codes in block **[1627]** *Debridement of burn*.

Clinical advice confirms that debridement, de-roofing of blisters and trimming of skin during a change of burn dressing, performed on the ward with no anaesthesia, is nonexcisional debridement. This type of nonexcisional debridement is an inherent component of changing a burn dressing and is not to be coded as per ACS 0016 *General Procedure Guidelines, Procedure Component*.

Note: This advice is specific to the classification of debridement of burn with change of dressing; do **not** apply to other scenarios for debridement.

Improvements to the classification of wound management have been flagged for review in a future edition of ACHI.

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Vacuum assisted wound closure (VAC) Dressings

Q:

Where multiple VAC dressings are applied in an episode, how many times should the code be assigned?

A:

Vacuum assisted wound closure (VAC) is a type of wound dressing which uses negative pressure to promote wound healing. The wound is covered with open cell foam or gauze dressing that moulds to the wound bed. A drainage tube is attached, the wound is then sealed and vacuum or negative pressure is applied via a pump. The suction pressure removes or 'debrides' loose tissue and has been shown to reduce swelling, aid wound closure and promote formulation of granulation tissue.

Dressings are routine treatment for burns, wounds and ulcers, however vacuum dressings are not, nor are they a routine part of any significant procedure being performed. ACHI classifies vacuum dressings as nonexcisional debridement:

90686-01 **[1628]** *Nonexcisional debridement of skin and subcutaneous tissue*

or

90686-00 **[1627]** *Nonexcisional debridement of burn.*

Do **not** apply the guidelines in ACS 0020 *Bilateral /multiple procedures,* ACS 1203 *Debridement* or ACS 1911 *Burns* when coding vacuum dressings, instead *a*pply the following guidelines for their application or replacement (change):

- when performed with cerebral anaesthesia (including that with excisional debridement), assign **once** for each operating theatre session.
  For example:
    - **Day 1** - excisional debridement of soft tissue of ulcer and application of vacuum dressing performed in theatre under general anaesthetic, assign:

      90665-00 **[1628]** *Excisional debridement of skin and subcutaneous tissue*

      and

      90686-01 **[1628]** *Nonexcisional debridement of skin and subcutaneous tissue*

      and the appropriate anaesthetic code.

    - **Day 5** – change of vacuum dressing performed in theatre under general anaesthesia, assign:

      90686-01 **[1628]** *Nonexcisional debridement of skin and subcutaneous tissue* and the appropriate anaesthetic code.

- when performed without cerebral anaesthesia, assign **once only for the episode of care**
  For example:

    - **Day 1** – patient transferred with vacuum dressing in situ:

      No code is assigned.

    - **Day 2** – change of vacuum dressing performed on the ward, assign:

      90686-01 **[1628]** *Nonexcisional debridement of skin and subcutaneous tissue*, once only.

    - **Day 4** – change of vacuum dressing performed on the ward.

      As 90686-01 **[1628]** *Nonexcisional debridement of skin and subcutaneous tissue* has already been assigned for this episode, **no** additional code is required.

- when vacuum dressings are performed with cerebral anaesthesia in an operating theatre and without cerebral anaesthesia on the ward in the same episode of care, assign **once for each operating theatre session**.

A code for any change of dressings undertaken on the ward is not required.

For example:

- **Day 1** – vacuum dressing applied in operating theatre under general anaesthetic, assign:

  90686-01 **[1628]** *Nonexcisional debridement of skin and subcutaneous tissue*

  and the appropriate anaesthetic code.

- **Day 3** – change of vacuum dressing undertaken on the ward.

  As 90686-01 **[1628]** *Nonexcisional debridement of skin and subcutaneous tissue* has already been assigned for this episode, **no** additional code is required.

- **Day 5** – change of vacuum dressing undertaken on the ward.

  As 90686-01 **[1628]** *Nonexcisional debridement of skin and subcutaneous tissue* has already been assigned for this episode, **no** additional code is required.

- **Day 6** – excisional debridement and application of new vacuum dressing in operating theatre under general anaesthetic, assign:

  90665-00 **[1628]** *Excisional debridement of skin and subcutaneous tissue* and

  90686-01 **[1628]** *Nonexcisional debridement of skin and subcutaneous tissue*

  and the appropriate anaesthetic code.

- **Day 9** – change of vacuum dressing undertaken on the ward.

  As 90686-01 **[1628]** *Nonexcisional debridement of skin and subcutaneous tissue* has already been assigned for this episode, **no** additional code is required.

As VAC dressings are classified to nonexcisional debridement, ACS 0042 *Procedures normally not coded,* point 7 – *Dressings*, does not apply.

This advice has a minor modification to correspond with an update in a subsequent edition ofICD-10-AM/ACHI/ACS.

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Ref No: Q2957 | Published On: 15-Dec-2015 | Status: Retired | Retired On: 30-Jun-2019

Prematurity and documentation of gestational age

Q:

Does ‘prematurity’ need to be documented in the clinical record or is documentation of gestational age sufficient to assign codes from P07.2 *Extreme immaturity* or P07.3 *Other preterm infants*? Should these codes be routinely assigned or do they need to meet ACS 0002 *Additional diagnoses?*

A:

Prematurity is a significant indicator of neonatal morbidity and mortality and as such should be documented in the clinical record. However clinicians may use the gestational age to reflect this, particularly for those closer to 37 completed weeks, and not specifically document the term premature.

The Tabular note at P07 *Disorders related to short gestation and low birth weight, not elsewhere classified,* also reinforces the importance of gestational age by the instruction to give priority of assignment to gestational age over birth weight.

Codes from P07.2- *Extreme immaturity* and P07.3- *Other preterm infants* should always be assigned for neonates with a gestational age documented as less than 37 completed weeks.

ACS 1618 *Low birth weight and gestational age* has been flagged for review for a future edition.

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Ref No: Q3015 | Published On: 15-Dec-2015 | Status: Retired | Retired On: 30-Jun-2019

ACS 0011 *Admission for surgery not performed*

Q:

What is the principal diagnosis for a same day episode of care, where the procedure is cancelled due to another condition, and that condition is investigated or treated, but the patient is still discharged that same day?

A:

ACS 0011 *Admission for surgery not performed* lists three examples with codes for conditions that are the reason for cancellation of an elective procedure:

- In examples 2 and 4 the conditions listed as the reason for cancellation do not meet the criteria in either ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses,* as they do not require admitted patient care. These conditions are coded to indicate the reason for the cancellation of the procedure and are sequenced after the relevant code from category Z53 *Persons encountering health services for specific procedures, not carried out*.
- Example 5 differs in that the pneumonia meets the criteria for assignment in ACS 0001 *Principal diagnosis.* That is, the pneumonia is chiefly responsible for occasioning the episode of admitted patient care.

Other examples include:

- Patient with osteoarthritis admitted for arthroscopy of the knee. The procedure is cancelled when the patient complains of chest pain on admission. The patient was seen by a cardiologist, and blood tests and ECG were performed, but no cause was found for the chest pain. The patient was discharged later in the day and the arthroscopy was rescheduled. Assign:
  R07.4 *Chest pain, unspecified*
  M17.1 *Other primary gonarthrosis*
  Z53.0 *Procedure not carried out because of contraindication*
- Patient with breast cancer was admitted for same-day chemotherapy. The chemotherapy session was cancelled as the patient was anaemic. The patient was transfused with two units of packed cells and discharged home that afternoon. Assign:
  D64.9 *Anaemia, unspecified*
  Z51.1 *Pharmacotherapy session for neoplasm*
  C50.9 *Breast, unspecified*
  M8000/3 *Neoplasm, malignant*
  Z53.0 *Procedure not carried out because of contraindication*

See also ACS 0002 *Additional diagnoses/Additional diagnosis reporting referred to in other standards*.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

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Complications of anaesthesia; in labour and delivery, and during the puerperium.

Q:

Do the *includes* notes at O74 *Complications of anaesthesia during labour and delivery* and O89 *Complications of anaesthesia during the puerperium* relate to the timing of the complication or when the anaesthetic was administered?

A:

The ICD-10-AM *includes* notes at O74 *Complications of anaesthesia during labour and delivery* and O89 *Complications of anaesthesia during the puerperium* are based on those in ICD-10:

O74 *Complications of anaesthesia during labour and delivery*

Includes: maternal complications arising from the administration of a general or local anaesthetic, analgesic or other sedation during labour and delivery

O89 *Complications of anaesthesia during the puerperium*

Includes: maternal complications arising from the administration of a general or local anaesthetic, analgesic or other sedation during the puerperium

The sentence structure of the above *includes* notes makes their meaning ambiguous. However, the two blocks are distinguished by the timing of the complication. That is, codes from these blocks should be assigned according to when **the complication** occurred; either *during labour and delivery*, or *during the puerperium*, not when the anaesthetic was administered.

For example, assign:

O74.5 *Spinal and epidural anaesthesia-induced headache during labour and delivery*

when an anaesthesia-induced headache caused by spinal and/or epidural anaesthesia occurs during labour and delivery.

Assign:

O89.4 *Spinal and epidural anaesthesia-induced headache during the puerperium*

when an anaesthesia-induced headache caused by spinal and/or epidural anaesthesia occurs during the puerperium.

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Dysexecutive Syndrome

Q:

How do you code dysexecutive syndrome?

A:

Dysexecutive syndrome is a broad term referring to acquired changes in the executive functioning of the brain such as personality, behaviour and executive cognitive functions (eg. planning, insight, judgement etc). Underlying causes can range from traumatic brain injury to ageing to neurological disease such as dementia and Parkinson's disease and the changes can be permanent or temporary. Whilst frontal lobe syndrome is synonymous with acquired personality changes, damage to other regions in the brain can also produce these changes and have thus been referred to as dysexecutive syndrome.

Clinical advice has clarified that as there is no specific code for dysexecutive syndrome in ICD-10 nor ICD-10-AM, as a best fit assign F07.0 *Organic personality disorder* following the index pathway:

Syndrome

- brain

- - personality change F07.0

Assign a code for the underlying cause if known, as per ACS 0002 *Additional diagnoses, Problems and underlying conditions*.

Indexing improvements will be considered for a future edition of ICD-10-AM.

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Coding of allergic reactions NOS and anaphylactic reactions

Q:

How should allergic reactions not otherwise specified (NOS) and anaphylactic reactions be coded? Should symptom codes be assigned for allergic reactions?

A:

The correct code assignment for allergic reactions NOS and anaphylactic reactions are outlined below.

Allergic reaction NOS:

T78.4 *Allergy, unspecified* following the Alphabetic Index:

Allergy, allergic (reaction) T78.4

Allergic reaction NOS to food:

T78.1 *Other adverse food reactions, not elsewhere classified* following the Alphabetic Index:

Allergy, allergic (reaction)

- food (any) (ingested) NEC T78.1

Anaphylaxis / anaphylactic shock due to food:

T78.0 *Anaphylaxis and anaphylactic shock due to adverse food reaction* following the Alphabetic Index:

Anaphylaxis

- due to

- - food reaction T78.0

When assigning a code classified to category T63 *Toxic effect of contact with venomous animals* additional codes should be assigned for any associated allergic reaction as per the instructional note at this category.

Symptoms such as wheeze, urticaria and swelling should not be coded when a diagnosis of allergic reaction or anaphylaxis has been established unless the symptom is significant in its own right and treated independently of the allergic reaction *(*see also *Note* at the beginning of Chapter18 *Symptoms, signs and abnormal clinical findings, not elsewhere classified)*.

Assign external cause codes from Y37 *Exposure to or contact with allergens* as appropriate.

This advice has a minor modification to correspond with an update in a subsequent edition ofICD-10-AM/ACHI/ACS.

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Ref No: Q2973 | Published On: 15-Sep-2015 | Status: Retired | Retired On: 30-Jun-2019

Classification of promethazine

Q:

Why is poisoning or adverse effect of promethazine, used in the treatment of allergic reactions and vomiting, classified to T43.3 *Poisoning by psychotropic drugs not elsewhere classified, phenothiazine antipsychotics and neuroleptics* and Y49.3 *Phenothiazine antipsychotics and neuroleptics causing adverse effects in therapeutic use* in ICD-10-AM?

A:

ICD-10-AM and its parent classification ICD-10, classifies drugs according to the active chemical ingredient (class) rather than by therapeutic indication. Promethazine is a phenothiazine derivative (the largest of the five main classes of antipsychotic (neuroleptic) drugs) in the same drug class as chlorpromazine (Thorazine) and trifluoperazine (Stelazine). However, unlike the other drugs in this class, promethazine is not used as an anti-psychotic. It is used as an anti-histamine, sedative, and antiemetic (anti-nausea).

The class and therapeutic indication for drugs often align but where they don't it may be incorrectly perceived as an error.

To assign the correct codes for promethazine poisoning or adverse effect in therapeutic use follow the Table of Drugs and Chemicals in the ICD-10-AM Alphabetic Index:

Promethazine (teoclate) ……T43.3 X41 X61 Y11 Y49.3

This is reinforced by the excludes notes for phenothiazine-based neuroleptics at T45.0 *Antiallergic and antiemetic drugs* and Y43.0 *Antiallergic and antiemetic drugs*.

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Missed miscarriage

Q:

How do you code missed miscarriage?

A:

Missed miscarriage is a synonymous term for missed abortion. Therefore, where *missed miscarriage* is documented, assign:

O02.1 *Missed abortion*

by following the index pathway:

Abortion

- missed O02.1

Enhancements to ICD-10-AM will be considered for a future edition.

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Coding of underlying cause of CKD (chronic kidney disease) in a patient who has received a renal transplant

Q:

When a patient has had a kidney transplant, is it necessary to code the original underlying cause of CKD, for example, FSGS (focal segmental glomerulosclerosis)?

A:

Assign Z94.0 *Kidney transplant status* and/or N18.- *Chronic kidney disease* for those patients who have received a kidney transplant only when the criteria in ACS 0002 *Additional diagnoses* is met as instructed in ACS 1438 *Chronic kidney disease:*

> *"For patients who have received a kidney transplant and documentation pertaining to this status satisfies criteria for coding under ACS 0002 Additional diagnoses, assign Z94.0 Kidney transplant status together with N18.3 Chronic kidney disease, stage 3 or higher, as indicated by an eGFR level."*

Do not assign a code for the original condition (eg FSGS and IgA nephropathy) that caused the CKD, leading to kidney transplantation, unless the condition recurs in the transplanted kidney.

The instructional note '*Use additional code to identify underlying disease*' at N18 *Chronic kidney disease* relates to the **current** cause of kidney failure which in a transplanted kidney may be graft rejection or recurrence of the original disease.

Example 1 -- A patient with history of ESRF secondary to FSGS received a kidney transplant in 2000. The patient was admitted (3 years later) with decreased renal function (eGFR 24-27) and biopsy of the transplanted kidney confirmed BK Virus nephropathy with no evidence of recurrent FSGS.

Codes:

N28.8 *Other specified disorders of kidney and ureter*

B97.8 *Other viral agents as the cause of diseases classified to other chapters*

N18.4 *Chronic kidney disease, stage 4*

Z94.0 *Kidney transplant status*

In this scenario, deterioration of kidney function is caused by BK virus nephropathy and there is no evidence of recurrence of FSGS in the transplanted kidney; therefore a code for FSGS is not assigned.

Example 2 -- A patient admitted with pneumonia. Patient had a kidney transplant in 1993 for IgA nephropathy which subsequently failed due to a recurrence of IgA nephropathy in the transplanted kidney, for which the patient received haemodialysis during admission.

Codes:

J18.9 *Pneumonia, unspecified*

N18.5 *Chronic kidney disease, stage 5*

N02.8 *Recurrent and persistent haematuria, other*

Z94.0 *Kidney transplant status*

In this scenario, the patient received haemodialysis treatment for CKD, attributed to recurrence of IgA nephropathy in the transplanted kidney; therefore a code for IgA nephropathy and transplant status should be assigned.

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Ninth Edition FAQs: Facial droop with hemiplegia

Q:

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

A:

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

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Ninth Edition FAQs: Ulcer of lower limb, ankle

Q:

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

A:

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

Ulcer/foot ***or***

Ulcer/lower limb/foot

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

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

Ulcer/skin/lower limb/specified site

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Ninth Edition FAQs: ACS 1221 *Pressure injury*

Q:

The ACS notes that pressure injuries that improve or deteriorate during hospitalisation should be assigned a code to reflect the highest stage for that site. Does this include when treatment for a pressure injury continues after a care type change?

A:

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

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Ninth Edition FAQs: ACS 2104 *Rehabilitation*

Q:

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

A:

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

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Ninth Edition FAQs: ACS 2104 *Rehabilitation*

Q:

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

A:

Follow the classification advice in ACS 0048 *Condition onset flag*, which specifies that a condition (or diagnosis) arising after admission should be assigned COF 1 *Condition with onset during the episode of admitted patient care*.

As per dot point six, this includes disease or administrative codes arising during the episode of admitted patient care.

Therefore, where Z50.9 *Care involving use of rehabilitation procedure, unspecified* is assigned as an additional diagnosis in an acute episode of care, assign COF 1.

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Ninth Edition FAQs: ACS 2104 *Rehabilitation*

Q:

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

A:

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

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

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

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Ref No: TN907 | Published On: 15-Sep-2015 | Status: Retired | Retired On: 30-Jun-2019

Ninth Edition FAQs: ACS 0110 *SIRS, sepsis, severe sepsis and septic shock*

Q:

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

A:

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

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

Principal diagnosis in some clinical episodes can be difficult to identify, particularly in episodes of sepsis with infection.

Therefore, it is necessary to continue to reference the criteria in ACS 0001 *Principal diagnosis* in order to ensure correct principal diagnosis selection.

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Ninth Edition FAQs: ACS 0110 *SIRS, sepsis, severe sepsis and septic shock*

Q:

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

A:

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

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

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Ninth Edition FAQs: ACS 0110 *SIRS, sepsis, severe sepsis and septic shock*

Q:

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

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

A:

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

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

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

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

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

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Ninth Edition FAQs: ACS 0003 *Supplementary codes for chronic conditions*

Q:

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

A:

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

(Coding Rule, September 2015)

Published 15 September 2015,
for implementation 01 October 2015.

Ref No: TN907 | Published On: 15-Sep-2015 | Status: Retired | Retired On: 30-Jun-2019

Ninth Edition FAQs: ACS 0003 *Supplementary codes for chronic conditions*

Q:

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

A:

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

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

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

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

Supplementary

- codes for chronic conditions

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

and assign U79.2 *Schizophrenia*.

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

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

Supplementary

- codes for chronic conditions

- - hypertension U82.3

and assign U82.3 *Hypertension*.

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

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for implementation 01 October 2015.

Ref No: TN907 | Published On: 15-Sep-2015 | Status: Retired | Retired On: 30-Jun-2019

Ninth Edition FAQs: ACS 0003 *Supplementary codes for chronic conditions*

Q:

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

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

A:

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

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

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for implementation 01 October 2015.

Ref No: TN907 | Published On: 15-Sep-2015 | Status: Retired | Retired On: 30-Jun-2019

Ninth Edition FAQs: ACS 0003 *Supplementary codes for chronic conditions*

Q:

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

A:

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

Published 15 September 2015,
for implementation 01 October 2015.

Ref No: TN907 | Published On: 15-Sep-2015 | Status: Retired | Retired On: 30-Jun-2019

Ninth Edition FAQs: ACS 0003 *Supplementary codes for chronic conditions*

Q:

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

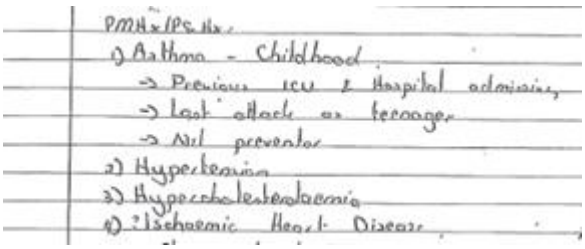
- Do conditions listed under the heading of 'past history' or 'background/problems' qualify?
- Do conditions need to be medicated to prove they are current?

A:

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

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

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



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

Published 15 September 2015,
for implementation 01 October 2015.

Ref No: TN907 | Published On: 15-Sep-2015 | Status: Retired | Retired On: 30-Jun-2019

Ninth Edition FAQs: ACS 0003 *Supplementary codes for chronic conditions*

Q:

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

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

A:

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

This advice has a minor modification to correspond with an update in a subsequent edition ofICD-10-AM/ACHI/ACS.

Published 15 September 2015,
for implementation 01 October 2015.

Ref No: TN907 | Published On: 15-Sep-2015 | Status: Retired | Retired On: 01-Jul-2017

Ninth Edition FAQs: Coronary angiography

Q:

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

A:

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

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

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for implementation 01 October 2015.

Ref No: Q2907 | Published On: 15-Sep-2015 | Status: Retired | Retired On: 30-Jun-2019

Procedures performed in radiology departments

Q:

Do you need to code procedures performed in privately owned/off site radiology departments?

A:

The purpose of the Admitted Patient Care National Minimum Data Set (APC NMDS) is to collect information about care provided to admitted patients in Australian hospitals.

Procedures performed while a patient is formally admitted should be coded (where they meet the criteria in ACS 0016 *General procedure guidelines*), irrespective of whether the facility subcontracts another department to perform the procedures, as they are still performed as part of the admitted episode of care.

However, a procedure qualifying for code assignment should not be coded if performed in another facility where the patient has been placed on leave from the admitting facility and admitted to another facility to have the procedure performed.

Additionally, procedures qualifying for code assignment performed in other facilities under a contractual arrangement should be coded as per the guidelines in ACS 0029 *Coding of contracted procedures*:

If a hospital treatment is carried out under a contracting arrangement existing between two hospitals, all procedures carried out under the contract are to be recorded and coded in both hospitals. The hospital not carrying out the procedure should flag the appropriate code.

Reference:

Australian Institute of Health and Welfare. (2014). *METeOR Metadata online registry.* Retrieved from http://meteor.aihw.gov.au/content/index.phtml/itemId/535047

Published 15 September 2015,
for implementation 01 October 2015.

Ref No: Q2955 | Published On: 15-Sep-2015 | Status: Retired | Retired On: 30-Jun-2019

Mullerianosis

Q:

How do you code mullerianosis?

A:

Mullerianosis refers to a structure that is composed of mullerian rests (that is endometrial, endosalpinx (tubal) and/or endocervical tissue), known as a choristoma. A choristoma is a mass of histologically normal tissue that is “not normally found in the organ or structure in which it is located”.

Mullerianosis may be developmental (that is, formed in utero during organ development in the embryo) or acquired. Acquired mullerian diseases (such as endometriosis) are the more common presentation.

Mullerianosis is generally a histological finding, not a clinical diagnosis. When documented on a histopathology report do not assign a code for this finding without confirming its significance with the treating clinician as per the guidelines in ACS 0010 *General abstraction guidelines, Findings with an unclear, or no associated condition documented*:

> *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 a diagnosis of mullerianosis is confirmed, assign as a best fit a code for endometriosis by selecting the appropriate site code under the lead term *Endometriosis*.

References:

Batt, R., Smith, R., Buck Louis, G., Martin, D., Chapron,C., Koninckx, P. and Yeh, J. (2007). Mullerianosis. *Histology and histopathology.* (2007). 22: 1161-1166. Retrieved from http://www.hh.um.es/pdf/Vol_22/22_10/Batt-22-1161-1166-2007.pdf

Published 15 September 2015,
for implementation 01 October 2015.

Ref No: Q2979 | Published On: 15-Sep-2015 | Status: Retired | Retired On: 01-Jul-2017

Bone graft substitute

Q:

How do you code grafting with synthetic bone substitute?

A:

Synthetic bone substitutes are classified in ACHI to bone graft by site; follow the index pathway:

Injection (around) (into) (of)– *see also Administration*

…

- bone

- - graft substitute (paste) — *see Graft/bone/specified site*

- - substitute material (paste) — *see Graft/bone/specified site*

Amendments to ACHI Alphabetic Index will be considered for a future edition.

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Ref No: Q2981 | Published On: 15-Sep-2015 | Status: Retired | Retired On: 01-Jul-2017

Autologous platelet-rich plasma dressing of chronic wounds

Q:

What is the correct procedure code for the autologous platelet-rich plasma dressing of chronic wounds?

A:

Autologous platelet-rich plasma (PRP) is blood plasma enriched with platelets. PRP contains increased concentration of proteins called growth factors which promotes wound healing and bone growth. Currently, autologous PRP is used in the treatment of chronic skin ulcers and wounds, reconstructive, cosmetic, orthopaedic, cardiovascular, oral maxillofacial, and dermatological surgery.

Autologous blood is centrifuged to separate the plasma from packed red blood cells and then further centrifuged to separate PRP from platelet-poor plasma. This concentrate is then activated with the addition of thrombin or calcium, resulting in a gelatinous platelet gel.

The PRP gel is applied to the wound which is covered by a gelatin hydrogel sheet or conventional hydrocolloid dressing.

There is no specific code in ACHI for autologous platelet-rich plasma dressing or topical application of PRP gel.

Code to 30055-00 **[1601]** *Dressing of wound* following the index pathway:

Dressing (to)

- wound 30055-00 **[1601]**

As per ACS 0042 *Procedures normally not coded*, dressings should not be coded except when:

- cerebral anaesthesia is required in order for the procedure to be performed
- it is the principal treatment in same-day episodes of care.

Improvements to the classification of dressings will be considered for a future edition of ACHI.

References:

Lacci, KM and Dardik, A 2010, 'Platelet-Rich Plasma: Support for Its Use in Wound Healing.' *Yale J Biol Med : Yale Journal of Biology and Medicine,* vol. 83, no. 1, pp.1–9. viewed 27 July 2015, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2844688/

Horn, D, Linzie, B and Huang, T 2007, 'The healing effects of autologous platelet gel on acute human skin wounds. *Archives of Facial Plastic surgery,* vol. 9, no. 3, pp.174-183. doi:10.1001. viewed 27 July 2015, http://archfaci.jamanetwork.com/article.aspx?articleid=481113

Published 15 September 2015,
for implementation 01 October 2015.

Ref No: Q2946 | Published On: 15-Sep-2015 | Status: Retired | Retired On: 01-Jul-2017

Haemodialysis associated steal syndrome

Q:

How do you code haemodialysis associated steal syndrome?

A:

Haemodialysis associated steal syndrome is a complication occurring in 6% of haemodialysis patients with a functioning arteriovenous (AV) fistula or graft. There is an imbalance between the low-resistance blood flow of the AV access and the high-resistance blood flow in the distal, arterial vasculature of the forearm and hand resulting in symptoms of poor blood supply such as hand pain, coldness and even digital gangrene. The lack of blood supply is due to:

- existing arterial insufficiency such as atherosclerosis and stenosis of the subclavian, axillary, and brachial artery proximal to an AV access, or distal arteriopathy, particularly in diabetes mellitus patients
- having too much blood flow through the AV fistula
- a combination of the above factors.

For steal syndrome in a patient with AV fistula or graft for dialysis, assign T82.8 *Other specified complications of cardiac and vascular prosthetic devices, implants and grafts* following the index pathway:

Complications (from) (of)

- arteriovenous fistula or shunt, surgically created

- - infection or inflammation

- - mechanical

- - specified NEC T82.8

with

Y84.1 *Kidney dialysis as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure*

Y92.22 *Health service area*.

Enhancements to ICD-10-AM will be considered for a future edition.

References:

Berman S, (2009). *Understanding Steal Syndrome: Causes and Prevention.* Endovascular today. Retrieved from: http://evtoday.com/2009/02/EVT0209_10.php

Leon C. and Asif, A. (2007). *Arteriovenous Access and Hand Pain: The Distal Hypoperfusion Ischemic Syndrome*. Clinical Journal of the American Society of Nephrologist. Retrieved from: http://cjasn.asnjournals.org/content/2/1/175.full

Published 15 September 2015,
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Ref No: Q2869 | Published On: 15-Sep-2015 | Status: Retired | Retired On: 01-Jul-2017

Application of ACS 0046 *Diagnosis selection for same-day endoscopy*

Q:

Could the application of ACS 0046 *Diagnosis selection for same-day endoscopy* please be clarified for the following scenarios:

Scenario 1: Patient admitted (same-day) for colonoscopy due to +FOBT. Diverticular disease and ulcerated sigmoid polyp was found. Sigmoid polyp was excised and sent to pathology. Histopathology report confirmed adenocarcinoma arising in adenoma.

Scenario 2: Patient with haemoptysis admitted for bronchoscopy/biopsy. Histopathology confirms carcinoma of the left lung.

Scenario 3: Patient with haematuria admitted for cystoscopy/biopsy. Histopathology confirms TCC of the bladder.

A:

ACS 0046 *Diagnosis selection for same-day endoscopy* was developed to provide coding instruction for same-day endoscopy episodes of care where conditions/findings are frequently documented without a causal link by the clinician. It applies to all episodes of care for same-day endoscopy except where specifically excluded in ACS 0046 as follows:

- "Cases where the patient is presenting for follow-up investigations. These cases are coded in accordance with ACS 2113 *Follow-up examinations for specific disorders*.
- Patients having endoscopies to further investigate a known condition, such as carcinoma of the stomach (these cases will be coded in accordance with ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*), or those presenting with a problem related to a known condition (these will be coded in accordance with ACS 0001 *Principal diagnosis*).
- Episodes for screening that are coded in accordance with ACS 2111 *Screening for specific disorders*."

Dot point one refers to same-day endoscopies to follow up conditions previously treated, thought to be cured or healed, but for which an endoscopy is performed to check for recurrence of the condition (sometimes referred to as a check endoscopy). Refer to ACS 2113 *Follow-up examinations for specific disorders.*

Dot point two refers to same-day endoscopies to further investigate/follow-up a current or chronic condition, such as current carcinoma of the stomach, coeliac disease etc. Refer to ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses.*

Dot point three refers to same-day endoscopies to screen for conditions that individuals are at risk of developing eg family history of bowel cancer. Refer to ACS 2111 *Screening for specific disorders*.

With respect to the scenarios cited, the first is noted to be a same-day endoscopy episode of care and therefore the principles in ACS 0046 *Diagnosis selection for same-day endoscopy* apply.

The second and third scenarios do not indicate whether they are same-day endoscopy episodes of care. If they are, ACS 0046 *Diagnosis selection for same-day endoscopy* applies as per the first scenario, otherwise ACS 0001 *Principal diagnosis* applies.

In all the scenarios cited, there is a statement that histopathology confirms a diagnosis of cancer, however, unless that confirmation is documented by or verified by the clinician then a causal link has not been established and the symptom should be assigned as the principal diagnosis and any findings as additional diagnoses.

The classification of same-day endoscopies is currently under review.

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for implementation 01 October 2015.

Ref No: Q2978 | Published On: 15-Sep-2015 | Status: Retired | Retired On: 01-Jul-2017

Total artificial heart (TAH) transplantation

Q:

What procedure code should be assigned for total artificial heart (TAH) transplantation?

A:

Total artificial heart (TAH) is a mechanical substitute consisting of two artificial ventricles with valves which act like a natural heart, pumping blood into the circulatory system. TAH is primarily used as a temporary treatment for patients with end stage heart failure awaiting heart transplantation, known as 'bridge to transplantation'. It has also been approved for permanent heart replacement for advanced heart failure patients who are not suitable for heart transplantation.

Implantation of a TAH requires surgical excision of both ventricles along with all native valves. The prosthetic device is anastomosed to the native atria and great vessels. The procedure is performed under cardiopulmonary bypass (CPB).

There is no specific code for TAH in ACHI. The most appropriate code is 38653-00 **[666]** *Other intrathoracic procedures on heart with cardiopulmonary bypass,* following the index pathway:

Procedure

- heart (intrathoracic) (without cardiopulmonary bypass) NEC

- - with cardiopulmonary bypass NEC 38653-00 **[666]**

There is no need to code the removal of ventricles and native valves as this is inherent in the procedure.

As TAH is increasingly being used in the clinical practice, a new procedure code will be considered for a future edition of ACHI.

References:

Parker, MS, Fahrner, LJ, Deuell, BPF, Olsen, KM, Kasirajan V, Shah, KB, Medina, AE, Doolin, KR, de Groot, PA and Goodman, WC 2014, 'Total Artificial Heart Implantation: Clinical Indications, Expected Postoperative Imaging Findings, and Recognition of Complications*', American Journal of Roentgenology,* vol. 202, no. 3, W191-201, DOI:10.2214/AJR.13.11066.

Published 15 September 2015,
for implementation 01 October 2015.

Ref No: Q2940 | Published On: 15-Sep-2015 | Status: Retired | Retired On: 01-Jul-2017

Fractional flow reserve (FFR)

Q:

What is the correct procedure code for ‘fractional flow reserve (FFR)’ measurement?

A:

FFR is the measurement of blood flow in a coronary artery at resting and maximal perfusion to determine functional significance of a coronary artery stenosis. The measurement is usually coupled with coronary angiography and/or angioplasty but it may be performed independently.

FFR measurement is obtained by using a pressure wire inserted into the coronary artery through a sheath. A vasodilatory medication such as adenosine is infused to achieve maximal coronary perfusion. Pressure readings and pressure ratio are recorded to determine the FFR value.

Currently ACHI does not contain a specific procedure code for FFR, however, as it is commonly performed in conjunction with coronary angiography assign an appropriate code from block **[668]** *Coronary angiography*, by following the index pathway:

Angiography

- coronary

A unique code for FFR will be considered for a future edition of ACHI.

References:

Shantouf,R. S. and Mehra A. (2015). Coronary fractional flow reserve. American Journal of Roentgenology. 204:3, W261-W265.

Published 15 September 2015,
for implementation 01 October 2015.

Ref No: Q2974 | Published On: 15-Sep-2015 | Status: Superseded | Superseded On: 15-Dec-2015 | Superseded By: TN1028

Coding from test results and findings on radiological reports

Q:

How do you decide when a test result or finding on a radiological report should be used to inform coding?

A:

ACS 0010 *General abstraction guidelines, Test results* differentiates between results/findings:

- that clearly add specificity to a documented condition which may be used to inform code assignment
- where the relationship between test results and a documented condition is unclear, test results are not to be used to inform code assignment without clinical confirmation.

Examples:

- Conditions/manifestations (where the classification assumes a causal link), that are listed in test results but not documented or confirmed by the clinician, are not to be used to inform code assignment. For example:
    - Patient with documented diabetes mellitus has a finding of fatty liver on a test result; do not use the fatty liver to assign E1-.72 **diabetes mellitus with features of insulin resistance*.
    - Although the classification links pneumonia and COPD, both conditions must be documented or confirmed by the clinician before applying the guidelines in ACS 1008 *Chronic obstructive pulmonary disease (COPD)*
    - Although the classification links ureteric calculus and hydronephrosis, both conditions must be documented or confirmed by the clinician to inform code assignment
- Metastases/secondary neoplasms that are listed in test results but not documented or confirmed by the clinician, are not to be used to inform code assignment.

Where clinical advice is unavailable to clarify the significance of a test result or imaging finding and a documented condition, clinical coders should not use the test result to inform code assignment.

Q:

Can radiological findings be used to identify all injuries in a multiple injury case?

A:

ACS 1907 *Multiple injuries* has been amended for Ninth Edition to incorporate previously published advice:

> When coding the **initial** admission of a multiple trauma, all injuries documented must be coded to represent the totality of multiple trauma.

ACS 1907 and the previous Coding Rule which informed the Ninth Edition update applies to multiple trauma where there is documentation of multiple injuries ranging from severe and life threatening to less severe eg contusions and grazes. The ACS specifies all documented injuries including contusions and grazes (unless associated with a more severe injury of the same site) must be coded to represent the totality of trauma.

In addition the guidelines must be applied in conjunction with ACS 0010 *General abstraction guidelines, Test results.* Therefore, radiological findings may be used to provide specificity to a documented condition (such as the site of a fracture). Do not code conditions identified on test results that are not documented in the clinical record or confirmed by the clinician.

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for implementation 01 October 2015.

Ref No: Q2951 | Published On: 15-Jun-2015 | Status: Retired | Retired On: 30-Jun-2019

Replacement of procidentia

Q:

How do you code replacement of procidentia (manual reduction of prolapsed uterus)?

A:

Procidentia is a synonymous term for (organ) prolapse and may refer to uterine prolapse or rectal prolapse.

A vaginal pessary or pack may be inserted as a conservative, noninvasive (temporary) management for procidentia/uterine prolapse, the purpose of which is to support the uterus and prevent further/repeat prolapse. The procidentia (prolapsed uterus) must be reduced prior to insertion of the vaginal pessary or packing.

ACHI does not include a specific code for replacement of procidentia/manual reduction of a prolapsed uterus. Clinical advice confirms that replacement of procidentia/manual reduction of a prolapsed uterus is inherent in the insertion of a vaginal pessary or packing. Therefore, assign one of the following codes:

92104-00 **[1900]** *Vaginal packing*

or

92107-00 **[1900]** *Insertion of other vaginal pessary*

Amendments to ACHI will be considered for a future edition.

Published 15 June 2015,
for implementation 01 July 2015.

Ref No: Q2895 | Published On: 15-Jun-2015 | Status: Retired | Retired On: 30-Jun-2019

Coding from documentation in previous admissions

Q:

There is a Coding Rule relating to diabetes mellitus which states that the condition must be documented in the current admission in order to assign a code for the diabetes. Should that rule be applied to all conditions where there is a coding instruction in a specialty standard to 'code where documented'?

A:

The Coding Rule *Documentation of diabetes mellitus,* published in June 2012, states that:

> '…previous admissions and correspondence can be used to inform assignment of diabetes mellitus codes. However, previous admissions and correspondence should not be used:
>
> - to assign diabetes mellitus if it has not been documented in the current admission...'

This instruction is relevant for all specialty standards instructing that certain conditions must be coded when documented (HIV/AIDS, viral hepatitis and tobacco use), that is, the conditions must be documented within the episode of care in order to be assigned a code.

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for implementation 01 July 2015.

Ref No: Q2894 | Published On: 15-Jun-2015 | Status: Retired | Retired On: 30-Jun-2019

Pulsed dose rate cervical and uterine brachytherapy

Q:

What is the correct code to assign for cervical and uterine pulsed dose rate brachytherapy?

A:

Clinical advice indicates that the radiobiology of pulsed dose rate brachytherapy (PDRB) is similar to low dose rate brachytherapy (LDRB).

For PDRB administration to cervical and uterine cancers, assign the appropriate low dose rate brachytherapy code from block **[1790]** *Brachytherapy, intracavitary, gynaecological*.

Q:

What is the correct code to assign for insertion of applicator(s) for cervical and intrauterine brachytherapy?

A:

There is no site specific code for insertion of brachytherapy applicator(s) into cervix or uterus as there is for the eye and prostate.

For consistency with the classification of brachytherapy applicator implantation for other sites assign 90442-00 **[1299]** *Other procedures on female genital organs* to indicate insertion of the applicators.

Improvements to ACHI will be considered for a future edition.

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for implementation 01 July 2015.

Ref No: Q2889 | Published On: 15-Jun-2015 | Status: Retired | Retired On: 30-Jun-2019

Posterior reversible encephalopathy syndrome

Q:

How do you code posterior reversible encephalopathy syndrome?

A:

Posterior reversible encephalopathy syndrome (PRES) (also known as reversible posterior leukoencephalopathy syndrome) presents with symptoms such as headaches, altered mental state, seizures and visual disturbances. The exact cause is unclear, but most cases of PRES occur with or are due to hypertension (including eclampsia), immunosuppression (including secondary to immunosuppressive treatment), autoimmune disease, antineoplastic agents and renal failure. Radiological (MRI) findings of oedema involving the posterior occipital and parietal lobes of the brain are indicative of PRES and are essential for diagnosis, as PRES is difficult to diagnose clinically. Early diagnosis and treatment is vital to prevent sequelae. Complete reversal of clinical symptoms within weeks is possible if treatment is commenced immediately; which includes withdrawing causative agents and treating severe hypertension and seizures.

The correct code to assign for posterior reversible encephalopathy syndrome is:

I67.8 *Other specified cerebrovascular diseases*

by following the index pathway:

Disease, diseased

- cerebrovascular

- - specified NEC I67.8

Enhancements to ICD-10-AM will be considered for a future edition.

References:

Lee, H-J. (2007). Posterior reversible encephalopathy syndrome. Applied radiology. 2007; 36(5):42-43. Retrieved from http://www.medscape.com/viewarticle/559553

Moratalla, M. (2010). Posterior reversible encephalopathy syndrome. Emergency medicine journal. 2010; 27:547 doi: 10.1136/emj.2008.069765

Staykov, D. and Schwab, S. (2012). Progressive reversible encephalopathy syndrome. Journal of intensive care medicine. Vol. 27. No. 1 11-24. doi: 10.1177/0885066610393634

Published 15 June 2015,
for implementation 01 July 2015.

Ref No: Q2740 | Published On: 15-Jun-2015 | Status: Retired | Retired On: 30-Jun-2019

Assigning Z38.- as the principal diagnosis

Q:

What codes, if any, can be assigned as additional diagnoses with Z38.- *Liveborn infants according to place of birth* as the principal diagnosis.

A:

Codes for newborns should be assigned following the guidelines in ACS 1607 *Newborn/neonate* which state:

> ‘A code from category Z38 *Liveborn infants according to place of birth* should be sequenced as the principal diagnosis **only** when the newborn is completely well (including those babies who have had a circumcision performed).’

Therefore, Z38.- should be sequenced as the principal diagnosis only in those circumstances where there are no additional morbidity codes that qualify for assignment to classify neonatal morbidity or suspected morbidity. Suspected morbidity would include Z03.71 *Observation of newborn for suspected infectious condition*.

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for implementation 01 July 2015.

Ref No: Q2897 | Published On: 15-Jun-2015 | Status: Retired | Retired On: 30-Jun-2019

ACS 0002 *Additional diagnoses* and alteration to treatment

Q:

Does a condition meet the criteria in ACS 0002 *Additional diagnoses* when the medication to treat the condition has been altered to manage an adverse effect or another condition, as in the following scenarios?

- Principal diagnosis of acute on chronic renal failure secondary to frusemide, with a past history of congestive cardiac failure treated with frusemide 80mg BD. Dose of frusemide was decreased to 40mg BD.
- Principal diagnosis of aspirin induced ulcers throughout upper gastrointestinal tract, with a past history of atrial fibrillation for which the patient had been commenced on aspirin. Aspirin was withheld for two days, and the patient was commenced on medication to treat the ulcers.

A:

Based on the limited information in the scenarios described, the conditions listed in the past history/background (congestive cardiac failure and atrial fibrillation) where medication to treat these conditions has been altered should be coded, as per the criteria in ACS 0002 *Additional diagnoses*; specifically dot point 1, ‘commencement, alteration or adjustment of therapeutic treatment’.

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Latent tuberculosis (TB)

Q:

How do you code latent tuberculosis (TB)?

A:

Latent tuberculosis infection (LTBI) refers to infection with Mycobacterium tuberculosis, without clinical symptoms/manifestations of tuberculosis. Carriers exhibit a positive reaction to the tuberculin skin (Mantoux) test or TB blood test. Carriers who are immunosuppressed, especially those with HIV infection, are at greater risk of developing active TB and may be treated prophylactically. The World Health Organization (WHO) estimates that approximately 10% of people with LTBI will develop active TB.

Assign Z22.3 *Carrier of other specified bacterial diseases* in ICD-10-AM for *latent tuberculosis*, by following the index pathway:

Carrier (suspected) of

- bacterial disease NEC Z22.3

To add further specificity, assign R76.1 *Abnormal reaction to tuberculin test* by following the index pathway:

Test(s)

- tuberculin, abnormal result R76.1

Enhancements to ICD-10-AM will be considered for a future edition.

References:

World Health Organization. (2015). *Guidelines on the management of latent tuberculosis infection* (WHO reference number: WHO/HTM/TB/2015.01). Retrieved from http://www.who.int/tb/publications/ltbi_document_page/en/

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Cellulitis with recent injury

Q:

The following scenarios are examples that relate to patients who are admitted with a diagnosis of cellulitis secondary to a recent injury:

- Small punctuate like ulcer on dorsum just proximal to IP joint with surrounding erythema. Patient had cut left thumb on nail clippers one week ago.
- Knee hot to touch with pus like exudate from a superficial graze. Patient had fallen two days ago.
- Finger swollen and red post removal of a splinter six days ago. Wound cleaned with saline, aspirated with fine needle, small incision made with scalpel, 1ml pus drained and given IV flucloxacillin.
- Swelling and tenderness of foot at laceration site the day after the sutures were removed.
- Finger cellulitis with ulceration at site of a burn a week previously.

What codes should be assigned for these scenarios?

A:

Cellulitis is a spreading infection of the dermis and subcutaneous tissues caused by certain types of bacteria entering the skin, and may result from insect bites, blistering, penetrating foreign bodies, burns, cuts etc. When coding cellulitis associated with a recent injury, apply the principles in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses* to determine code assignment and sequence.

Where cellulitis is chiefly responsible for occasioning the episode of care, it should be sequenced as the principal diagnosis. Assign other codes as appropriate following the guidelines in ACS 1911 *Burns*, ACS 1916 *Superficial injuries*, ACS 1917 *Open wounds* and instructional notes in the Tabular List as appropriate. The principles of ACS 0001 and ACS 0002 must be applied on their merits.

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Procurement of iliac vessels with multiple organs for transplantation

Q:

How do you code procurement of iliac artery and vein, harvested with multiple organs for transplantation?

A:

Procurement of iliac vessels is inherent in procurement of multiple organs for transplantation.

Iliac vessels (common, external and internal iliac artery and vein) are commonly collected to provide ‘backup’ material for the reconstruction of vessels in the retrieved organ and/or in the recipient. The ‘backup’ vessels are most often used with liver, pancreas, small intestine or kidney transplantation. For example, harvested iliac vessels may be used if kidney vessels are damaged during procurement. Clinical advice agrees that iliac vasculature is not harvested with the intention of being a “free standing” transplant in its own right.

Therefore, it is not necessary to assign a specific code for iliac vessels harvested as part of multiple organ procurement for transplantation. Assign procurement procedure codes for the specific organs harvested – see ACS 0030 *Organ and tissue procurement and transplantation, Organ/tissue procurement and transplantation table*.

Enhancements to ACHI will be considered for a future edition.

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Anal fistula plug

Q:

What is the correct procedure code for insertion of anal fistula plug?

A:

Anal fistula plug is a relatively new type of procedure used for the treatment of an anal fistula. The procedure involves implantation of a plug into the tract of a fistula and suturing it in place. The plug, composing of a biocompatible material, is capable of forming a collagen scaffold which promotes tissue regeneration and facilitates healing and closure of the anal fistula.

Where insertion of perianal fistula plug is performed, assign 90344-02 **[929]** *Administration of agent to lesion or tissue of anorectal region*, by following the index pathway:

Closure

- fistula

- - with biological sealant

- - - anorectal 90344-02 **[929]**

Improvements to ACHI will be considered for this procedure in a future edition.

References:

The National Institute for Health and Clinical Excellence (NICE) (2011). Interventional procedure overview of closure of anal fistula using a suturable bioprosthetic plug. Retrieved from: https://www.nice.org.uk/guidance/ipg410/evidence/closure-of-anorectal-fistula-using-a-suturable-bioprosthetic-plug-overview2

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Cerebellar ataxia secondary to previous petrol sniffing

Q:

What is the correct code assignment for a patient presenting with ataxia which after investigation is diagnosed as being due to cerebellar atrophy secondary to previous petrol sniffing?

A:

Ataxia is an inability to coordinate muscle activity during voluntary movement and is often a symptom of an underlying disorder of the cerebellum. Where a diagnosis of ataxia and cerebellar atrophy secondary to previous petrol sniffing is made during an admission, a code for the ataxia is not required as per the guidelines in ACS 0001 *Principal diagnosis, Problems and underlying conditions, point 1*.

Assign:

G31.9 *Degenerative disease of nervous system, unspecified* following the index pathway:

Atrophy, atrophic

- brain (cortex) (progressive) *(see also Degeneration/brain)* G31.9

and

F18.1 *Mental and behavioural disorders due to use of volatile solvents, harmful use* as it is the underlying cause of cerebellar atrophy, following the index pathway:

Use (of)

- harmful

- - inhalants F18.1

Sequelae codes are not assigned as cerebellar atrophy is not a late effect but a direct result from the harmful use of petrol sniffing (refer to ACS 0008 *Sequelae).*

Index amendments will be considered for a future edition of ICD-10-AM.

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Ref No: Q2922 | Published On: 15-Jun-2015 | Status: Retired | Retired On: 01-Jul-2017

Subgaleal haematoma

Q:

What is the correct code to assign for a subgaleal haematoma not due to birth trauma?

A:

Subgaleal haematoma occurs when there is bleeding into the space between the skull periosteum and the scalp galea aponeurosis. This condition is commonly seen after traumatic birth in neonates but it may also occur after a fall or blow to the head. As the haemorrhage occurs outside the cranium it is not regarded as intracranial injury although an extensive subgaleal haematoma may require monitoring for signs of neurological deficits to exclude intracranial injury, especially where there is loss of consciousness.

A subgaleal haematoma should be coded to S00.05 *Superficial injury of scalp, contusion* following the index pathways:

Haematoma (skin surface intact) (traumatic) *(see also Contusion)*

and

Contusion (skin surface intact)

- scalp S00.05

with appropriate external cause codes.

Code also any closed head injury/loss of consciousness as per ACS 1905 *Closed head injury/loss of consciousness/concussion*.

Improvements to ICD-10-AM will be considered for a future edition.

References:

Agrawal, A. et al (2006). Delayed extensive subgaleal haematoma following head injury. Paediatric Oncall Journal. Retrieved from: http://www.pediatriconcall.com/Journal/Article/FullText.aspx?artid=798&type=J&tid=&imgid=&reportid=158&tbltype

Luijkx,T., Jones, J. et al (2015). Subgaleal haematoma. Radiopaedia.org. Retrieved from: http://radiopaedia.org/articles/sub-galeal-haematoma

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Ref No: Q2950 | Published On: 15-Jun-2015 | Status: Retired | Retired On: 01-Jul-2017

Admission for subtherapeutic INR (underwarfarinisation) and bridging therapy for temporary cessation of an anticoagulant

Q:

What is the correct principal diagnosis to assign when a patient on a long-term oral anticoagulant is admitted due to subtherapeutic INR?

A:

Assign R79.8 *Other specified abnormal findings of blood chemistry* as the principal diagnosis where underwarfarinisation or subtherapeutic INR (without a resultant condition) is documented as being the primary reason for occasioning the admission, following the index pathway:

Abnormal, abnormality, abnormalities

- chemistry, blood

- - specified NEC R79.8

Assign Z92.1 *Personal history of long term (current) use of anticoagulant* as an additional diagnosis.

Q:

What is the correct code assignment for bridging therapy for temporary cessation of an anticoagulant?

A:

Bridging therapy is a recent term used to describe the temporary discontinuation of long term oral anticoagulants (eg warfarin) and replacing with a short action agent such as clexane or heparin.

Patients on long term oral anticoagulants undergoing bridging therapy may be admitted because their INR levels are significantly lower than the therapeutic range (ie subtherapeutic INR or underwarfarinisation) in which case assign R79.8 as specified above.

When patients are admitted for a planned surgery and they receive bridging therapy prior to the surgery, assign a code for the condition requiring surgery as the principal diagnosis, followed by Z92.1 *Personal history of long term (current) use of anticoagulant* as per ACS 0303 *Abnormal coagulation profile due to anticoagulants* (See also Coding Rules: *Anticoagulant therapy pre and post surgery*).

Improvements to ICD-10-AM for abnormal coagulation profile due to anticoagulants will be considered for a future edition.

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Assignment of the condition onset flag for multiple conditions/sites classifiable to one ICD-10-AM code.

Q:

Where a patient has multiple conditions/sites classifiable to a single ICD-10-AM code that qualifies for different condition onset flag values, which condition onset flag value should be assigned? For example, a stage I pressure injury on the ankle (arising during admission) and a stage I pressure injury on the foot (present on admission). Both are discrete pressure injuries classifiable to one ICD-10-AM code, L89.09 *Pressure injury, stage I, other site of lower extremity (excluding heel and toe)*.

A:

The goal of the condition onset flag (COF) is to provide:

> *an insight into the kinds of conditions patients already have when entering hospital and those conditions that arise during the episode of admitted patient care. A better understanding of those conditions arising during the episode of admitted patient care may inform prevention strategies particularly in relation to complications of medical care (ACS 0048 Condition onset flag.)*

Therefore, where multiple conditions/sites are classifiable to a single ICD-10-AM code that qualifies for different condition onset flag values, assign COF 1 *Condition with onset during the episode of admitted patient care*.

Improvements to the ACS will be considered for a future edition.

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Ref No: Q2864 | Published On: 15-Jun-2015 | Status: Retired | Retired On: 01-Jul-2017

Posterior cerebral artery syndrome with infarction

Q:

What is the correct code assignment for posterior cerebral artery syndrome with infarction:

I66.2† *Occlusion and stenosis of posterior cerebral artery* and G46.2* *Posterior cerebral artery syndrome* (I66.2†)

or

I63.5 *Cerebral infarction due to unspecified occlusion or stenosis of cerebral arteries*?

A:

The dagger and asterisk pair I66.2† *Occlusion and stenosis of posterior cerebral artery* and G46.2* *Posterior cerebral artery syndrome (I66.2†)* can only be assigned following the index pathway:

Syndrome

- cerebral artery

- - posterior I66.2†, G46.2*

For posterior cerebral artery syndrome with infarction there is no legitimate dagger and asterisk pair that can be assigned. Codes from category I66 are clearly excluded when resulting in cerebral infarction.

Therefore the correct code to assign for posterior cerebral artery syndrome with infarction NOS is I63.5 *Cerebral infarction due to unspecified occlusion or stenosis of cerebral arteries.*

Do not assign G46.2* *Posterior cerebral artery syndrome (I66.2†)* as an additional code as an asterisk code can only be assigned with its corresponding dagger code as specified in the Alphabetic Index.

A proposal to update ICD-10 has been submitted to the World Health Organization.

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Trial of void admissions in the puerperium

Q:

What codes should be assigned for an obstetric patient who is re-admitted in the puerperal period for a trial of void (TOV) following a forceps delivery under local anaesthetic in her previous admission? Would the TOV be considered to be postoperative?

A:

There are many reasons why a patient may develop urinary retention in the postpartum period, including:

- changes in the bladder during pregnancy
- primiparity
- prolonged labour, particularly second stage
- assisted/instrumental delivery
- perineal injury.

Therefore, unless the clinical documentation indicates that the urinary retention is directly related to the use of instrumentation during delivery, the trial of void should be coded as *non postop*, as in the guidelines in ACS 1904 *Procedural complications,* which state that:

> *'if it cannot be determined whether a condition meets the definition of a procedural complication, it should not be coded as such'.*

Assign the following codes for a postpartum admission for trial of void - non postoperative:

TOV – successful

Z46.6 *Fitting and adjustment of urinary device*

Z39.0- *Postpartum care and examination immediately after delivery (see ACS 1548 Postpartum condition or complication)*

TOV - unsuccessful

Z46.6 *Fitting and adjustment of urinary device*

O99.8 *Other specified diseases and conditions complicating pregnancy, childbirth and the puerperium* (following the index pathway *Puerperal,puerperium/disorder/nonobstetric NEC*)

R33 *Retention of urine*

Z39.0- *Postpartum care and examination immediately after delivery (see ACS 1548 Postpartum condition or complication)*

Also assign procedural codes as instructed in ACS 1436 *Admission for trial of void/non postop.*

ACS 1436 *Admission for trial of void* will be reviewed for a future edition of the Australian Coding Standards.

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Peritonitis in a peritoneal dialysis patient

Q:

How should peritonitis in a peritoneal dialysis patient be coded when there is no documentation that the complication is due to the device?

A:

Peritonitis is a significant complication in a peritoneal dialysis (PD) patient. The peritonitis may be PD-related or secondary (enteric). PD-related peritonitis is due to touch contamination with pathogenic skin bacteria or to catheter-related infection. Secondary peritonitis is caused by underlying pathology of the gastrointestinal tract. Conditions that may lead to secondary peritonitis include cholecystitis, appendicitis, ruptured diverticulum, treatment of severe constipation, perforation during endoscopy, bowel ischaemia, and incarcerated hernia. Secondary peritonitis is less common than PD-related peritonitis (Burkart, J M, 2004).

Therefore, for peritonitis in a peritoneal dialysis patient without further specification assign T85.71 *Infection and inflammatory reaction due to peritoneal dialysis catheter,* following the index pathway:

Complication

- dialysis

- - catheter

- - - peritoneal

- - - - infection or inflammation T85.71

and

K65.- *Peritonitis*

Y84.1 *Kidney dialysis*

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

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

Do not assign K91.8 *Other postprocedural disorders of digestive tract, not elsewhere classified* following the index entry Peritonitis/postprocedural as it is a less specific code.

Improvements to ICD-10-AM will be considered for a future edition to ensure that the index pathway supports the guidelines in ACS 1904 *Procedural complications*.

References:

Burkart, J M. (2004). Clinical manifestations and diagnosis of peritonitis in peritoneal dialysis.

Retrieved from: http://www.uptodate.com/contents/clinical-manifestations-and-diagnosis-of-peritonitis-in-peritoneal-dialysis

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High output ileostomy

Q:

Is high output ileostomy classified as a procedural complication?

A:

High output ileostomy (HOS) refers to excessive effluent (> 2000ml per day) from an ileostomy, resulting in fluid, sodium and magnesium depletion, with malnutrition as an extreme late complication.

HOS is a likely outcome when there is less than 200cm of residual small intestine and no colon. Other causes include: intra-abdominal sepsis, partial bowel obstruction, (infectious) enteritis and recurrence of disease in the remaining intestine (eg Crohn's disease). HOS management includes treatment of the underlying cause, replacement of water and electrolyte imbalances, anti-diarrhoeal medications and nutritional support.

HOS is considered a procedural complication as per the definition in ACS 1904 *Procedural complications*:

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

Therefore, follow the guidelines in ACS 1904 and assign:

K91.4 *Colostomy and enterostomy malfunction*

with additional code(s) for any manifestation(s) (eg dehydration, electrolyte imbalance)

followed by:

Y83.3 *Surgical operation with formation of external stoma*

Y92.22 (Place of occurrence) *Health service area*

References:

Baker, M., Williams, R., and Nightingale, J. (2009). Causes and management of high-output stoma. Doi: 10.1111/j.1463-1318.2009.02107.x

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Baby born prior to admission with placenta delivered in hospital

Q:

What should be the principal diagnosis where a patient delivers a baby prior to admission, but the placenta is delivered following admission? Is delivery of the placenta part of the delivery episode, that is, the delivery is not complete until the placenta is delivered?

A:

The period between the delivery of the fetus and expulsion of the placenta and fetal membranes is the third and final stage of labour/delivery. Therefore where a patient has delivered a baby prior to the admitted episode of care but the placenta is expelled during the admitted episode of care assign:

- the appropriate code from O80 – O84 *Delivery* (also see Coding Rule *Manual removal of placenta in a single vaginal delivery*, published June 2014)
- the appropriate code from Z37.- *Outcome of delivery*
- Z39.03 *Postpartum care after unplanned, out of hospital delivery* to indicate that stage two has occurred prior to admission (this is an exception to the guidelines in ACS 1548 *Postpartum condition or complication*).

The reference to the delivery of ‘a baby prior to admission to hospital’ in ACS 1519 *Delivery prior to admission* should be considered to also include the delivery of the placenta. The wording in this standard and ACS 1548 *Postpartum condition or complication* will be reviewed for a future edition of the Australian Coding Standards (ACS) to clarify ‘delivery’.

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Retroperitoneal fibrosis without ureteric obstruction.

Q:

How do you code retroperitoneal fibrosis without ureteric obstruction?

A:

Retroperitoneal fibrosis (RPF) (Ormond's disease) is a rare condition that results in inflammation and fibrosis within the retroperitoneal space. The inflammation and fibrosis usually begins around the distal aorta and spreads toward the inferior vena cava, kidneys and surrounding structures, resulting in compression.

Signs and symptoms of RPF are dependent upon the specific body structure that is being compressed by the fibrotic mass. When RPF surrounds and compresses the ureters it causes obstruction and may lead to hydronephrosis and consequently kidney failure if left untreated. Compression of the inferior vena cava results in deep venous thrombosis and lower extremity oedema. Impaired blood flow in the intestines may lead to necrosis.

Approximately 70% of the cases of RPF are idiopathic. Other causes include drug-induced, malignancies, complication of external beam radiotherapy, certain infections (tuberculosis, histoplasmosis) or complication of previous abdominal surgery or trauma.

The indexing and classification of *idiopathic retroperitoneal fibrosis (Ormond's disease)* in ICD-10-AM is consistent with ICD-10 and other ICD-10 modifications (ICD-10-CM, ICD-10-CA), which defaults to N13.5 *Kinking and stricture of ureter without hydronephrosis* via the index pathways:

Fibrosis, fibrotic

- retroperitoneal, idiopathic (with ureteral obstruction) N13.5

Ormond's disease (with ureteral obstruction) N13.5

DO NOT follow the above index pathways to classify retroperitoneal fibrosis.

The default is a specific manifestation of the retroperitoneal fibrosis (that is, ureteric obstruction); there is no code option for retroperitoneal fibrosis *without* ureteric obstruction.

The WHO is considering creating a unique code for retroperitoneal fibrosis in a future edition of ICD-10. In the interim, assign the following code for *retroperitoneal fibrosis (Ormond's disease)*:

K66.8 *Other specified disorders of peritoneum*

by following the index pathway:

Disease, diseased

- peritoneum

- - specified NEC K66.8

If there is documentation of ureteric obstruction associated with retroperitoneal fibrosis, assign a code for the manifestation (as well as K66.8) by following the index pathway:

Obstruction, obstructed, obstructive

- ureter

Note: where retroperitoneal fibrosis is documented as a manifestation of another condition (for example, IgG4 related disease), assign a code for the aetiology by following the relevant index pathways and the guidelines in ACS 0001 *Principal diagnosis, Problems and underlying conditions* and ACS 0002 *Additional diagnoses.*

(See also Coding Rules IgG4-related disease).

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IgG4-related disease

Q:

How do you code immunoglobulin G4-related disease?

A:

Immunoglobulin G4-related disease (IgG4-related disease) (IgG4-RD) is synonymously known as:

- IgG4-related systemic disease or IgG4-related sclerosing disease (IgG4-RSD)
- IgG4-related autoimmune disease
- IgG4-related multiorgan lymphoproliferative syndrome (IgG4-MOLPS)
- IgG4-associated multifocal systemic fibrosis
- systemic IgG4 plasmacytic syndrome (SIPS)

IgG4-RD is a fibroinflammatory condition characterised by elevated levels of IgG4-positive plasma cells in affected organ tissue, with fibrosis and with or without elevated serum IgG4 concentrations. Elevated serum IgG4 concentrations were first recognised in patients with autoimmune pancreatitis; manifestations outside of the pancreas were later identified and the condition was recognised as a systemic condition in 2003.

IgG4-RD may manifest in the pancreas, hepatobiliary tract, salivary glands, periorbital tissues, kidneys, lungs, lymph nodes, meninges, aorta, breast, prostate, thyroid, pericardium, retroperitoneum and skin. Many conditions that were previously considered to be confined to single organs are now recognised as part of the spectrum of IgG4-RD, for example, Mikulicz's syndrome, Riedels' thyroiditis and retroperitoneal fibrosis. Symptoms of IgG4-RD are dependent upon the organ in which it manifests. There may be organ swelling (due to the presence of a fibrotic mass), damage or failure of the target organ. For example, patients may present with urinary symptoms due to obstruction of the ureter(s) from extensive retroperitoneal fibrosis.

Diagnosis of IgG4-RD includes histopathological identification of the presence of extensive numbers of IgG4-positive plasma cells in the affected tissue. Elevated serum IgG4 concentrations are suggestive but not a definitive diagnosis of IgG4-RD. Treatment includes administration of glucocorticoids, but immunosuppressive or B-cell depleting therapy may also be required.

The classification of IgG4-related disease is currently being considered internationally.

In the interim, assign the following code for IgG4-related disease (and all synonymous terms):

D89.8 *Other specified disorders involving the immune mechanism, not elsewhere classified*

by following the index pathway:

Disorder

- immune mechanism

- - specified type NEC D89.8

Also assign codes for specific manifestations (for example, retroperitoneal fibrosis), with sequencing as per the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses.*

(See also Coding Rules: Retroperitoneal fibrosis).

References:

Guma, M., and Firestein, G. (2012). IgG4-related diseases. Best Practice and Research Clinical Rheumatology. Volume 26, Issue 4, August 2012, pages 425-438. doi:10.1016/j.berh.2012.07.001

Khosroshahi, A., and Stone, J. (2011). A clinical overview of IgG4-related systemic disease. Current Opinion in Rheumatology. Volume 23(1), January 2011, p57-66. doi 10.1097/BOR.0b013e3283418057

Stone, J., Zen, Y., and Deshpande, V. (2012). IgG4-related disease. The New England Journal of Medicine 2012; 366:539-551. February 9, 2012 doi: 10.1056/NEJMra1104650

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Z58.7 *Exposure to tobacco smoke* (passive smoking)

Q:

Can Z58.7 *Exposure to tobacco smoke* be assigned when passive smoking is documented as the cause of a condition?

A:

Z58.7 *Exposure to tobacco smoke* is a WHO code that was implemented in ICD-10-AM Fifth Edition. The decision at the time of implementation, which was included in the pre-implementation education, was that the code should not be assigned because there was no accompanying standard to guide its assignment, and this has been supported and reinforced by a number of states in the intervening years.

The above advice was never officially included in the Australian Coding Standards (ACS). Therefore, a decision was made to list Z58.7 *Exposure to tobacco smoke* in the new Ninth Edition ACS 0049 *Disease codes that must never be assigned* to support the original advice. An ACS 0049 symbol has been added to Z58.7 in the ICD-10-AM Tabular List.

The above is an interim measure; ACCD has tentatively included the creation of specific guidelines for the assignment of Z58.7 on its work program for Tenth Edition. Until such guidelines are developed, Z58.7 must never be assigned for inpatient morbidity coding, as per the instructions in ACS 0049.

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Same-day endoscopy for chronic incurable diseases

Q:

What is the appropriate principal diagnosis for same-day endoscopic examination for chronic incurable conditions such as coeliac disease?

A:

Coeliac disease is a permanent intolerance to gluten proteins, present in wheat, rye, and barley. It is an autoimmune disorder, characterised by a chronic inflammatory state of the small intestinal mucosa and submucosa, which can impair digestion and absorption of nutrients, leading to malnutrition. Coeliac disease is diagnosed by small bowel biopsy in conjunction with specific blood tests. The only treatment is a strict lifetime gluten-free diet, which in a significant number of patients manages the disease, by allowing the small intestine mucosa to heal. A small percentage of patients will have refractory or treatment resistant coeliac disease.

Chronic incurable diseases, such as coeliac disease, Crohn's disease or ulcerative colitis, that require ongoing treatment such as lifelong dietary restrictions or ongoing medication to manage the disease may be admitted for endoscopic surveillance or follow up. While the follow up examination may appear normal it does not mean the disease has been eradicated or cured.

ACS 2113 *Follow up examinations for specific disorders* provides guidance for the assignment of codes in categories Z08 and Z09 for conditions which may be cured or eradicated after treatment such as bladder cancer and gastric ulcer:

> "Codes from category Z08 *Follow-up examination* ***after treatment*** *for malignant neoplasms* or Z09 *Follow-up examination* ***after treatment*** *for conditions other than malignant neoplasms* should be assigned as the principal diagnosis when a patient is admitted for follow-up of a condition and no residual condition or recurrences are found.
>
> …
>
> The appropriate code describing the **type of previous treatment** from category Z08 or Z09 should be assigned as the principal diagnosis."

Chronic conditions such as coeliac disease, Crohn's disease and ulcerative colitis cannot be eradicated or cured and with treatment/management ongoing, assignment of codes from these categories is inappropriate.

Therefore for chronic incurable conditions such as these, assign a code for the disease following the principles of ACS 0001 *Principal diagnosis*.

Endoscopic follow-up/surveillance is an inherent part of the management process for a condition that cannot be cured or eradicated, and therefore assignment of a code from Z08 or Z09 as an additional diagnosis is not required.

In the scenario cited the correct code to assign as principal diagnosis is K90.0 *Coeliac disease*.

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Positive coeliac gene test

Q:

What is the correct code to assign for a patient with a positive coeliac gene test without:

- any signs or symptoms of coeliac disease
- history of coeliac disease and
- histological confirmation from endoscopic biopsy of small bowel?

A:

While 99% of patients with coeliac disease have a positive test for HLA DQ2 and/or HLA DQ8 genes, only 1 in 30 people with a positive test for these genes develop coeliac disease. A positive gene test only indicates susceptibility to the disease which means the individual is *at risk* for developing coeliac disease. Therefore, a positive coeliac gene test should not be regarded as an abnormal result or a sign/symptom of coeliac disease.

It is appropriate to follow the guidelines in ACS 2111 *Screening for specific disorders* and assign Z13.83 *Special screening for examination for digestive tract disorder* as individuals with a positive coeliac gene test are asymptomatic and they are being screened for coeliac disease, but it is not detected or has never been detected.

References:

Coeliac Australia (2014). Gene testing (HLA genes). Retrieved from http://www.coeliac.org.au/diagnosis/

The University of Chicago, Celiac Disease Centre (2014). Genetic testing. Retrieved from http://www.uchospitals.edu/pdf/uch_007936.pdf

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Injection of SpaceOAR® (spacing organs at risk) via TRUS

Q:

What is the correct procedure code for injection of SpaceOAR® under TRUS (transrectal ultrasound) guidance?

A:

Injection of SpaceOAR® is a rectal separation technique performed prior to radiation therapy to protect rectal tissue from radiation. This is achieved by injecting a water based gel (SpaceOAR®) into the anterior perirectal fat under TRUS guidance. The gel solidifies once injected, forming a mass/barrier separating the prostate and rectum.

The correct code for SpaceOAR® via TRUS is 90560-00 **[1552]** *Administration of other agent into soft tissue, not elsewhere classified*, by following the index pathway:

Injection

- soft tissue NEC 90560-00 **[1552]**

Improvements to the Alphabetic Index will be considered for a future edition of ACHI

References:

ASERNIPS (Australian Safety and Efficacy Register of New Interventional Procedures – Surgical) (2010). Inert liquid-to-solid gels for prostate-rectum separation during prostate radiation therapy. ASERNIP, Department of Health and Ageing, ACT. Retrieved from: http://www.surgeons.org/media/305258/prostate_rectum_separation.pdf

Augmenix, Inc. Products (2015). Retrieved from: http://www.augmenix.com/products/spaceoar/

Published 15 June 2015,
for implementation 01 July 2015.

Ref No: Q2945 | Published On: 15-Mar-2015 | Status: Retired | Retired On: 30-Jun-2019

Reversible cerebral vasoconstriction syndrome (RCVS)

Q:

How do you code reversible cerebral vasoconstriction syndrome (RCVS)?

A:

Reversible cerebral vasoconstriction syndrome is synonymously known as:

- acute benign cerebral angiopathy
- Call or Call-Fleming syndrome
- CNS pseudovasculitis
- isolated benign cerebral vasculitis
- reversible cerebral segmental vasoconstriction
- reversible cerebrovascular vasoconstriction syndrome

Reversible cerebral vasoconstriction syndrome is characterised by severe headaches, with or without other acute neurological symptoms, and diffuse segmental constriction of cerebral arteries that resolves spontaneously within 3 months.

There is currently no specific code or index pathway for *reversible cerebral vasoconstriction syndrome* in ICD-10 (or ICD-10-AM). A submission will be sent to the WHO update reference committee (URC). In the interim, assign I67.8 *Other specified cerebrovascular disease* by following the index pathway:

Disease

- cerebrovascular

- - specified NEC I67.8

Enhancements to ICD-10-AM will be considered for a future edition.

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for implementation 01 April 2015.

Ref No: Q2911 | Published On: 15-Mar-2015 | Status: Retired | Retired On: 30-Jun-2019

Tongue channelling via coblation

Q:

What is the correct procedure code for tongue channelling via coblation?

A:

The term ‘coblation’ means ‘controlled ablation’. Tongue channelling via coblation is also known as coblation tongue reduction, a technique that reduces the overall size of the tongue to eliminate snoring and sleep apnoea symptoms. The procedure is performed by applying radiofrequency energy to the base of the tongue through a probe, which is inserted into the deep tissue of the tongue. Radiofrequency energy causes shrinkage of the deep musculature and soft tissue of the tongue.

Where tongue channelling via coblation is documented, assign 45675-01**[1665]** *Reduction of tongue size*, by following the index pathway:

Reduction

- size

- - tongue (macroglossia) 45675-01 **[1665]**

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

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for implementation 01 April 2015.

Ref No: Q2890 | Published On: 15-Mar-2015 | Status: Retired | Retired On: 30-Jun-2019

Obstetric additional diagnosis sequencing

Q:

Is there a sequencing rule for the O80–O84 *Delivery* codes when they are assigned as an additional diagnosis? For example, if the principal diagnosis is an antepartum condition such as pre-eclampsia but the patient also has a perineal tear during the delivery, should the O80–O84 code immediately follow the antepartum principal diagnosis, that is, be sequenced as the second code?

A:

The *Note* at O80–O84 *Delivery* states:

‘Other abnormalities/complications classifiable elsewhere in Chapter 15 may be assigned in conjunction with codes O80–O84 to fully describe the delivery episode’.

There are no sequencing rules when codes from O84–O84 *Delivery* are assigned as an additional diagnosis, apart from being sequenced before Z37.- *Outcome of delivery*, as in the instructional note at Z37.- :

‘*Code first the delivery (O80–O84)*’.

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for implementation 01 April 2015.

Ref No: Q2862 | Published On: 15-Mar-2015 | Status: Retired | Retired On: 30-Jun-2019

Invasive and in-situ neoplasms of the prostate

Q:

If a trans-rectal ultrasound (TRUS) guided biopsy of the prostate identifies adenocarcinoma (M8140/3) and high grade intraepithelial neoplasia (M8148/2), do you code both or just the adenocarcinoma?

A:

Where a histopathology report details both in situ and invasive cancer within the prostate, the behaviour takes precedence over the histological type and only the morphology and site code for the invasive cancer should be coded.

The sentence in ACS 0233 *Morphology*:

> "*If a morphological diagnosis contains two histological terms which have different M codes, select the highest number as it is usually more specific*."

is referring to multiple histological types found within a lesion in one organ, and does not provide guidance with respect to differing morphological behaviours.

In the scenario cited where multiple histological terms/morphologies with different behaviours are reported in a TRUS biopsy of the prostate, only assign codes for the invasive neoplasm (ie adenocarcinoma).

This will be clarified in ACS 0233 *Morphology* in a future edition.

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Ref No: Q2853 | Published On: 15-Mar-2015 | Status: Retired | Retired On: 30-Jun-2019

Increased S/D (systolic/diastolic ratio) and AEDF (absent end diastolic flow)

Q:

What code should be assigned when increased S/D (systolic/diastolic ratio) or AEDF (absent end diastolic flow) is documented as a reason for induction of labour or caesarean section?

A:

Both systolic/diastolic blood flow velocity ratio (S/D ratio) and end diastolic flow (EDF) are measurements of umbilical artery blood flow in the Doppler ultrasound assessment. Many studies have come to the conclusion that increased S/D and absent end diastolic flow (AEDF) are useful markers in detecting at risk fetuses and in predicting placental insufficiencies.

Assign O36.5 *Maternal care for poor fetal growth* for documentation of increased S/D or AEDF as it includes maternal care for known or suspected placenta insufficiency. This is the usual indication for intervention such as induction of labour or elective caesarean section.

Improvement to ICD-10-AM will be considered for a future edition.

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for implementation 01 April 2015.

Ref No: Q2880 | Published On: 15-Mar-2015 | Status: Retired | Retired On: 30-Jun-2019

Debridement of skin with suturing

Q:

Is it necessary to assign a code for suturing of skin in addition to a code for (excisional) debridement?

A:

When excisional debridement is performed, it is not necessary to assign an additional code for suturing of a wound at the same site of the debridement. The suturing of the wound is a component of the procedure, as per the guidelines in ACS 0016 *General Procedure Guidelines, Procedure components.*

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

Published 15 March 2015,
for implementation 01 April 2015.

Ref No: Q2820 | Published On: 15-Mar-2015 | Status: Retired | Retired On: 01-Jul-2017

Cellulitis of an infected blister

Q:

Patient admitted for cellulitis of an infected blister of the index finger. Swabs taken of the blister grew *Staphylococcus aureus* which clinical documentation confirmed as the source of the infection. Should a code for cellulitis be assigned as well as T79.3 *Post traumatic wound infection, not elsewhere classified,* as per ACS 1916 *Superficial injuries?*

A:

ACS 1916 *Superficial injuries* instructs that T79.3 *Post traumatic wound infection, not elsewhere classified* and a code for the associated infectious agent should be assigned as additional codes if a superficial injury is infected. The instruction in the specialty standard should be followed despite T79.3 being an NEC code.

However it does not preclude the assignment of a more specific code for the infection, such as cellulitis in the scenario cited.

For example:

Patient admitted for cellulitis of an infected blister of the index finger. Documentation in the clinical record confirms an associated infection with *Staphylococcus aureus*.

The following codes would be assigned (and sequenced following the principles in ACS 0001 *Principal diagnosis)*:

L03.01 *Cellulitis of finger*

S60.82 *Blister of wrist and hand*

T79.3 *Post traumatic wound infection, not elsewhere classified*

B95.6 *Staphylococcus aureus as the cause of diseases classified to other chapters*

and appropriate external cause of injury codes.

ACS 1916 *Superficial injuries* has been identified for review for a future edition.

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for implementation 01 April 2015.

Ref No: Q2694 | Published On: 15-Mar-2015 | Status: Retired | Retired On: 01-Jul-2017

Total parenteral nutrition (TPN)

Q:

Should total parenteral nutrition be coded?

A:

Total parenteral nutrition (TPN) is the administration of nutrients to a patient usually via a central venous catheter and is usually a short term treatment, although in some conditions has been used as a long term therapy.

TPN is classified in ACHI under Pharmacotherapy and the guidelines in ACS 0042 *Procedures not normally coded, point 8* should be followed*:*

8. Drug treatment/pharmacotherapy

Drug treatment should not be coded except if:

- the substance is given as the principal treatment in same-day episodes of care
- drug treatment is specifically addressed in a coding standard (see ACS 0044 *Chemotherapy,* ACS 1316 *Cement spacer/beads* and ACS 1615 *Specific diseases and interventions related to the sick neonate*).

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS

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Ref No: Q2898 | Published On: 15-Mar-2015 | Status: Retired | Retired On: 01-Jul-2017

Necrotising myopathy NOS

Q:

How do you code necrotising myopathy? Is it necessary to assign R02 *Gangrene, not elsewhere classified* an additional code to specify the necrotising component?

A:

Assign G72.8 Other specified myopathies for necrotising myopathy NOS, by following the index pathway:

Myopathy G72.9

- specified NEC G72.8

The term ‘necrotising’ relates to muscle fibre necrosis, a feature of necrotising myopathy identified histologically in biopsied muscle tissue. Do not assign R02 Gangrene, not elsewhere classified to identify the necrosis.

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Ref No: Q2913 | Published On: 15-Mar-2015 | Status: Retired | Retired On: 01-Jul-2017

Metallosis due to joint prostheses

Q:

How do you code metallosis due to metal-on-metal joint prostheses (for example, total hip replacements)?

A:

Metallosis may occur due to the adverse effects of metal debris from metallic joint prostheses, particularly following total hip replacement.

The acetabular cup and implant head in metal-on-metal implants are composed of cobalt-chromium alloys. Continuous movement of the hip joint results in micro-particles of metal being released into the soft tissues; these micro-particles may result in necrosis surrounding the implant or corrode and release metal ions into the systemic circulation resulting in elevated serum levels of chromium and cobalt. Metal poisoning occurs when toxic levels of these metals accumulate, leading to implant failure, tissue and bone necrosis, and organ damage.

Metallosis may result in localised or systemic effects, such as:

- tissue or bone necrosis or pseudotumour formation adjacent to the prosthesis
- cardiomyopathy or heart failure
- visual impairment, that may lead to blindness
- skin rashes
- nervous system dysfunction (cognitive impairment, memory loss, depression)
- thyroid dysfunction

Patients may describe joint pain, a metallic taste, headaches, anorexia and weight loss.

A revision procedure is required to replace the metal-on-metal implant with a nonmetallic implant (for example, ceramic and polyethylene).

As the metallosis is due to a breakdown of the prosthesis it is classified as a mechanical complication of the device. Therefore, where there is documented evidence of metallosis due to a joint prosthesis, assign:

T84.0 *Mechanical complication of internal joint prosthesis*

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

Y92.22 *Heath service area*

Where documentation specifies that the patient has excessively high serum levels of cobalt or chromium, assign as an additional diagnosis:

R79.0 *Abnormal level of blood mineral*

As per the guidelines in ACS 1904 *Procedural complications*: *An additional code from Chapters 1 to 19 should be assigned where it provides further specificity.*
Additional codes for any specific manifestations should be assigned based on documentation in the clinical record and the criteria for code assignment in ACS 0002 *Additional diagnoses*.

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Ref No: Q2918 | Published On: 15-Mar-2015 | Status: Retired | Retired On: 01-Jul-2017

External cause code for complication of vascular access device (portacath)

Q:

What external cause code is assigned with a complication code for vascular access device (eg portacath)?

A:

A vascular access device is an implanted venous catheter with a reservoir attached (see note in Z45.2 *Adjustment and management of vascular access device*).

When classifying a complication of a vascular access device (eg portacath), assign as the external cause of injury code:

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

by following the index pathway *Complication/implant, implantation/artificial/internal device.*

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Ref No: Q2910 | Published On: 15-Mar-2015 | Status: Retired | Retired On: 01-Jul-2017

O60 *Preterm labour and delivery*

Q:

Does preterm labour and/or delivery have to meet the criteria in ACS 0002 *Additional diagnoses* before a code from O60 *Preterm labour and delivery* is assigned?

A:

The following are general guidelines for coding a delivery episode of care:

- follow the guidelines in ACS 0001 *Principal diagnosis, Obstetrics* to determine sequencing of codes for antepartum conditions and O80-O84 *Delivery*
- assign codes for conditions/complications (antepartum, labour and delivery, puerperal or non-obstetric) that meet the criteria in ACS 0002 *Additional diagnoses* and the guidelines in specific standards in Chapter 15 *Pregnancy, childbirth and the puerperium* of the ACS
- assign codes for the following (when applicable to the case):

  O30 Multiple gestation

  O60 Preterm labour and delivery

  O09 Duration of pregnancy (see criteria in ICD-10-AM Tabular List)
- assign a code from Z37 Outcome of delivery

Codes from O60 Preterm labour and delivery must be assigned when onset of labour and/or delivery occurred before 37 completed weeks of gestation. Specific guidelines for assignment of O60 are included in ACS 1511 Termination of pregnancy and 1550 Discharge/transfer in labour.

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Ref No: Q2920 | Published On: 15-Mar-2015 | Status: Retired | Retired On: 01-Jul-2017

Urolift® procedure

Q:

What is the correct code to assign for UroLift® procedure?

A:

The UroLift® procedure is a minimally invasive treatment for benign prostatic hypertrophy where small implants are permanently placed in the prostate through a cystoscope to hold back the enlarged prostate lobes in a retracted position so that it no longer blocks the urethra. Typically 4-6 implants are placed to retract the enlarged prostatic tissue. It is also known as prostatic urethral lift (PUL) procedure.

Assign:

90409-00 **[1160]** *Implantation of other device(s), prostate*, by following the index pathway:

Implant, implantation — *see also* Insertion

- device

- - prostate NEC 90409-00 **[1160]**

An additional code 36812-00 **[1089]** *Cystoscopy* should also be assigned as per ACS 0023 *Laparoscopic/arthroscopic/endoscopic surgery*.

Index amendments will be considered for a future edition of ACHI.

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Ref No: Q2904 | Published On: 15-Mar-2015 | Status: Superseded | Superseded On: 15-Dec-2015 | Superseded By: Q2977

Vacuum assisted wound closure (VAC) Dressings

Q:

Should VAC dressings be coded?

A:

Vacuum assisted wound closure (VAC) is a type of wound dressing which uses negative pressure to promote wound healing. The wound is covered with open cell foam or gauze dressing that moulds to the wound bed. A drainage tube is attached, the wound is then sealed and vacuum or negative pressure is applied via a pump. The suction pressure removes or 'debrides' loose tissue and has been shown to reduce swelling, aid wound closure and promote formulation of granulation tissue.

VAC dressings are classified in ACHI as a nonexcisional debridement and therefore assign the following code as appropriate when performed:

90686-01 **[1628]** *Nonexcisional debridement of skin and subcutaneous tissue*

or

90686-00 **[1627]** *Nonexcisional debridement of burn.*

As VAC dressings are classified to nonexcisional debridement, ACS 0042 *Procedures not normally coded,* point 7 – *Dressings*, does not apply.

This will be clarified in ACS 0042 *Procedures normally not coded, point 7 – Dressings* in a future edition.

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Ref No: Q2944 | Published On: 15-Mar-2015 | Status: Retired | Retired On: 30-Jun-2015

Locked-in syndrome

Q:

What code should be assigned for locked-in syndrome?

A:

Locked-in syndrome is a rare neuropsychological disorder. Its primary features are complete paralysis of voluntary muscles in all parts of the body except for those responsible for eye movements (Cardwell, 2013). The most common aetiologies include haemorrhage or infarction of the basilar or vertebral arteries, brain injury, tumour or infection.

In 2013 WHO introduced a specific code for locked-in syndrome (G83.5) which has been incorporated into ICD-10-AM Ninth Edition.

In the interim, assign G83.8 *Other specified paralytic syndromes* for this condition. Assign an additional code for the underlying cause of the paralytic syndrome, if known. For example, a patient was admitted with locked-in syndrome following a brain stem infarction, assign:

G83.8 *Other specified paralytic syndromes*

I63.9 *Cerebral infarction, unspecified*

See ACS 0001 *Principal diagnosis, Problems and underlying conditions.*

Reference:

Cardwell, M. S (2013). Locked-in syndrome**.** *The Journal of Texas Medicine,109(2), e1.*

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Ref No: Q2856 | Published On: 15-Dec-2014 | Status: Retired | Retired On: 30-Jun-2019

Adipose-derived stem cell therapy

Q:

How do you classify adipose-derived stem cell therapy?

A:

Stem cells may be used as an adjunct therapy during certain procedures to encourage cell regeneration. For example, stem cells may be injected into a joint following chondroplasty for a chondral defect, with the expectation that they are able to convert to cartilage-like cells and encourage cartilage regeneration.

Adipose-derived stem cells may be used as they are abundant in quantity and are harvested by liposuction. Following liposuction, the tissue is processed outside of the body (to separate the stem cells from the fat and other cells etc) and then injected back into the patient's defective joint.

Adipose-derived stem cell therapy more closely resembles autologous chondrocyte implantation than traditional stem cell transplantation, which is performed via bone marrow transplantation. Therefore, where adipose-derived stem cell therapy is performed, assign:

14203-01 **[1906]** *Direct living tissue implantation*

by following the index pathway:

Implant, implantation

- living tissue

- - by

- - - direct implantation

Amendments to ACHI Alphabetic Index will be considered for a future edition.

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Ref No: Q2893 | Published On: 15-Dec-2014 | Status: Retired | Retired On: 30-Jun-2019

ACS 1544 *Complications following abortion and ectopic molar pregnancy*

Q:

Is example 2 in ACS 1544 *Complications following abortion and ectopic molar pregnancy* correct and if so does this mean that multiple codes can be assigned to add specificity to O03-O07 codes ie those which specify 'other and unspecified complications'?

A:

ACS 1544 Complications following abortion and ectopic and molar pregnancy was revised in an erratum to first edition as follows:

First Edition:

> O08 should be assigned as an additional code with O00-O02 (Ectopic pregnancy, Hydatidiform mole, Other abnormal products of conception) to identify associated complications."O08 may be assigned with categories O03-O07 (Spontaneous abortion, Medical abortion, Other abortion, Unspecified abortion, Failed attempted abortion) where the addition of this code provides fuller details of the complications.

First Edition errata:

> An O08 code should also be assigned as an additional code to identify a complication associated with categories O00-O02 (Ectopic pregnancy, Hydatidiform mole, Other abnormal products of conception).

The modification to the standard indicated that codes from O08 should not be assigned in addition to codes in the range O03-O07. Categories O03-O06 (Spontaneous abortion, Medical abortion, Other abortion, Unspecified abortion) are intended to classify complications from an abortion occurring **during the same episode of care** and codes from O08 Complications following abortion and ectopic and molar pregnancy are intended to classify complications arising from an abortion **occasioning a subsequent episode of care**.

Example 2 should have been amended as part of the erratum to First Edition ie O08.6 Damage to pelvic organs and tissues following abortion and ectopic and molar pregnancy should have been removed. The following amendments to this example will be included in the first errata to Ninth Edition:

> EXAMPLE 2:
>
> Incomplete abortion with perforation of uterus.
>
> Codes: O06.3 *Unspecified abortion, incomplete, with other and unspecified complications*
>
> ~~O08.6 *Damage to pelvic organs and tissues following abortion and ectopic and molar pregnancy*~~
>
> O71.02 *Traumatic rupture of uterus before onset of labour*
>
> O09.- *Duration of pregnancy*

An additional code O71.02 *Traumatic rupture of uterus before onset of labour* is assigned to provide further details of the complication, by following the index pathway:

Perforation, perforated (nontraumatic)

- uterus

- - obstetric trauma (during labour)

- - - before onset of labour 071.02

ACS 1544 is not explicit about whether chapter codes such as acute kidney failure (N17.-), urinary tract infection (N39.0) can be assigned in addition to codes in the range O03–O07. However, following the principles of multiple coding (see ACS 0002 *Additional diagnoses*) assignment of codes from other chapters may be assigned if they provide further specificity.

The classification for pregnancy with abortive outcome (O00–O08) and ACS 1544 have been flagged for review in a future edition of ICD-10-AM.

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for implementation 01 January 2015.

Ref No: Q2871 | Published On: 15-Dec-2014 | Status: Retired | Retired On: 30-Jun-2019

Diabetes with gouty arthropathy

Q:

Should diabetes be associated with gouty arthropathy?

A:

People with diabetes are prone to a number of musculoskeletal complications. Many of these problems are not unique to diabetes but occur more frequently in this condition. Both neurogenic arthropathy and arthropathy NEC with diabetes are classified to E1-.61 **Diabetes mellitus with specified diabetic musculoskeletal and connective tissue complication*.

Although gout and diabetes have common risk factors (ie they often occur together), ICD-10-AM does not classify diabetes with gouty arthropathy.

Therefore, diabetes with gouty arthropathy should not be assigned to E1-.61 * *Diabetes mellitus with specified diabetic musculoskeletal and connective tissue complication*.

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Ref No: Q2667 | Published On: 15-Dec-2014 | Status: Retired | Retired On: 01-Jul-2017

T88.4 *Failed or difficult intubation*

Q:

When should difficult intubation be coded?

A:

Difficult intubation is more common than failed intubation, which is a medical emergency, and should be clearly documented, in the clinical record. There are in principle three markers of a difficult intubation: the anaesthetist's/intubator's (clinical) opinion, the patient, and the procedure.

Clinical opinion

Difficult intubation would normally be documented if there was significant difficulty, as it is important that it be known for future anaesthetics.

Patient level markers

Patient level markers of potentially difficult intubation are routinely described as a grade 1-4 as per the Cormack-Lehane system, or the Mallampati (MP) score.

The Cormack-Lehane system (original or modified) describes the best view possible at laryngoscopy; external manipulation and **B**ackward, **U**pward, **R**ightward **P**ressure (BURP), cricoid pressure or correct positioning may be used to gain the best view.

Original Cormack and Lehane classification

Grade	Description
1	Most of the glottis is visible
2	At best almost half of the glottis is seen, at worst only the posterior tip of the arytenoids is seen
3	Only the epiglottis is visible

Modified Cormack-Lehane classification

Grade	Description	Approximate frequency	Likelihood of difficult intubation
1	Full view of glottis	68%	<1%
2a	Partial view of glottis	24%	4.3%
2b	Only posterior extremity of glottis seen or only arytenoid cartilages	6.5%	67.4%
3	Only epiglottis seen, none of glottis seen	1.2%	87.5%
4	Neither glottis nor epiglottis seen	Very rare	Very likely


IHACPA

The Mallampati score is based on the structures visualised with maximal mouth opening and tongue protrusion in the sitting position. The Mallampati rule states that there is a relationship between what is seen on direct per-oral pharyngeal visualisation and that seen with laryngoscopy.

Procedure level markers

Procedure level markers include use of video-laryngoscope or introducers. These do not of themselves necessarily indicate difficult intubation (eg they may be used for practice or training purposes or routinely used by particular anaesthetists/intubators).

Types of introducers include:

- Bonfils
- Bougie
- CMAC
- MAC3 or MAC #3
- McCoy blade.

Classification

T88.42 D*ifficult intubation* should be assigned when:

- *difficult intubation* is specifically documented **and**
- there is documentation of a Cormack-Lehane or Mallampati score of grade 2 or higher.

Use of advanced techniques (video-laryngoscopy or introducers) may indicate difficult intubation, but for classification purposes the above criteria must first be met before T88.42 is assigned. Where documentation is unclear, coders should seek clinical advice.

The above advice also applies to:

- O29.62 *Difficult intubation during pregnancy*
- O74.72 *Difficult intubation during labour and delivery*
- O89.62 *Difficult intubation during the puerperium*.

Reference:

Amantea, S., Jefferson, P., Rodrigues, M., Bruno, F., and Garcia, P. (2003) Mallampati score [Figure]. In Rapid airway access. Jornal de Pediatria. Vol. 79. Suppl.2 Porto Alegre Nov. 2003. http://dx.doi.org/10.1590/S0021-75572003000800002

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS

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Ref No: Q2809 | Published On: 15-Dec-2014 | Status: Retired | Retired On: 01-Jul-2017

Vacuum rotation with forceps delivery

Q:

What are the correct procedure codes to assign for a patient who had a rotational ventouse performed for obstructed labour due to malposition (resulting in a normal fetal position), following which the suction was lost on the cap and Neville Barnes forceps were used to deliver the baby? When following the ACHI index pathway:

Rotation

- vacuum (of fetal head) 90469-00 **[1338]**

- - with delivery 90469-00 **[1338]**

- - failed 90469-01 **[1338]**

it was noted that the default code is the same as the code for with delivery, however it doesn't seem correct to assign the code for failed as the vacuum rotation was successful.

A:

A vacuum device, or ventouse, is used in an instrument assisted vaginal delivery to achieve extraction, although rotation of the baby's head can be performed during the vacuum delivery (or attempted delivery). Where the use of the vacuum does not result in extraction of the baby, such as where the pressure cup detaches from the baby's head, it is classified as a failed vacuum extraction. The ACHI codes at block **[1338]** *Vacuum extraction* are split by 'with delivery' or 'failed extraction'.

In the case cited, although rotation was achieved, delivery was not; therefore the code for failed vacuum extraction should be assigned, with the code for the forceps delivery, as follows:

90469-01 **[1338]** *Failed vacuum extraction*

90468-01 **[1337]** *Mid-cavity forceps delivery*.

The entries for Rotation/vacuum in the Alphabetic Index will be amended for a future edition of ACHI, to support the correct code assignment for failed vacuum extraction where vacuum rotation has been performed.

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Ref No: Q2804 | Published On: 15-Dec-2014 | Status: Retired | Retired On: 01-Jul-2017

Wound ooze

Q:

Should postprocedural wound ooze be coded?

A:

Postprocedural wound ooze may refer to:

- *Serous exudate* – drainage of a clear, thin, watery fluid from a surgical wound. This type of wound ooze is a normal and expected part of the healing process
- *Haemoserous (serosanguinous) exudate* – drainage of a thin, watery, pink coloured fluid composed of blood and serum. This type of wound ooze is also a normal and expected part of the healing process
- *Sanguinous exudate or haemorrhage* – indicates a trauma to blood vessels
- *Purulent (pussy) exudate* – a yellow, grey or green odiferous discharge – indicates infection.

While small amounts of serous or serosanguinous exudate from a postprocedural wound is considered normal, excessive or increasing discharge may indicate a postprocedural complication.

Wound observation/monitoring and dressing management are routine postprocedural care and wound ooze should only be coded when there is documentation of care or management of the wound that is beyond routine care.

Evidence that wound ooze has met the criteria for code assignment in ACS 0002 *Additional diagnoses* includes:

- Consultation/treatment by a clinician, including a wound specialist or stoma therapist (if this is outside of routine wound management in your facility)
- Application of vacuum dressing or other dressing/device outside of the routine type of dressing material (for example, stoma bags may be used in place of conventional dressings where there is excessive discharge of exudate)
- Unexpected/unplanned return to theatre for wound exploration/insertion of a drain.

The above list should not be considered exhaustive and each case must be considered on its own merits. Where there is uncertainty as to whether wound ooze is in excess of the normal healing process or is indicative of haemorrhage or infection (and these terms are not documented), confirmation should be sought from the treating clinician.

When the above guidelines have been followed and criteria have been met, assign the following codes for **wound ooze NOS**:

T81.8 *Other complications of procedures, not elsewhere classified*

Y83-Y84 *Surgical and other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure*

Y92.22 (Place of occurrence) *Health service area*

Assign codes for postoperative haemorrhage or infection by following the guidelines in ACS 1904 *Procedural complications*.

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Ref No: Q2825 | Published On: 15-Dec-2014 | Status: Retired | Retired On: 01-Jul-2017

Dislodged and leaking intravenous cannulas

Q:

Is it appropriate to assign T82.5 *Mechanical complication of other cardiac and vascular devices and implants* for an intravenous catheter that has been resited due to dislodgment or leakage?

A:

Some form of peripheral IV therapy is common treatment for a patient in an acute admitted episode of care. Among the most common complications associated with peripheral infusion therapy are infiltration and extravasation.Infiltration occurs where the infusion cannula becomes dislodged from the vein and fluids are infused into the surrounding tissues, which can result from:

- improper insertion into the vein
- damage to the lining of the vein causing it to swell and preventing forward flow of the fluid being infused
- presence or formation of a clot within the vein or around the cannula
- puncture or erosion through the wall of the vein by the cannula
- dislodgement of the catheter through patient movement or improper securement.

IV infiltrations occur frequently but most do not cause serious tissue damage. Common signs of infiltration include:

- oedema at the insertion site
- taut or stretched skin
- blanching or coolness of the skin
- slowing or stopping of the infusion
- leaking of intravenous fluid out of the insertion site.

While infiltration may cause patient discomfort and require re-insertion it should only be coded where it causes serious outcomes/complications. Serious outcomes result in marked tissue damage as a consequence of large infiltrations or extravasations of irritant solutions such as those containing calcium, potassium, antibiotics, vasopressors or chemotherapy agents. The extent of the damage/injury from infiltration/extravasation is related to how much of the fluid or medication has leaked into the tissues, and when intervention began. Early detection and resiting of the cannula may avoid serious tissue damage.

Therefore resiting of a cannula alone or because of dislodgement or leaking is not sufficient to assign T82.5 *Mechanical complication of other cardiac and vascular devices and implants*. It should be assigned, however, in instances where major tissue damage has occurred requiring intervention beyond resiting.

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for implementation 01 January 2015.

Ref No: Q2866 | Published On: 15-Dec-2014 | Status: Retired | Retired On: 01-Jul-2017

Graves' cardiomyopathy

Q:

How do you classify Graves' cardiomyopathy/cardiomyopathy secondary to Graves' disease?

A:

ICD-10-AM Alphabetic Index lists the following codes for cardiomyopathy secondary to thyrotoxicosis:

Cardiomyopathy (familial) (idiopathic)

…

- thyrotoxic E05.9† I43.8*

E05.9+ *Thyrotoxicosis, unspecified*

I43.8* *Cardiomyopathy in other diseases classified elsewhere*

An additional code may be assigned to specify the type of thyrotoxicosis, if documented. For example:

Graves' disease E05.0

E05.0 *Thyrotoxicosis with diffuse goitre*

Sequencing of the above codes is determined by the Conventions Used in the Tabular List of Diseases. For example, where documentation supports the assignment of Graves' disease as the principal diagnosis, sequence as:

E05.0 *Thyrotoxicosis with diffuse goitre*

E05.9+ *Thyrotoxicosis, unspecified*

I43.8* *Cardiomyopathy in other diseases classified elsewhere*

Amendments will be considered to simplify the classification of these conditions for a future edition of ICD-10-AM.

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Ref No: Q2848 | Published On: 15-Dec-2014 | Status: Retired | Retired On: 01-Jul-2015

Weaning of continuous ventilatory support (CVS)

Q:

When should noninvasive ventilation (NIV) performed after continuous ventilatory support (CVS) be considered weaning? Does ‘weaning’ have to be stated or should any NIV after CVS be considered weaning?

A:

Where an intubated patient is given NIV following CVS it should be considered as weaning and included in the duration of CVS, ending at the time of extubation.

For the purposes of the classification, any NIV given following extubation should not be considered as weaning from CVS, and should be coded separately where it meets the guidelines in ACS1006 *Ventilatory support* (see also ACS 1615 *Specific diseases and interventions related to the sick neonate*).

Amendments have been made to ACS 1006 *Ventilatory support* in Ninth Edition to further clarify weaning from CVS and the calculation of the duration of CVS.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS

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Ref No: Q2879 | Published On: 15-Dec-2014 | Status: Retired | Retired On: 30-Jun-2015

Interpretation of completed cumulative hours in ACS 1006 *Ventilatory support*

Q:

If a patient is intubated and receives continuous ventilatory support (CVS) for less than one hour should the intubation and CVS be coded?

A:

As per ACS 1006*Ventilatory support*, where a patient is intubated and ventilated for less than one hour, the intubation and ventilation are not coded (see *Classification* points 1c and 2b, and *Transferred intubated patients*).

Amendments have been made to ACS 1006 in Ninth Edition to further clarify this coding guideline.

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Ref No: TN742 | Published On: 15-Dec-2014 | Status: Retired | Retired On: 30-Jun-2015

Wedge resection of ingrown toenail

Q:

What code is assigned for wedge resection of ingrown toenail?

A:

Assign 47915-00 **[1632]** *Wedge resection of ingrown toenail* by following the index pathway:

Resection

-nail

- - toe

- - - ingrown

- - - - wedge.

DO NOT follow the excludes note at 47916-00 **[1632]** *Partial resection of ingrown toenail*; the wrong code is listed. It has been corrected in ACHI Ninth Edition.

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for implementation 01 January 2015.

Ref No: Q2817 | Published On: 15-Dec-2014 | Status: Retired | Retired On: 30-Jun-2015

Pelvic peritoneal adhesions complicating a caesarean delivery

Q:

What is the code assignment for pelvic peritoneal adhesions complicating a caesarean delivery?

A:

In the absence of a specific index pathway for *Pregnancy* or *Delivery/complicated by/adhesions* it is difficult to determine the correct code assignment for adhesions complicating pregnancy/delivery. However, correct code assignment is determined by the following:

- the includes note at category O34 *Maternal care for known or suspected abnormality of pelvic organs* which specifies “the listed conditions as a reason for observation, hospitalisation or other obstetric care of the mother, or for caesarean section before onset of labour”
- ACS 1506 *Malpresentation, disproportion, and abnormality of maternal pelvic organs* and by following the index pathway:

Pregnancy

…

- complicated by — *see also Pregnancy/management affected by*

- - abnormal, abnormality

- - - pelvic organs or tissues O34.9

- - - - **specified NEC O34.8**

- - - - - affecting

- - - - - - **labour or delivery O65.5**

Therefore, for pelvic adhesions complicating a caesarean delivery without labour; for example, division of adhesions during a caesarean section, assign:

O34.8 *Maternal care for other abnormalities of pelvic organs*

with

N73.6 *Female pelvic peritoneal adhesions*

or

N99.4 *Postprocedural pelvic peritoneal adhesions* (if the adhesions are documented as being due to previous surgery).

If the pelvic adhesions require intervention during labour (not a caesarean delivery without labour) assign:

O65.5 *Labour and delivery affected by abnormality of maternal pelvic organs*

with

N73.6 *Female pelvic peritoneal adhesions*

or

N99.4 *Postprocedural pelvic peritoneal adhesions* (if the pelvic (peritoneal) adhesions are documented as being due to previous surgery)

Improvements to the Alphabetic Index have been made for the Ninth Edition of ICD-10-AM.

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for implementation 01 January 2015.

Ref No: Q2750 | Published On: 15-Sep-2014 | Status: Retired | Retired On: 30-Jun-2019

Low grade versus noninvasive papillary urothelial carcinoma

Q:

Are low grade and noninvasive papillary urothelial carcinoma the same?

A:

Clinical advice confirms that:

- the morphological descriptions ‘low grade’ and ‘noninvasive’ are not synonymous as a tumour can be both ‘low grade’ and ‘invasive’, ie ‘low grade’ is not equivalent to ‘noninvasive’
- low grade papillary urothelial carcinoma NOS should default to carcinoma in situ unless it is specified as ‘invasive’ wherein it is considered to be malignant.

There is currently no index pathway which specifies **low grade** when papillary urothelial carcinoma is so described, therefore assign:

D09.0 *Carcinoma in situ of bladder*

M8130/2 *Papillary Transitional Cell Carcinoma, non-invasive*

following the index pathway:

Carcinoma

…

- papillary

- - urothelial (M8130/3) — see also *Neoplasm/bladder/malignant*

- - - noninvasive (M8130/2) D09.0

….

- urothelial

- - papillary, noninvasive (M8130/2) D09.0

There is also no index pathway which specifies **low grade invasive** when papillary urothelial carcinoma is so described, therefore assign:

C67.- *Malignant neoplasm of bladder*

M8130/3 *Papillary Transitional Cell Carcinoma*

following the index pathway:

Carcinoma

…

- papillary

- - urothelial (M8130/3) — see also *Neoplasm/bladder/malignant*

Clinical advice also indicates that the description ‘low malignant potential’ is not synonymous with ‘low grade’ and therefore must be specifically documented before assigning the following code:

Carcinoma

…

- papillary

- - urothelial

- - - of low malignant potential (M8130/1) D41.4

Indexing improvements to support this code assignment will be considered for a future edition.

See also ACS 0010 General abstraction guidelines.

Published 15 September 2014,
for implementation 01 October 2014.

Ref No: Q2840 | Published On: 15-Sep-2014 | Status: Retired | Retired On: 30-Jun-2019

Malpresentation, disproportion and abnormality of maternal pelvic organs

Q:

When should codes from O32-O34 versus O64-O66 be assigned?

A:

The codes from O64-O66 are assigned when a condition classifiable to O32-O34 is first diagnosed **during** labour, **OR** requires care and/or intervention **during** labour because it is considered that the condition has affected the labour and/or delivery. This is consistent with the guidelines in ACS 1506 *Fetal presentation, disproportion and abnormality of maternal pelvic organs*, the includes notes at O32-O34 and the relevant index entries.

To summarise the guidelines in ACS 1506:

- Where care or intervention is required due to malpresentation, disproportion or abnormality of the maternal pelvic organs **before** the onset of labour, assign a code from block O32-O34 (that is, known before onset of labour, care or intervention required before onset of labour, eg breech presentation diagnosed before the onset of labour and proceeds to elective caesarean section without labour).
- Where the malpresentation, disproportion or abnormality of maternal pelvic organs requires care and/or intervention **during** labour, assign a code from blocks O64-O66 (that is, known before onset of labour, care or intervention required during labour; this includes failed trial of labour).
- Where the malpresentation, disproportion or abnormality of maternal pelvic organs is first diagnosed **during** labour, assign a code from blocks O64-O66 (that is, not known before onset of labour).

(See also ACS 1506 *Fetal presentation, disproportion and abnormality of maternal pelvic organs.)*

Amendments to ACS 1506 will be considered for a future edition of the Australian Coding Standards.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

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for implementation 01 October 2014.

Ref No: Q2845 | Published On: 15-Sep-2014 | Status: Retired | Retired On: 01-Jul-2017

Sequencing of codes for laceration with nerve and tendon injuries.

Q:

What is the correct sequencing of codes for a laceration involving tendon and nerve injury, but only the tendon and laceration are repaired (ie the nerve injury is noted in theatre but not repaired), should the nerve injury be coded and sequenced first, or is the nerve injury an incidental finding and the tendon injury sequenced first?

A:

For the scenario cited, both the tendon and nerve damage should be coded and sequencing determined by following the guidelines in ACS 1908 *Laceration with nerve and tendon damage:*

In cases of laceration involving nerve and tendon damage, codes should be sequenced as follows:

- laceration with nerve damage – most severe
- laceration with tendon damage – moderately severe
- laceration uncomplicated – least severe

Therefore, assign codes in the sequence below:

Principal diagnosis: Injury to nerve

Additional diagnoses: Injury to tendon

Open wound

External cause codes

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Ref No: Q2877 | Published On: 15-Sep-2014 | Status: Retired | Retired On: 30-Jun-2015

Epiploic appendagitis

Q:

What is the correct code for epiploic appendagitis?

A:

Epiploic appendages, also known as appendices epiploicae or epiploic appendices, are small fat filled sacs, covered by the peritoneum, attached in rows along the colon (Gelrud, 2006). Epiploic appendagitis is a term that describes the swelling and inflammation of epiploic appendages, a condition mainly caused by the torsion of the epiploic appendages or spontaneous thrombosis of its draining veins, both of which compromise the vascular supply to the epiploic appendages. Occasionally epiploic appendagitis can occur secondary to a deep abdominal infection such as diverticulitis, appendicitis or pancolitis.

If it is clear from the documentation that the cause of epiploic appendagitis is torsion or venous thrombosis, assign K55.0 *Acute vascular disorders of intestine*, by following the index pathway:

Torsion

- appendix epiplocae

OR

Thrombosis, thrombotic

- intestine

If there is no cause of epiploic appendagitis documented in the clinical record, and clarification is unable to be obtained from the clinician, assign K65.9 *Peritonitis, unspecified*, by following the index pathway:

Epiploitis (see also Peritonitis) K65.9

If epiploic appendagitis is complicated by abscess formation, assign K65.0 *Acute peritonitis*, by following the index pathway:

Abscess (embolic) (infective) (metastatic) (multiple) (pyogenic) (septic)

- epiploon, epiploic K65.0

Improvements to the Alphabetic Index for epiploic appendagitis will be considered for a future edition.

References:

Gelrud, A., Cárdenas, A. and Chopra, A. (2006). Epiloic appendagitis. Up To Date. Retrieved from: http://mactin.com/zeno/web/zeno-med-file/Epiploic%20appendagitis.pdf
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for implementation 01 October 2014.

Ref No: TN722 | Published On: 15-Sep-2014 | Status: Retired | Retired On: 30-Jun-2015

Poisoning due to helium – external cause codes

Q:

What external cause codes are assigned for accidental poisoning or intentional self-harm due to helium (nonmedicinal) NOS?

A:

The correct external cause codes to assign for poisoning due to helium (nonmedicinal) NOS are:

- Accidental X47.8 *Accidental poisoning by and exposure to other specified gas and vapours*
- Intentional self-harm – X67.8 *Intentional self-poisoning by and exposure to other specified gas or vapours*

NOTE: The codes listed in the Table of Drugs and Chemicals; *Helium (nonmedicinal) NEC/Poisoning/Accidental and Helium (nonmedicinal) NEC/Poisoning/Intentional Self-harm* are invalid three character codes; the fourth character 8 is also required.

Amendments to the ICD-10-AM Table of Drugs and Chemicals will be included in Ninth Edition.

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Ref No: TN715 | Published On: 15-Sep-2014 | Status: Retired | Retired On: 30-Jun-2015

Polyp of the cervix complicating pregnancy

Q:

How do you code polyp of the cervix complicating pregnancy?

A:

Where there is documentation of observation or other obstetric care for polyp of the cervix in pregnancy (before the onset of labour), assign O34.4 *Maternal care for other abnormalities of cervix* by following the index pathway:

Maternal care

- abnormality

- - cervix uteri

- - - affecting

- - - - pregnancy O34.4

DO NOT follow the index pathway *Polyp, polypus/cervix (uteri)/affecting/pregnancy*, as the WRONG code is listed. The ACCD will amend the ICD-10-AM Alphabetic Index for a future edition.

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for implementation 01 October 2014.

Ref No: Q2899 | Published On: 15-Sep-2014 | Status: Retired | Retired On: 30-Jun-2015

Percutaneous repair of mitral valve using MitraClip®

Q:

What is the correct code to assign for percutaneous mitral valve repair with the MitraClip® device?

A:

Percutaneous mitral valve repair with MitraClip® device is a new procedure to treat mitral regurgitation without cardiopulmonary bypass. The MitraClip® is inserted by a catheter through the femoral vein and guided to the left atrium. A transeptal puncture is performed and the device is positioned by grasping both leaflets of the mitral valve. Once the device is properly attached to the leaflets of the mitral valve the catheter is removed.

This is different from percutaneous balloon mitral valvuloplasty which is performed to treat mitral stenosis. In this procedure the balloon tipped catheter is positioned in the opening of the stenosed heart valve and the balloon is inflated repeatedly to widen the valve opening. Once the valve is widened, the balloon tipped catheter is removed.

Currently there is no specific code in ACHI for mitral valve repair with Mitraclip®. However a new code is being considered for a future edition. In the interim, assign 38270-02 **[626]** *Percutaneous balloon mitral valvuloplasty* following the index pathway:

Valvuloplasty

- heart (without valve replacement)

- - mitral valve

- - - percutaneous (balloon) 38270-02 **[626]**

Although different in technique, both are percutaneous procedures performed to repair the mitral valve.

Bibliographies:

Abbott Vascular (2014). MitraClip Percutaneous Mitral Valve Repair System. Retrieved from: http://www.abbottvascular.com/int/mitraclip.html

Adler DH (2014). Mitral valvuloplasty treatment and management. Retrieved from: http://emedicine.medscape.com/article/1533651-treatment#a1133

Jilaihanssi H, Hussaini A & Kar S (2011). MitraClip: a novel percutaneous approach to mitral valve repair. Journal of Zhejiang University Science Aug 2011; 12(8): 633–637.

doi: 10.1631/jzus.B1101009 Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3150716/

Lange R and Benz M (2012), Percutaneous mitral valve repair. Retrieved from: http://emedicine.medscape.com/article/1839696-overview#aw2aab6b2b2

Maisano F, Skantharaja R, Denti P, Giacomini A & Ottavio P (2009). Mitral Annuloplasty. Multimedia manual of cardio-thoracic surgery Vol 2009, (0918) doi: 10.1510/mmcts.2008.003640. Retrieved from http://mmcts.oxfordjournals.org/content/2009/0918/mmcts.2008.003640.full

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for implementation 01 October 2014.

Ref No: Q2831 | Published On: 15-Jun-2014 | Status: Retired | Retired On: 01-Jul-2017

Manual removal of placenta in a single vaginal delivery

Q:

What is the correct delivery code to assign for a single vaginal delivery with manual removal of placenta (ie O80 *Single spontaneous delivery* or O83 *Other assisted single delivery*)?

A:

For classification purposes the O80-O84 range of codes describe the delivery component of an obstetric episode of care, including expulsion of the placenta. O80 *Single spontaneous delivery* is intended to describe those deliveries with minimal or no assistance. O83 *Other assisted single delivery* describes those with more than minimal assistance, including breech extraction, version with extraction etc.

Separation of the placenta is a normal part of the delivery process and common techniques to facilitate delivery of the placenta include controlled cord traction (CCT) or fundal expression after spontaneous or oxytocin induced placental separation. Manual removal of the placenta (MROP) is quite different, being performed for reasons such as:

- Failure of delivery of the placenta more than one hour after delivery of the fetus
- Excessive loss of blood before the placenta has been delivered and the placenta needs to be removed manually to reduce the continuing blood loss
- Retained placental tissue within the uterus soon after the expulsion of the placenta, which may be due to partial or complete morbid adhesion (eg placenta accrete, or placenta percreta), requiring the patient to be transferred from the delivery suite to operating room for MROP

In these situations the correct delivery code to assign is O83 *Other assisted single delivery* as there is more than minimal assistance required.

However O83 *Other assisted single delivery* should not be assigned where portions of placenta remain in the uterus and require evacuation of retained tissue at a later stage, as the initial delivery process required only minimal assistance. This would be considered a later complication of incomplete removal of the placenta and O80 *Single spontaneous delivery* should be assigned.

Improvements to ICD-10-AM will be considered for a future edition to reflect this advice.

References:

Tandberg A., Albrechtsen S. and Iversen O.E. (1999). Manual removal of the placenta, Incidence and clinical significance. Acta Obstetricia et Gynecologica Scandinavica, Vol 78, pages: 33–36.

Foster J.C. (2007). Graduate nurse-midwife curriculum tutorial 2: birth of the placenta. College of nursing, University of Utah. Spencer S. Eccles Health Sciences Library. Available:

http://library.med.utah.edu/nmw/mod2/Tutorial2/manual_removal.html

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for implementation 01 July 2014.

Ref No: Q2842 | Published On: 15-Jun-2014 | Status: Retired | Retired On: 01-Jul-2017

Transfusion Related Acute Lung Injury (TRALI)

Q:

What code do you assign for transfusion related acute lung injury (TRALI)?

A:

Transfusion related acute lung injury (TRALI) is an acute immunological transfusion reaction that occurs either during or within hours of transfusion. The reaction usually manifests as hypoxia and noncardiogenic bilateral pulmonary oedema progressing to respiratory failure. Patients are treated with oxygen, may require mechanical ventilation and usually recover within a few days.

Below is a summary of the steps to follow – as per ACS 1904 *Procedural complications* – when coding transfusion related acute lung injury:

- Refer to the Alphabetic Index under the lead term which best describes the complication, for the subterm *procedural* or *postprocedura*l:

For example - Oedema/lung – no index option for *(post)procedural*

- In some cases, rather than the generic term *(post)procedural*, the subterm may directly describe the procedure involved:

For example - Oedema/lung – no index option for *(due to) transfusion*

- If there is no specific subterm for *(post)procedural* in the Alphabetic Index under the lead term, follow the look up for *Complication(s)*, followed by the relevant body system to which the complication pertains and then *(post)procedural*:

For example - **Complication(s)**/respiratory/postprocedural/specified NEC J95.8

- The lead term **Complication(s)** may also be followed by a subterm directly describing the type or nature of the complication

For example - **Complication(s)**/transfusion/reaction NEC T80.8

The index pathway **Complication(s)**/transfusion/reaction leads to the assignment of T80.8 Other complications following infusion, transfusion and therapeutic injection. This code provides greater specificity regarding the procedure that caused the complication.

- An additional code from Chapters 1 to 19 should be assigned where it provides further specificity

Therefore, where transfusion related acute lung injury (TRALI) is documented, assign:

T80.8 *Other complications following infusion, transfusion and therapeutic injection*

with an additional code for the manifestation (for example, noncardiogenic lung oedema) and appropriate external cause codes, for example:

Y84.8 *Other medical procedures* by following the External Causes index pathway:

Complication (delayed) (medical or surgical procedure) (of or following) Y84.9

- with misadventure (see also Misadventure(s) to patient(s) during surgical or medical care) Y69

…

- transfusion

- - procedure Y84.8

OR

Y69 *Unspecified misadventure during surgical and medical care* (if the complication occurred during the transfusion) by following the External Causes index pathway:

Misadventure(s) to patient(s) during surgical or medical care Y69

…

- transfusion (see also Misadventure(s) to patient(s) during surgical or medical care/by type/transfusion) Y69

And Y92.22 *Health service area*

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS

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Ref No: Q2821 | Published On: 15-Jun-2014 | Status: Retired | Retired On: 01-Jul-2017

Total hip replacement revision wound infection

Q:

What is the correct code to assign for wound infection following a revision of a total hip replacement?

A:

The correct code to assign for superficial (skin and subcutaneous) and deep (soft tissue) surgical wound infections following a revision total hip replacement is T81.4 *Wound infection following a procedure*, *not elsewhere classified,* following the index pathway:

Infection, infected (opportunistic)

- postprocedural wound T81.4

When there is a direct causal relationship between the joint prosthesis and postprocedural infection for example postprocedural pyogenic arthritis of the hip due to the infected joint prosthesis, assign T84.5 *Infection and inflammatory reaction due to internal joint prosthesis,* following the index pathway:

Infection, infected (opportunistic)

- due to or resulting from

- - device, implant or graft *(see also Complications/by site and type)*

- - - joint prosthesis T84.5

This advice is supported by guidelines in ACS 1904 *Procedural complications, Hospital acquired wound infection*.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS

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for implementation 01 July 2014.

Ref No: Q2811 | Published On: 15-Jun-2014 | Status: Retired | Retired On: 01-Jul-2017

Complication of a skin flap

Q:

What code is assigned for complication (eg necrosis) of skin flap?

A:

ICD-10-AM classifies procedural complications according to the type of procedure that was performed and this is supported by the Alphabetic Index and the guidelines for classifying procedural complications in ACS 1904 *Procedural complications*.

A rotation flap is a type of tissue transplant. Therefore, a complication of a skin flap that meets the criteria for coding should be classified to:

T86.88 *Failure and rejection of other transplanted organs and tissues* by following the index pathway:

Complications (from) (of)

…

- organ or tissue transplant, failure or rejection (immune or nonimmune cause) (partial) (total) T86.9

…

- - skin (allograft) (autograft) T86.88

- - specified NEC T86.88

Assign an additional code where it provides further specificity (as per ACS 1904 *Procedural complications*), for example R02 *Gangrene for necrosis*.

Assign Y83.4 *Other reconstructive surgery* by following the External Causes of Injury index pathway:

Complication

…

- transplant, transplantation (heart) (kidney) (liver) (whole organ, any) Y83.0

- - partial organ Y83.4

and Y92.22 *Health service area*

The ACCD will consider amendments to ICD-10-AM Alphabetic Index for a future edition.

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Ref No: Q2846 | Published On: 15-Jun-2014 | Status: Retired | Retired On: 01-Jul-2017

Capsular contracture of breast implant

Q:

How do you code capsular contracture of a breast implant, where there is no documentation of infection or a mechanical complication?

A:

Capsular contracture is a common and unavoidable complication of breast prosthesis implantation. Capsular contracture occurs when the fibrous scar tissue that has formed around a breast implant shrinks and tightens, causing distortion, firmness and pain.

Where there is documentation of capsular contracture of breast implant without further specification of cause, assign T85.88 *Other complications of internal prosthetic device, implant and graft NEC* by following the index pathway:

Complications (from) (of)

…

- breast implant (prosthetic) T85.9

…

- - specified NEC T85.88

Where there is documentation that the complication was due to an infection or mechanical complication, assign a code from T85 *Complications of other internal prosthetic devices, implants and grafts* by following the index pathways:

Complications (from) (of)

…

- breast implant (prosthetic) T85.9
- - infection or inflammation T85.78
- - mechanical T85.4
- - specified NEC T85.88

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for implementation 01 July 2014.

Ref No: Q2860 | Published On: 15-Jun-2014 | Status: Retired | Retired On: 01-Jul-2017

Bronchial thermoplasty

Q:

How do you code bronchial thermoplasty?

A:

Bronchial thermoplasty (BT) is a relatively new procedure performed for the treatment of asthma. BT is performed by the application of radiofrequency or thermal energy directly to the airway via a bronchoscope. The purpose of the procedure is to reduce airway smooth muscle mass at the target areas in the bronchus.

The ACCD is currently reviewing ACHI Chapter 7 *Procedures on Respiratory System*, with particular reference to bronchoscopic and destruction procedures, for a future edition.

In the interim, assign the following codes for bronchial thermoplasty:

90165-00 **[547]** *Other procedures on bronchus*

41898-00 **[543]** *Fibreoptic bronchoscopy*

References:

Castro, M., Musani, A., Mayse, M. and Shargill, N. (2010). Bronchial thermoplasty: a novel technique in the treatment of severe asthma. Therapeutic Advances in Respiratory Disease 2010 4: 101 DOI: 10.1177/1753465810367505

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for implementation 01 July 2014.

Ref No: Q2764 | Published On: 15-Jun-2014 | Status: Retired | Retired On: 30-Jun-2015

Sepsis with organ failure

Q:

If sepsis is documented and the patient is in acute organ failure, can we assume severe sepsis and assign R65.1 *Systemic inflammatory response syndrome [SIRS] of infectious origin with acute organ failure*?

A:

ACS 0110 *Sepsis, severe sepsis and septic shock* contains definitional information relating to the concepts of systemic inflammatory response syndrome (SIRS), infection, sepsis, severe sepsis and septic shock. These definitions are provided for reference and guidance, but should not be used to determine code assignment. The Classification section of ACS 0110 should be referenced for specific advice regarding the coding of these conditions.

A code from R65 *Systemic inflammatory response syndrome (SIRS)* should only be assigned:

- where SIRS is documented
- as an additional code where there is documentation of severe sepsis.

Do not assume severe sepsis when there is documentation of sepsis with organ failure. Coders should check with the treating clinician if unsure of whether to assign codes for sepsis or severe sepsis due to documentation issues.

A review of ACS 0110 will be considered for a future edition.

(Coding Rules, June 2014)

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Ref No: Q2852 | Published On: 15-Jun-2014 | Status: Retired | Retired On: 30-Jun-2015

Coronary artery vasospasm

Q:

How do you code vasospasm of the coronary arteries?

A:

Coronary artery vasospasm (Prinzmetal angina, vasoplastic angina, variant angina) may occur spontaneously or be triggered by hyperventilation or by drug or tobacco use. Coronary artery vasospasm results in occlusion in either a normal or diseased arterial segment and usually occurs at rest rather than as a consequence of physical exertion or emotional stress.

Indexing of this condition is consistent with ICD-10. There is currently no subterm under the lead term Vasospasm for coronary artery. Indexing amendments will be considered for a future edition of ICD-10-AM.

In the interim, where coronary artery vasospasm is documented, assign I20.1 *Angina pectoris with documented spasm* by following the index pathway:

Spasm(s), spastic, spasticity

…

- coronary (artery) I20.1

References:

Nazir, S.A, Nazir, S., Kumar, S., and Ilsley, C. (2010) Multifocal severe coronary artery vasospasm mistaken for diffuse atherosclerosis: a case report. Case reports in medicine. Volume 2010 (2010), Article ID 202156, 4 pages http://dx.doi.org/10.1155/2010/202156

Wang, S. (2012). Coronary Artery Vasospasm. Medscape. Retrieved from http://emedicine.medscape.com/article/153943-overview

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Ref No: Q2857 | Published On: 15-Jun-2014 | Status: Retired | Retired On: 30-Jun-2015

Z06.67 *Resistance to multiple antibiotics*

Q:

Where there is documentation of resistance to two or more specified antibiotics and they are classified to the same Z06 code, should you assign Z06.67?

A:

Amendments were made to Z06 *Resistance to antimicrobial drugs* for ICD-10-AM Eighth Edition following updates to ICD-10.

Z06 contains subcategories (Z06.50 - Z06.58 and Z06.61 - Z06.63) for specific types of antibiotics.

Z06.68 *Resistance to other single specified antibiotic* classifies resistance to other types of antibiotics, including:

- Tetracyclines (eg doxycycline)
- Aminoglycosides (eg gentamicin, tobramycin)
- Macrolides (eg erythromycin)
- Sulfonamides (eg co-trimoxazole)

Z06.68 *Resistance to other single specified antibiotic* is assigned by following the index pathway:

Resistance

- antibiotic(s)

- - specified (single) Z06.68

Note that the term single is a nonessential modifier.

Z06.67 *Resistance to multiple antibiotics* should only be assigned as per the note:

Note: This code should only be assigned when an infectious agent is resistant to two or more antibiotics but the type of antibiotics are not specified. Where multiple resistant antibiotics are specified, code each resistant antibiotic separately.

When there is documentation of resistance to two or more antibiotics that are classified to the same Z06 code, the specific code for the type of antibiotic should be assigned once, not Z06.67. For example, both gentamicin and tobramycin are examples of aminoglycoside antibiotics. Therefore, where resistance to gentamicin and tobramycin is documented, assign Z06.68 *Resistance to other single specified antibiotic*. Z06.67 should NOT be assigned as the type of antibiotic has been specified.

Amendments to ICD-10-AM will be considered for a future edition to clarify the assignment of Z06.67.

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Ref No: Q2755 | Published On: 15-Jun-2014 | Status: Retired | Retired On: 30-Jun-2015

Dissection of coronary artery during angioplasty

Q:

What is the correct code to assign for dissection of the coronary artery during angioplasty?

A:

Coronary artery dissection is a significant complication associated with coronary angioplasty interventions. It may occur during interventional angioplasties such as directional coronary atherectomy or transluminal extraction coronary atherectomy where a guide wire/catheter is wedged into the wall of a blood vessel, resulting in mechanical trauma to the inner layer of the coronary artery; or during the conventional balloon angioplasty where the balloon is intended to inflate and compress the plaque but the dilation force created by the balloon exceeds the elastic threshold of the blood vessel, causing an internal split.

There are certain factors such as an underlying arteriopathy or operative technique that may increase the risk of coronary artery dissection, however the occurrence of coronary artery dissection during angioplasties is directly or indirectly related to use of cardiac and vascular devices (as described above). ACS 1904 *Procedural complications* states:

“Where the complication relates to a prosthetic device, implant or graft, such as a cardiac valve, look up the main term *Complication(s)* and then by the device (if known and listed) or by the subterm of ‘*prosthetic device, implant or graft*”

Therefore, the correct code to assign for coronary artery dissection during coronary angioplasty interventions is T82.8 *Other specified complications of cardiac and vascular prosthetic devices, implants and grafts* by following the index entry:

Complications (from) (of)

- balloon implant or device

- -vascular (counterpulsation)

- - - specified NEC T82.8

OR

Complications (from) (of)

- cardiac (see also Disease/heart)

- - device, implant or graft

- - - specified NEC T82.8

Also assign an additional code to further specify the condition as per the guidelines in ACS 1904 *Procedural complications/ Classification of Procedural Complications:*

“An additional code from Chapters 1 to 19 should be assigned where it provides further specificity.”

For documentation of coronary artery dissection, assign I25.4 *Coronary artery aneurysm*. This code is to be updated to specify I25.4 *Coronary artery aneurysm and dissection* as part of the 2013 WHO

URC updates to be incorporated in the Ninth Edition of ICD-10-AM, and is therefore, the most appropriate code to assign.

As the dissection occurs intraoperatively, assign Y65.8 *Other specified misadventures during surgical and medical care* and Y92.22 *Health service area* also as per the guidelines in ACS 1904 *Procedural complications/ Classification of external causes of procedural complications/ misadventure*.

Additional index entries for coronary artery dissection will be created for a future edition.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

References:

Kern, M.J. (2012). The Interventional Cardiac Catheterization Handbook (3rd ed). (pp.116-118) Elsevier Health Sciences,

Rogers, J. H., & Lasala, J.M. (2004). Coronary artery dissection and perforation complicating percutaneous coronary intervention. The Journal of Invasive Cardiology; 16(9). Retrieved from: http://www.invasivecardiology.com/article/3052

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for implementation 01 July 2014.

Ref No: Q2725 | Published On: 15-Mar-2014 | Status: Retired | Retired On: 01-Jul-2017

Failure to progress in first or second stage of labour

Q:

There has been confusion regarding the clinical meaning of “failure to progress in 1st stage” or “failure to progress in 2nd stage” of labour. How do you code these conditions?

A:

Failure to progress (FTP) is a general term that may indicate protracted/prolonged cervical dilation or fetal descent or complete arrest/cessation of cervical dilation or fetal descent.

FTP in labour may be caused by:

• fetal size/malpresentation

• pelvic size/shape/inadequacy

• abnormal uterine contractility

Failure/to/ progress (in labour) NEC is classified to O62.9 *Abnormality of forces of labour, unspecified* as per the index pathway below:

Failure, failed

- to

- - progress (in labour) NEC O62.9

Note that O62.9 is a ‘not elsewhere classified’ code, so where documentation specifies the cause of the FTP, code the cause instead of O62.9.

The clinical scenarios cited (FTP 1st stage and FTP 2nd stage) do not specify any cause for the FTP. Therefore O62.9 *Abnormality of forces of labour, unspecified* should be assigned in both of these incidences.

Where prolonged labour (stage one or stage two) is documented with failure to progress, also assign an appropriate code from O63 *Long labour*.

(See also Coding Rules: Failed trial of labour and failure to progress)

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for implementation 01 April 2014.

Ref No: Q2672 | Published On: 15-Mar-2014 | Status: Retired | Retired On: 01-Jul-2017

Inappropriate behaviour due to acquired brain injury.

Q:

How do you code the following scenario: patient presents with impulsive, disinhibited and inappropriate behaviour due to a history of acquired brain injury as a result of a motor vehicle accident 10 years ago?

A:

For the scenario cited, refer to the guidelines in ACS 1912 *Sequelae of injuries, poisoning, toxic effects and other external causes:*

The coding of sequelae of injury, poisoning, toxic effects or other external causes requires three codes:

• the residual condition or nature of the sequela (current condition)

• the cause of the sequela (the previous condition)

• the external cause of the injury, poisoning, toxic effect, etc.

The residual condition or nature of the sequela is sequenced first, followed by the cause of the late effect.

The following codes should be assigned for inappropriate behaviour due to an acquired brain injury as the result of a past motor vehicle accident:

F07.8 *Other organic personality and behavioural disorder due to brain disease, damage and dysfunction*

T90.5 *Sequelae of intracranial injury*

Y85.0 *Sequelae of motor-vehicle accident*

with appropriate place of occurrence (Y92.-) code

By following the index pathways:

Disorder
- mental (nonpsychotic) (or behavioural)
- - following organic brain damage
- - - specified NEC F07.8

Sequelae
- injury NEC
- - - brain T90.5

(External cause of injury)

Sequelae
- motor vehicle accident Y85.0

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Ref No: Q2642 | Published On: 15-Mar-2014 | Status: Superseded | Superseded On: 15-Jun-2016 | Superseded By: Q3054

Situational crisis

Q:

How do you code ‘situational crisis’ as this term is not currently indexed in ICD-10-AM?

A:

Situational crisis is a culturally acceptable, normal reaction to a stressful life event, such as the death of a family member or threatened job loss.

If, however, the symptoms are ongoing, beyond normal, acute stress or are more intense, it becomes a problem of adjustment and the ongoing symptoms are now considered to have developed into a disorder. This may be described as a situational crisis, but the main problem is one of adjustment.

Where ‘situational crisis’ is documented, coders should look for documentation within the clinical record or seek clarification from the treating clinician to determine if the patient has a condition classifiable to *Chapter 5 Mental and behavioural disorders* (F00-F99) for example, an acute stress reaction or an adjustment disorder. If documentation or clinical advice clarifies that the patient has a mental or behavioural disorder, assign an appropriate code from F00-F99.

When clinical advice is unavailable, assign R45.89 *Other symptoms and signs involving emotional state*.

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

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Ref No: Q2796 | Published On: 15-Mar-2014 | Status: Retired | Retired On: 30-Jun-2015

Endobronchial valve

Q:

What is the correct code to assign for insertion or removal of endobronchial valve(s)?

A:

Endobronchial valve placement is a new, minimally invasive technique that is currently being investigated as a treatment option for a number of lung conditions. One of the most common uses is to treat emphysema where the alveoli (air sacs) in the lungs lose their elasticity leading to hyperextension of the lung.

The procedure involves placing an endobronchial valve(s) to the target location of the bronchial tree through either a fibreoptic or rigid bronchoscope. Single or multiple valves may be inserted during the procedure.

The valve inserted is a one way valve which prevents air from flowing into the over-inflated region of the lung during inspiration but allows air and secretions to exit during expiration. Over time, the reduction in airflow to the diseased portions of the lung may improve the elastic recoil which in turn improves lung function.

Currently ACHI does not provide a specific code for insertion or removal of endobronchial valve(s).

Classification of bronchoscopic interventions are currently under review.

For insertion of endobronchial valve(s), assign:

90165-00 **[547]** *Other procedure on bronchus*.

An additional code for bronchoscopy should also be assigned as per ACS 0023 *Laparoscopic/arthroscopic/endoscopic surgery*.

For removal of endobronchial valve(s), assign:

41898-03 **[544]** *Fibreoptic bronchoscopy with removal of foreign body*

OR

41895-00 **[544]** *Rigid bronchoscopy with removal of foreign body*

References:

NICE (National Institute for Health and Clinical Excellence) Interventional Procedure overview (2009). Bronchoscopic lung volume reduction with airway

valves for advanced emphysema. Retrieved from http://www.nice.org.uk/nicemedia/pdf/IP%20770%20Bronchoscopic%20lung%20volume%20reduction%

20for%20advanced%20emphysema%20post%20IPAC%20141209%20for%20web.pdf Q2796_Final_Endobronchial valve.doc Page 5 13/03/2014

Olympic Respiratory Amercia (2012). Wish there was something different you could do to control postoperative air leaks? Retrieved from: http://www.spiration.com/downloads/Airleaks/US/Approved%20Site%20Flyer.pdf

Shah, P.L. & Herth F.J. (2013). Current status of bronchoscopic lung volume reduction with endobronchial valves. Thorax. doi:10.1136/thoraxjnl-2013-203743

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Ref No: Q2816 | Published On: 15-Mar-2014 | Status: Retired | Retired On: 30-Jun-2015

Faecal microbiota transplantation (FMT)

Q:

What is the correct procedure code to assign for faecal microbiota transplantation?

A:

Faecal microbiota transplantation (FMT), also known as faecal bacteriotherapy, faecal transplant, intestinal microbiota transplantation (IMT) or human probiotic infusion, is an alternative treatment for patients who have failed standard treatment for *Clostridium difficile* infections (CDI).

The procedure involves collecting a stool sample from a healthy donor, processing it into a liquid suspension and instilling it into the gastrointestinal tract via various routes including nasogastric or nasoenteric tube, gastroduodenoscopy, flexible sigmoidoscopy, colonoscopy or enema. Instillation by colonoscopy to caecum is the preferred method for the vast majority of FMTs based on the results of published studies.

The correct code to assign for FMT is:

92075-00 **[1895]** *Gastrointestinal tract instillation, except gastric gavage*

An additional code should also be assigned where the microbiota installation is delivered via an endoscope as per

ACS 0023 *Laparoscopic/arthroscopic/endoscopic surgery.* For example:

32090-00 **[905]** *Fibreoptic colonoscopy to caecum*

The classification of FMT will be reviewed for a future edition of ACHI.

Bibliography:

Brandt, L.J. & Aroniadis, O.C. (2013). An overview of fecal microbiota transplantation: techniques, indications, and outcomes.

Gastrointestinal Endoscopy, 78 (2), pages 240-249. Doi:10.1016/j.gie.2013.03.1329

Gough, E., Shaikh, H. and Manges, A.R. (2001). Systematic Review of Intestinal Microbiota Transplantation (Fecal Bacteriotherapy) for Recurrent Clostridium difficile Infection. Clinic Infection Diseases, 53 (10), pages 994-1002. Doi:10.1093/cid/cir632

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Ref No: Q2834 | Published On: 15-Mar-2014 | Status: Retired | Retired On: 30-Jun-2015

Occlusion of coronary artery bypass grafts

Q:

A patient with a history of coronary artery bypass grafts (CABGs) is electively admitted for a coronary angiogram to investigate the cause of their chest pain. The coronary angiogram report reveals occlusion of the existing bypass grafts and there is no plan for reoperation.

What is the correct code to assign for occlusion of coronary bypass grafts?

A:

Occlusion of coronary bypass grafts may occur as a result of natural disease progression leading to atheroma formation in the implanted arteries or veins. It may also be caused by acute graft failure mainly attributable to acute graft thrombosis, graft kinking/overstretching, postoperative graft spasm or anastomotic stenosis. Therefore, code assignment should be guided by the documentation in the clinical record.

If it is clear from the documentation that occlusion of a coronary bypass graft is due to atherosclerosis, assign:

I25.12 *Atherosclerotic heart disease of autologous bypass graft*

or

I25.13 *Atherosclerotic heart disease of nonautologous bypass graft.*

If the documentation specifies that the occluded coronary bypass graft is caused by a complication of the graft assign:

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

Additional codes such as I24.0 *Coronary thrombosis not resulting in myocardial infarction* should also be assigned to provide further specification of the condition, as per ACS 1904 *Procedural complications*.

T82.8 should only be assigned when there is a documented link between an occluded graft and the initial surgery, as per ACS 1904 *Procedural complications/readmission* for treatment of procedural/postprocedural complications:

- If documentation does not state that the condition arose as a complication of the initial surgery, only the condition is coded
- Where documentation clearly states that the condition arose as a complication of the initial surgery the condition should be coded as a procedural/post procedural complication

If occlusion of a coronary bypass graft is documented without further specification, clarification should be sought from the clinician.

Where this is not possible, assign:

I25.12 *Atherosclerotic heart disease of autologous bypass graft*

or

I25.13 *Atherosclerotic heart disease of nonautologous bypass graft.*

This is consistent with the advice in ACS 0941 *Arterial disease* that occlusion is usually due to atherosclerosis.

Likewise embolism of CABG from the rupture of intimal plaque may occur spontaneously in acute coronary syndrome or iatrogenically during percutaneous coronary interventions.

Therefore, code assignment for embolism of CABG should be guided by the following from ACS 0940 *Ischaemic heart disease*:

“Embolism or occlusion of a bypass graft is classified to T82.8 *Other specified complications of cardiac and vascular prosthetic devices, implants and grafts*.”

AND ACS 0941 *Arterial disease/Embolism*:

“If embolism of a coronary artery is documented (and the patient has not progressed to myocardial infarction), assign I24.0 *Coronary thrombosis not resulting in myocardial infarction*.

In the latter case where the patient progresses to myocardial infarction, assign an appropriate code from category I21 *Acute myocardial infarction*.

The presence of atherosclerosis (for example in atheroembolism) where documented should also be indicated by an additional diagnosis code from category I25.1- *Atherosclerotic heart disease*.”

Q:

Would the code assignment differ if reoperation was planned for the occluded CABGs?

A:

Occlusion of CABGs can be treated medically or surgically depending on clinical and angiographic characteristics. Code selection for this condition is not altered by the choice or priority of treatment option.

Q:

According to ACS 0909 Coronary artery bypass graft and ACS 0940 Ischaemic heart disease, a diseased graft is classified to I25.12 Atherosclerotic heart disease of autologous bypass graft or I25.13 Atherosclerotic heart disease of nonautologous bypass graft and an occluded graft is classified to T82.8 Other specified complications of cardiac and vascular prosthetic devices, implants and grafts.

Is there difference between a diseased graft and an occluded graft?

A:

The terms diseased graft and occluded graft are interchangeable. As stated above, code assignment for each case is based on the clinical documentation. If the cause of bypass graft occlusion cannot be established based on the available documentation, clarification should be sought from the clinician. Where this is not possible, assign:

I25.12 *Atherosclerotic heart disease of autologous bypass graft*

or

I25.13 *Atherosclerotic heart disease of nonautologous bypass graft.*

Consideration will be given to reviewing the ACS with respect to coronary bypass graft occlusion in a future edition.

References:

Baim, D.S., Wahr, D., George B, Leon, M.B., Greenberg, J., Cutlip, D.E., Kaya, U., Popma, J.J., Ho, K., Kuntz, R.E. (2002). Randomized trial of a distal embolic protection device during percutaneous intervention of saphenous vein aorto-coronary bypass grafts. Circulation, 105:1285–1290. Available: http://www.invasivecardiology.com/article/2512

Beijk, M.A. and Harskamp, R.E. (2013). Treatment of Coronary Artery Bypass Graft Failure, Artery Bypass, Dr Wilbert S. Aronow (Ed.). DOI: 10.5772/54928.

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Ref No: Q2773 | Published On: 15-Mar-2014 | Status: Retired | Retired On: 30-Jun-2015

Hypertension due to acute kidney failure

Q:

Coding Q&A December 2011 Hypertension due to acute kidney disease advised that: ”Hypertension can arise due to acute kidney disease, therefore I15.0 *Renovascular hypertension* and I15.1 *Hypertension secondary to other kidney disorders* can be assigned as per the guidelines in ACS 0925 *Hypertension and related conditions*”

Could you clarify whether the reference to ‘acute kidney disease’ in the Q&A above also includes acute kidney failure?

A:

Unlike chronic kidney disease (CKD) which has a well-established definition, acute kidney disease is a general term with no exact definition being described in the literature, although it has occasionally been used in reference to acute kidney failure, the term which is now widely called acute kidney injury.

The term acute kidney disease in the Q&A cited is used broadly to mean all acute kidney diseases and disorders which have been specified as the cause of hypertension including acute kidney failure and other acute kidney diseases such as acute glomerulonephritis and acute interstitial nephritis.

Assign codes from category N17 *Acute kidney failure* and I15 *Secondary hypertension* when hypertension is documented as being ‘due to’ or ‘secondary to’ acute kidney failure’ following the guidelines in ACS 0925 *Hypertension and related conditions/Secondary hypertension*.

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Examination and observation following fall from pedestrian conveyance

Q:

Fall from a pedestrian conveyance appears to satisfy the definition for a transport accident, so should Z04.1 *Examination and observation following transport accident* be assigned for examination and observation following fall from a pedestrian conveyance?

A:

Examination and observation following fall from a pedestrian conveyance is classified to Z04.3 *Examination and observation following other accident*, as fall from pedestrian conveyance (not in collision with pedestrian) is classified to W02 *Fall involving ice-skates, skis, roller-skates, skateboards, scooters and other pedestrian conveyances* – which does not fall within the range for a transport accident (V00-V99).

Amendments will be considered for a future edition of ICD-10-AM to clarify code selection.

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for implementation 01 April 2014.

Ref No: Q2797 | Published On: 15-Mar-2014 | Status: Retired | Retired On: 30-Jun-2015

Purple Toe Syndrome

Q:

How do you code purple toe syndrome?

A:

Purple toe syndrome occurs rarely as an adverse effect of warfarin. The patient develops bilateral purple discolouration of the feet usually within a short time of commencing warfarin therapy due to the release of atheromatous plaque emboli and cholesterol microemboli that have lodged in the vessels of the peripheries. Purple toe syndrome is synonymous with blue toe syndrome and cholesterol embolism syndrome.

Where purple toe syndrome is documented as an adverse effect of warfarin, assign a code from I70.2 *Atherosclerosis of arteries of extremities*, by following the index pathways:

Atheroembolis – *see Arteriosclerosis*

OR

Blue

- toe syndrome – see Arteriosclerosis

Arteriosclerosis

- extremities I70.20
- - with
- - - gangrene I70.24
- - - intermittent claudication I70.21
- - - rest pain I70.22
- - - ulceration I70.23

Assign additional codes:

Y44.2 *Anticoagulants causing adverse effects in therapeutic use*

Y92.22 *Health service area*

Amendments to ICD-10-AM Alphabetic Index will be considered for a future edition.

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for implementation 01 April 2014.

Ref No: Q2774 | Published On: 15-Mar-2014 | Status: Retired | Retired On: 30-Jun-2015

Raynaud’s gangrene

Q:

How do you code Raynaud’s syndrome with gangrene?

A:

There is currently an inconsistency with the indexing of I73.0 *Raynaud’s syndrome* and the guidelines in the *Conventions used in the Tabular List of Diseases* example 15 regarding gangrene in Raynaud’s syndrome. The guidelines in the *Conventions* should be followed and two codes assigned for this condition.

That is, where Raynaud’s syndrome with gangrene/Raynaud’s gangrene is documented assign:

I73.0 *Raynaud’s syndrome*

R02 *Gangrene, not elsewhere classified*

Amendments will be considered for a future edition to clarify the classification of Raynaud’s syndrome with and without gangrene.

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for implementation 01 April 2014.

Ref No: Q2819 | Published On: 15-Mar-2014 | Status: Retired | Retired On: 30-Jun-2015

Thrombin injection into false aneurysm

Q:

What is the correct code for percutaneous thrombin injection into false aneurysm?

A:

A false aneurysm (also known as a pseudoaneurysm), is leakage of arterial blood when there is a breach in the vessel wall but is contained by the adventitia or surrounding perivascular soft tissue. False aneurysms may occur after arterial puncture for a diagnostic cardiac catheterisation, an arteriogram or after an arterial intervention.

One treatment option for false aneurysms is a minimally-invasive procedure performed under local anaesthesia whereby a needle is placed percutaneously into the false aneurysm under ultrasound guidance with injection of thrombin, an enzyme that promotes rapid clot formation and thus obliterating the false aneurysm cavity when injected.

The most appropriate code for thrombin injection into false aneurysm is

45027-01 **[742]** *Administration of agent into vascular anomaly* following the

index pathway:

Injection

- vascular

- - anomaly 45027-01 **[742]**

- - malformation 45027-01 **[742]**

Improvements will be considered for this procedure for a future edition of ACHI.

References:

Weerakkody Y, D'Souza D, et al (no date). False aneurysm. Retrieved from: http://radiopaedia.org/articles/false_aneurysm

Webber G, Jang J, Gustavson S and Olin J (2007). Contemporary Management of Postcatheterization Pseudoaneurysms. Retrieved from:

http://circ.ahajournals.org/content/115/20/2666.full

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Ref No: Q2762 | Published On: 15-Mar-2014 | Status: Retired | Retired On: 30-Jun-2015

Endovenous thermal ablation of varicose veins

Q:

What is the correct procedure code to assign for endovenous radiofrequency ablation (RFA) or endovenous laser therapy (EVLT) for the treatment of varicose veins?

A:

Endovenous thermal ablation is a new, minimally invasive endovenous technique for the treatment of varicose veins.

There are two types of endovenous thermal ablation that are in use: Endovenous radiofrequency ablation (RFA) and endovenous laser therapy (EVLT). In contrast to the traditional ligation or stripping, RFA is designed to ablate the incompetent veins through a percutaneously inserted catheter using imaging guidance. Through the catheter tip, radiofrequency energy or laser energy is delivered to the wall of an incompetent vein, resulting in irreversible occlusion of the vein.

Currently ACHI does not provide a specific code for EVLT or RFA for the treatment of varicose veins.

Therefore assign an appropriate site code from block **[727]** *Interruption of sapheno-femoral or sapheno-popliteal junction varicose veins* to classify endovenous thermal ablation of varicose veins. An additional code will be created for this procedure for Ninth Edition.

Bibliographies:

Medical Services Advisory Committee (MSAC) public summary document (2012): Application No. 1166 - Radiofrequency ablation for the treatment of varicose veins due to chronic venous insufficiency. Retrieved from: http://www.msac.gov.au/internet/msac/publishing.nsf/Content/app1166-1

Weiss, M., Weiss, R., Feied, CF., Elston, DM., Crawford, GH., Albertini, JG., Butler,DF., Ratner, D.(2012). Radiofrequency Ablation Therapy for Varicose Veins. Retrieved from: http://emedicine.medscape.com/article/1085800-overview#a15

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Ref No: Q2805 | Published On: 15-Mar-2014 | Status: Retired | Retired On: 30-Jun-2015

Primary osteoarthritis

Q:

How do you classify osteoarthritis NOS?

A:

To classify osteoarthritis NOS clinical coders should be guided by the instructional note in

ICD-10-AM *Tabular List* at M15-M19:

ARTHROSIS

(M15–M19)

Note: In this block the term osteoarthritis is used as a synonym for arthrosis or osteoarthrosis.

The term primary has been used with its customary clinical meaning of no underlying or determining condition identified.

Excludes: osteoarthritis of spine (M47.-)

The note is consistent with the guidelines in ACS1343 *Erosion of knee*.

Therefore, Osteoarthritis/arthrosis/osteoarthrosis NOS is classified as primary osteoarthritis, meaning that no underlying condition has been identified.

Where osteoarthritis of the knee is documented without further specification, follow the index pathway for Osteoarthritis/knee/primary:

Osteoarthritis

- knee

- - primary (unilateral) M17.1 *Other primary gonarthrosis*

- - - bilateral M17.0 *Primary gonarthrosis, bilateral*

Consideration to amending the ICD-10-AM Alphabetic Index to clarify the classification of osteoarthritis will be made for a future edition.

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for implementation 01 April 2014.

Ref No: Q2711 | Published On: 15-Mar-2014 | Status: Retired | Retired On: 30-Jun-2015

Stapled Transanal Rectal Resection (STARR)

Q:

What code should be assigned for stapled transanal rectal resection (STARR)?

A:

STARR (stapled transanal rectal resection) is performed for the treatment of rectal prolapse and/or rectocele in patients with obstructive defaecation syndrome.

The procedure involves anterior and posterior full-thickness resection of the rectal wall resulting in a circumferential transanal resection of the rectum.

Clinical advice supports the assignment of 32111-00 **[933]** *Excision of rectal mucosa for rectal prolapse*.

Indexing improvements will be considered for this procedure in a future edition of ACHI.

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Ref No: Q2843 | Published On: 15-Mar-2014 | Status: Retired | Retired On: 30-Jun-2015

ACS 1615 *Specific interventions for the sick neonate* – Catheterisation and infusions

Q:

Should 13300-00 **[738]** *Catheterisation/cannulation of other vein in neonate* be allocated three times because three different sites were used for cannulation?

A:

The procedure code 13300-00 **[738]** *Catheterisation/cannulation of other vein in neonate* has been removed from ACS 1615 (see below) as per errata 2, December 2013, and as such should not be coded.

Catheterisation in a neonate

13300-01 **[738]** *Scalp vein catheterisation/cannulation in neonate*

13300-02 **[738]** *Umbilical vein catheterisation/cannulation in neonate*

13319-00 **[738]** *Central vein catheterisation in neonate*

13303-00 **[694]** *Umbilical artery catheterisation/cannulation in neonate*

Note: When multiple catheterisations are performed during an episode of care and the same procedure code applies, assign the procedure code once only

Q:

As ACS 1615 *Specific interventions for the sick neonate* now requires both the catheterisation/cannulation and the infusion to be coded in neonates, why do the words “Includes: infusion” appear at these codes within blocks 738 and 694 to indicate that the infusion of the substance is not required?

A:

Infusion should be coded (when the criteria are met) in addition to catheterisation in a neonate only for the specific infusions listed in ACS 1615 and ACS 0302 *Blood transfusions*. That is:

- Parenteral fluid therapy
- Parenteral antibiotics/anti-infectives
- Blood products.

Consideration will be given to removing the includes note in a future edition.

Q:

If catheterisation/cannulation codes are now required for neonates why is there not a "*Code also when performed*" note in block 1920 to alert coders to also code the catheterisation/cannulation for neonates?

A:

Block **[1920]** *Administration of pharmacotherapy* has a reference to ACS 1615 *Specific interventions for the sick neonate*, indicating the guidelines in this standard should be followed to clarify which catheterisation/cannulation should be coded for neonates. There is no need to add a note to the Tabular List.

Q:

Aren't catheters the "route" of administration for infusions and therefore not to be coded?

A:

Catheterisations are the route of administration for infusions and would not normally be coded, however, catheterisations in a neonate must be coded as per the criteria in ACS 1615. This is a specialty standard and the guidelines regarding the assignment of codes for catheterisations are included in this standard as they are clinically significant procedures when performed on neonates. This advice is reinforced in ACS 0042 *Procedures normally not coded, point 5* which exempts catheterisation in neonates.

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Ref No: Q2761 | Published On: 15-Dec-2013 | Status: Retired | Retired On: 30-Jun-2019

Pancytopenia

Q:

Where there is documentation of pancytopenia and one or two of the blood abnormalities in the clinical record, is a code assigned for each of the specific blood abnormalities as well as the pancytopenia code? Do each of the blood abnormalities have to meet the criteria in ACS 0002 *Additional Diagnoses*?

A:

ACS 0304 *Pancytopenia/Definition* states:

Pancytopenia is a general term for the simultaneous decrease in haemoglobin level (anaemia), white cell count (leukocytopenia/neutropenia/leukopenia) and platelet count (thrombocytopenia).

Attempt to obtain clarification from the clinician of the specific blood abnormalities (anaemia, neutropenia and thrombocytopenia) and assign codes for these conditions rather than assigning the default for pancytopenia.

Assign codes for each of the specific blood abnormalities only if they meet the criteria of additional diagnosis in ACS 0002 *Additional Diagnoses*.

Do not assign an additional code for ‘pancytopenia’ (D61.9 *Aplastic anaemia, unspecified*).

Amendments to ACS 0304 *Pancytopenia* will be considered for a future edition.

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for implementation 01 January 2014.

Ref No: Q2810 | Published On: 15-Dec-2013 | Status: Retired | Retired On: 01-Jul-2017

Balloon catheter induction of labour

Q:

What is the correct code assignment for balloon catheter induction of labour without documentation of surgical induction?

A:

The Alphabetic Index of Interventions requires you to determine whether an induction is medical or surgical before you select the specific type of induction. Medical induction of labour is a pharmacological method, commonly using drugs such as Syntocinon, Prostin or Cervagem. Surgical induction of labour uses

non-pharmacological methods, such as artificial rupture of membranes and insertion of balloon catheters.

Balloon catheters are used to apply local pressure to dilate the cervix and overstretch the lower uterine segment, indirectly stimulating the secretion of prostaglandins. This is commonly done using a Foley catheter; however variations such as a double balloon catheter are also in use.

The correct code for balloon catheter induction of labour, without medical induction, is 90465-04 **[1334]** *Other surgical induction of labour*, following the index pathway:

Induction

- labour

- - surgical 90465-03 **[1334]**

- - - by

- - - - cervical dilation 90465-04 **[1334]**

Bibliography:

Eke, A., & Okigbo C. (2012). Mechanical methods for induction of labour: RHL commentary. Retrieved from the WHO Reproductive Health Library website: http://apps.who.int/rhl/pregnancy_childbirth/induction/cd001233_ekea_com/en/index.html

Pennell, C., Henderson, J., O'Neill, M., McCleery, S., Doherty, D.& Dickinson, J. (2009). Induction of labour in nulliparous women with an unfavourable cervix: a randomised controlled trial comparing double and single balloon catheters and PGE2 gel. BJOG: An International Journal of Obstetrics & Gynaecology, 116, 1443–1452. doi: 10.1111/j.1471-0528.2009.02279.x

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Ref No: Q2832 | Published On: 15-Dec-2013 | Status: Retired | Retired On: 01-Jul-2017

Haemolung (Respiratory Assist System)

Q:

Our hospital has been approved to perform a procedure not yet used in Australia called Haemolung. How should we code this procedure?

A:

Haemolung (respiratory assist system) is the brand name of a respiratory dialysis device that provides extracorporeal gas exchange to a patient's blood. It is similar to extracorporeal membrane oxygenation, but this device removes carbon dioxide as well as adding oxygen to the blood.

Blood is diverted from either the femoral or jugular veins via a double lumen venous catheter. Deoxygenated blood drains from the body into the device. Carbon dioxide is removed and the blood is oxygenated across a membrane containing heparin to prevent thrombus formation. The oxygenated blood returns to the body via a centrifugal pump.

Use of the device is still being trialled.

NCCH advises that Haemolung (respiratory assist system)/respiratory dialysis should be classified to 90225-00 **[642]** *Extracorporeal membrane oxygenation [ECMO]* given its similarity to this procedure.

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for implementation 01 January 2014.

Ref No: Q2824 | Published On: 15-Dec-2013 | Status: Retired | Retired On: 30-Jun-2015

Selective Internal Radiation Therapy (SIRT) into the liver

Q:

What is the correct procedure code to assign for Selective Internal Radiation Therapy (SIRT) into the liver?

A:

Selective internal radiation therapy (SIRT), also known as radio-embolisation, is a type of microbrachytherapy used to treat unresectable liver cancer. The procedure is typically perfomed in two stages. At the initial work up stage, radiographic imaging and prophylactic occlusion of gastric, gastro-duodenal or pancreatic arteries by selective coil are performed to prevent severe radiation damage to the foregut structures such as stomach, duodenum and pancreas.

The second stage (treatment stage) involves infusing millions of radioactive beads (Yttrium 90 resin microspheres) directly into the arterial blood supply of the liver through either a surgically implanted port or a percutaneous transfemoral hepatic artery catheter. These microspheres embolise the arterioles around the malignancy and also emit radiation to destroy the cancerous cells.

For the initial workup stage, the correct procedure code to assign is:

35321-05 **[768]** *Transcatheter embolisation of blood vessels, abdomen*

For the treatment stage, the correct codes to assign are:

35321-05 **[768]** *Transcatheter embolisation of blood vessels, abdomen*

and

15360-00 **[1792]** *Brachytherapy, intravascular*

Consideration will be given to improving the index for intravascular brachytherapy for a future edition of ACHI.

Bibliography:

National Institute for Health and Care Excellence (2013). Selective internal radiation therapy for primary liver cancer. Retrieved from: http://guidance.nice.org.uk/IPG460/DraftGuidance

SIRTeX (n.d.). About SIRT. Retrieved from: http://www.sirtex.com/au/clinicians/about-sirt/

Stubbs, R.S., Wickremesekera, S.K.(2004). Selective internal radiation therapy (SIRT): a new modality for treating patients with colorectal liver metastases. HPB (Oxford), 6(3), Pages133–139. doi: 10.1080/13651820410025084

Welsh, J., Kennedy, A., Thomadsen, B. (2006). Selective internal radiation therapy (SIRT) for liver metastases secondary to colorectal adenocarcinoma. International Journal of Radiation Oncology*Biology*Physics, 66(2), Supplement, Pages S62–S73. Doi: 10.1016/j.ijrobp.2005.09.011

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Ref No: Q2775 | Published On: 15-Dec-2013 | Status: Retired | Retired On: 30-Jun-2015

Renal sclerosis and nephrosclerosis

Q:

What is the difference between nephrosclerosis and renal sclerosis?

The index assigns nephrosclerosis to I12.9 *Hypertensive kidney disease without kidney failure*. Does a causal relationship between nephrosclerosis and hypertension need to be documented in order to assign I12.-?

A:

Clinical advice indicates that nephrosclerosis is not synonymous with renal sclerosis and they should be classified separately in ICD-10-AM.

Renal sclerosis is a rarely used term, referring to scarring or shrinkage of the whole kidney or where scars are at least visible in parts of the kidney macroscopically.

Nephrosclerosis by contrast is a term commonly used to describe the scarring changes in the glomeruli (tiny blood vessels in the kidney) and interstitium of the kidney, as seen under a microscope.

ICD-10 defaults the classification of nephrosclerosis to I12.9 *Hypertensive kidney disease without kidney failure*. Clinical advice indicated that while not all cases of nephrosclerosis are caused by hypertension, the condition fits best within I12.- as in nephrosclerosis both hypertension and chronic kidney disease are usually present with no other recognisable cause. Therefore, for nephrosclerosis assign I12.0 *Hypertensive kidney disease with kidney failure* or I12.9 *Hypertensive kidney disease without kidney failure*, as appropriate.

ICD-10-AM classifies renal sclerosis to N26 *Unspecified contracted kidney* but there is a note at N26 which excludes *"contracted kidney due to hypertension(112.-)."*

A code from I12.- should only be assigned if renal sclerosis is clearly documented as being due to hypertension.

Indexing improvements for nephrosclerosis will be considered for a future edition of ICD-10-AM.

Bibliography:

Rule., A.D., Cornell., L.D., Poggio., E.D.(2011). Senile Nephrosclerosis – Does it explain the decline in glomerular filtration rate with aging? Nephron Physiol, 119 (suppl 1), pages 6-11. Doi.org/10.1159/000328012

Marín., R., Gorostidi., M., Ojea. B.D. (2010). Nephrosclerosis. The Cinderella of chronic kidney disease. Nefrologia, 30(3), pages 275-279. Doi. 10.3265/Nefrologia.pre2010.Apr.10329

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Ref No: Q2833 | Published On: 15-Dec-2013 | Status: Retired | Retired On: 30-Jun-2015

Insertion of fiducial markers into the gastro-oesophageal junction

Q:

What is the correct procedure code to assign for insertion of fiducial markers into the gastro-oesophageal junction?

A:

Fiducial markers are inserted into target lesions or soft tissue as landmarks for precise delivery of radiation therapy. Traditionally, fiducial markers have been implanted into the prostate, lungs and spine via a percutaneous or surgical approach under image guidance. Recent advances have led to fiducial markers being placed into target lesions in deep structures that are not accessible by a percutaneous approach, such as the gastrointestinal tract, mediastinum and abdomen, using endoscopic ultrasound (EUS) guidance.

ACHI currently only has specific codes for insertion of fiducial markers into the prostate. Classification of fiducial markers for other sites will be reviewed for a future edition of ACHI.

In the interim, insertion of fiducial markers in any location other than the prostate or lung should be assigned to an appropriate site code for 'other procedures.' Additional code(s) should also be assigned where EUS or laparoscopy is performed in conjunction with fiducial marker placement.

For insertion of fiducial markers into the gastro-oesophageal junction, assign:

90305-00 **[890]** *Other procedures on stomach* and

30688-00 **[1949]** *Endoscopic ultrasound*

For insertion of fiducial markers into the prostate, assign:

37217-00 **[1160]** *Implantation of fiducial marker, prostate*

For insertion of fiducial markers into the lung, assign:

38812-00 **[550]** *Percutaneous needle biopsy of lung*

See also Coding Q&A, June 2013, Insertion of fiducial markers into the lung percutaneously.

References:

DiMaio, C., Nagula, S., Karyn A. Goodman, K., Alice Y. Ho, A., Markowitz, A., Schattner, M., Gerdes,H. (2010). EUS-guided fiducial placement for image-guided radiation therapy in GI malignancies by using a 22-gauge needle. Gastrointestinal Endoscopy, 71(7), 1204–1210. doi:10.1016/j.gie.2010.01.003

Pishvaian, A.C., Collins,B., Gagnon,G., Ahlawat, S.,Haddad, N.G. (2006). EUS-guided fiducial placement for CyberKnife radiotherapy of mediastinal and abdominal malignancies. Gastrointestinal Endoscopy, 64, 412–417. doi:10.1016/j.gie.2006.01.048

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for implementation 01 January 2014.

Ref No: Q2787 | Published On: 15-Dec-2013 | Status: Retired | Retired On: 30-Jun-2015

Microfracture of the ankle

Q:

What is the appropriate code for microfracture of the ankle?

A:

Microfracture involves penetration of bone at the base of a cartilage defect. This causes formation of a “superclot” in the base of the lesion. The theory behind this treatment is that the superclot contains factors and cells which allow cartilage regeneration. The area of cartilage damage is debrided and an “awl” (or arthroscopic pick) is used to produce hole(s) in the bone at the base of the defect (see Coding Matters, Volume 11, Number 4).

The appropriate code to assign for microfracture of the ankle is 49703-05 **[1544]** *Arthroscopic chondroplasty of ankle* by following the index pathway:

Chondroplasty

- ankle 90599-00 **[1544]**

- - arthroscopic 49703-05 **[1544]**

The NCCH will consider index entries for microfracture for a future edition of ACHI.

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Ref No: Q2807 | Published On: 15-Dec-2013 | Status: Retired | Retired On: 30-Jun-2015

Impaired Mobility

Q:

How do you code impaired mobility when there is no underlying cause documented?

A:

The NCCH advises that impaired/reduced mobility should be classified to R26.8 *Other and unspecified abnormalities of gait and mobility*.

Z74.0 *Need for assistance due to reduced mobility* is not a viable option for classifying impaired/reduced mobility. Codes from Chapter 21 *Factors influencing health status and contact with health services* (Z00–Z99) are assigned when there is not an appropriate disease code available in Chapters 1-20 as per the note at the beginning of Chapter 21:

Note: Categories Z00–Z99 are provided for occasions when circumstances other than a disease, injury or external cause classifiable to categories A00–Y89 are recorded as 'diagnoses' or 'problems'.

The indexing of R26.8, based on ICD-10, is not optimal and NCCH will consider amendments for a future edition of ICD-10-AM.

(see also ACS 1802 *Signs and Symptoms*)

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T-incision (or J-incision) caesarean section

Q:

How do you code a T-incision (or J-incision) caesarean section?

A:

An inverted T-incision (or J-incision) caesarean section is a rarely performed type of caesarean section. These types of incisions incorporate both a horizontal and vertical incision and are associated with increased risk and complications, similar to those that occur with a classical caesarean section.

Where T-incision (or J-incision) caesarean section is documented, assign an appropriate code for classical caesarean section:

16520-00 **[1340]** *Elective classical caesarean section*

16520-01 **[1340]** *Emergency classical caesarean section*

The NCCH will consider amendments to the Alphabetic Index for a future edition.

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Ref No: Q2705 | Published On: 15-Dec-2013 | Status: Retired | Retired On: 30-Jun-2015

Acquired Oesophageal Dysmotility

Q:

How do you code oesophageal dysmotility that is acquired?

A:

ICD-10-AM has the following index entry for dysmotility of the oesophagus:

Dysmotility, oesophagus, congenital Q39.82

There is currently no index entry for acquired oesophageal dysmotility.

Oesophageal dysmotility is synonymous with oesophageal dyskinesia classifiable to K22.4 *Dyskinesia of oesophagus*.

Therefore, acquired dysmotility of the oesophagus should be assigned K22.4.

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

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Removal of silicone oil from eye post retinal detachment repair

Q:

What is the correct principal diagnosis for a patient admitted for removal of silicone oil post retinal detachment repair?

A:

Assign Z48.8 *Other specified surgical follow-up care* by following the index pathway:

Aftercare (see also Care)

- following surgery

- - specified NEC Z48.8

This is consistent with the classification of admissions for removal of arteriovenous shunt or for removal of nasolacrimal tube where Z48.8 *Other specified surgical follow-up care* is assigned as per the ICD-10-AM Alphabetic Index.

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Ref No: TN565 | Published On: 12-Dec-2013 | Status: Retired | Retired On: 30-Jun-2019

Eighth Edition FAQs Part 2: ACS 0048 *Condition onset flag*

Q:

Could Condition Onset Flag (COF) value of 1 be assigned to a patient who is admitted with diabetes and develops uncontrolled diabetes during the episode of admitted patient care?

A:

Clinical advice indicates that diabetes can become uncontrolled during the course of an admission, therefore COF 1 should be assigned for E1-.65 *** *diabetes mellitus with poor control* where it is clearly documented that controlled diabetes develops into poorly controlled or unstable diabetes during the episode of care. (see ACS 0048 *Condition onset flag, Guide For Use, Point 5.*)

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Eighth Edition FAQs Part 2: Respiratory failure, mixed type I and type II

Q:

What code should be assigned where the clinician documents mixed type I and type II respiratory failure? Can both codes be assigned?

A:

Respiratory failure results in abnormal blood gases and is always the consequence of another condition. Clinical advice confirms that type I and type II respiratory failure cannot occur at the same time, as in type I respiratory failure the carbon dioxide levels are normal or low, in contrast to type II respiratory failure where carbon dioxide levels are high.

However, type I and type II respiratory failure could occur at separate times during the course of an admission. Therefore codes for type I and type II respiratory failure can be assigned according to the documentation in the episode of care, noting that they cannot occur at the same time.

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Eighth Edition FAQs Part 2: Respiratory failure, type I acute and chronic

Q:

If a patient has acute and chronic type I respiratory failure should both be coded?

A:

Where the type I respiratory failure is documented as both acute and chronic during an episode of care, assign a code for each (see ACS 0001 *Principal diagnosis, Acute and chronic conditions*).

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Eighth Edition FAQs Part 2: High flow nasal cannula (HFNC)

Q:

Where high flow therapy is delivered through a mask, is it the same as high flow nasal cannula therapy?

A:

Clinical advice indicates that high flow therapy delivered through a mask is not the same as high flow nasal therapy. High flow nasal cannula therapy depends on the nasal airways partly sealing the cannula to generate a pressure gradient to improve oxygenation and this cannot be generated with a face mask even if high flow oxygen is administered. Therefore, despite the modalities listed for NIV in ACS 1006 *Ventilatory support* including mask, high flow therapy must be delivered through a nasal cannula to be coded as non-invasive ventilation.

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Eighth Edition FAQs Part 2: Laparoscopic gastric band

Q:

What ACHI code(s) should be assigned when a patient has their laparoscopic gastric band repositioned?

A:

There is no specific code in ACHI for repositioning of a laparoscopic gastric band, therefore the procedure should be assigned to 90943-01 **[889]** *Other laparoscopic procedures for obesity* where the repositioning is performed laparoscopically, or 90943-00 **[889]** *Other procedures for obesity* where the repositioning is performed as an open procedure. The NCCH will consider improvements to the classification of laparoscopic gastric band repositioning for a future edition of ACHI.

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Eighth Edition FAQs Part 2: ACS 0402 Cystic fibrosis

Q:

Should gastric manifestations of CF be coded to E84.1 *Cystic fibrosis with intestinal manifestations* or E84.8 *Cystic fibrosis with other manifestations*?

A:

Gastric manifestations are not distinguished in the ICD-10-AM classification of cystic fibrosis and should, therefore, be assigned to E84.8 *Cystic fibrosis with other manifestations.*

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Eighth Edition FAQs Part 2: Nitric oxide therapy

Q:

Is nitric oxide therapy only to be coded for neonates?

A:

Both the guidelines in ACS 1615 *Specific interventions for the sick neonate* and the *Code also when performed* note at block **[569]** *Ventilatory support* indicate that a code for nitric oxide therapy should only be assigned for neonates. For clarity, an additional instructional note will be included at 92210-00 **[1889]** *Nitric oxide therapy* in the second errata to Eighth Edition.

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Eighth Edition FAQs Part 2: Percutaneous heart valve replacement

Q:

Would a coronary angiography with cardiac catheterisation always be performed as part of a percutaneous heart valve replacement?

A:

Clinical advice indicates that coronary angiography with cardiac catheterisation is always performed with a percutaneous heart valve replacement and should be coded separately by following the index pathway:

Angiography

- coronary

- - with catheterisation of heart

This will be clarified further in the second errata to Eighth Edition.

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Eighth Edition FAQs Part 1: Minimally invasive procedures proceeding to open procedures

Q:

If a patient has a diagnostic laparoscopy performed and then proceeds to have an open procedure, should a code be assigned for the diagnostic laparoscopy?

A:

A code for the diagnostic laparoscopy should be assigned in addition to the open procedure code(s). It is only appropriate to assign 90343-01 *Laparoscopic procedure proceeding to open procedure* where the procedure was intended to be performed using a minimally invasive technique but then is converted to an open procedure due to a complication or other unplanned circumstance. These codes should not be used for diagnostic endoscopy/laparoscopy/arthroscopy.

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Eighth Edition FAQs Part 1: Single event multilevel surgery (SEMLS)

Q:

Can the codes from block **[1580]** *Single event multilevel surgery [SEMLS*] be assigned where a child with cerebral palsy has the multiple procedures performed as in the Tabular List, however the clinician has not documented SEMLS?

A:

Single event multilevel surgery, or SEMLS, needs to be documented in order to assign the codes from block **[1580]** *Single event multilevel surgery [SEMLS]*. If there is uncertainty as to whether it is SEMLS being performed then the clinical coder should clarify with the clinician.

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Eighth Edition FAQs Part 1: Haemorrhoids

Q:

If haemorrhoids are documented as either ‘internal’ or ‘external’ do they still have to be assigned a code for unspecified?

A:

The classification of haemorrhoids is by degree. If the degree is not specified, the correct code to assign is K64.9 *Haemorrhoids, unspecified* following the index entry:

Haemorrhoids (bleeding) (external) (internal) (without mention of degree) K64.9

The terms ’internal’ and ‘external’ are nonessential modifiers that do not affect the code assignment.

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Eighth Edition FAQs Part 1: Haemorrhoids

Q:

What code(s) should be assigned when multiple grades of haemorrhoids are documented or terminology such as grade II-III haemorrhoids is used?

A:

While there is currently nothing in the classification to preclude the assignment of multiple codes to reflect different stages of haemorrhoids, clinical advice indicates that it is only necessary to assign one code for the most severe haemorrhoid grade.

Improvements to the classification will be considered in the future to reflect this advice.

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Eighth Edition FAQs Part 1: Haemorrhoids

Q:

What haemorrhoid code should be assigned when a patient is admitted for banding of haemorrhoids?

A:

ACS 0942 *Banding of haemorrhoids* was deleted for Eighth Edition as the banding related to internal haemorrhoids, which is no longer relevant now that haemorrhoids are classified by degree. Therefore code assignment is determined by the clinical documentation.

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Eighth Edition FAQs Part 1: Haemorrhoids

Q:

Where there is no degree specified for the haemorrhoids but the clinician has documented ‘retract spontaneously’, can the haemorrhoids be assumed to be second degree, as in the inclusion term in the Tabular List at K64.1 *Second degree haemorrhoids*?

A:

Following the coding process, the code for second degree haemorrhoids can be assigned in this case by following the index entry first:

Haemorrhoids

- 2nd degree (grade/stage II) (with prolapse but retracts spontaneously)

then by reference to the inclusion term at K64.1 *Second degree haemorrhoids* in the Tabular List, where it specifies ‘Haemorrhoids that prolapse on straining but retract spontaneously.’ (refer to Tabular List of Diseases, *Guidance in the use of ICD-10-AM*).

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Eighth Edition FAQs Part 1: Resistance to antimicrobial and antineoplastic drugs

Q:

Where MRSA is documented by the clinician, can the information from the pathology report be used where it provides the information about whether the MRSA is multi resistant or methicillin resistant?

A:

The guidelines in ACS 0010 *General abstraction guidelines*, direct that diagnostic results should be used to add specificity to already documented conditions that meet the criteria for code assignment. As it is important to establish whether MRSA is referring to methicillin resistance as opposed to the less specific and less common usage ‘multi resistance’ the diagnostic results should be referenced (see ACS 0112 *Infection with drug resistant microorganisms*).

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Eighth Edition FAQs Part 1: Resistance to antimicrobial and antineoplastic drugs

Q:

Can a code for resistance to antibiotics be assigned where the resistance is not documented by the clinician, however the information is in the pathology report and the antibiotic treatment is changed?

A:

The clinician must document the drug resistance in the record in order to assign a code from Z06.- *Resistance to antimicrobial drugs* (see ACS 0112 *Infection with drug resistant microorganisms*).

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Eighth Edition FAQs Part 1: Jaundice:

Q:

Where a neonate is readmitted for phototherapy, does the procedure code for phototherapy need to be assigned in addition to the ICD-10-AM code for jaundice?

A:

The code for phototherapy of the newborn, 90677-00 **[1611]** *Other phototherapy, skin,* should only be assigned where the phototherapy is sustained for >12 hours as per the specific instructions contained within ACS 1615 *Specific diseases and interventions related to the sick neonate*.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS

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Eighth Edition FAQs Part 1: ACS 0048 *Condition onset flag*

Q:

Why can't a COF 1 be assigned to J44.1 *Chronic obstructive pulmonary disease with acute exacerbation, unspecified* where the acute exacerbation arises during the episode of care?

A:

A chronic disease that is present on admission and is exacerbated during the episode of care should be assigned a COF of 2 (refer ACS 0048 *Condition onset flag, Permissible values*).

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Eighth Edition FAQs Part 1: ACS 0048 *Condition onset flag*

Q:

What COF should be assigned where a patient is admitted with chronic obstructive pulmonary disease and develops an acute respiratory infection during the episode of care?

A:

When two conditions are described within a combination code, such as J44.0 *Chronic obstructive pulmonary disease with acute lower respiratory infection*, assign COF 1 if one of those conditions meets the criteria for assignment of COF 1 and the condition is not represented by another code with a COF value of 1 (refer ACS 0048 *Condition onset flag, Guide for use, point 5*)

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Eighth Edition FAQs Part 1: ACS 2114 *Prophylactic surgery*

Q:

Patients who have neoplastic bone disease sometimes have a nail inserted into the diseased bone to assist in the prevention of fractures. As the clinicians refer to this as prophylactic surgery should a code from Z40.- Prophylactic surgery be assigned?

A:

ACS 2114 *Prophylactic surgery* principally provides instruction for assigning ICD-10-AM codes where prophylactic surgery is performed on healthy organs in patients who have known risks for the development of malignant disease. The standard does not currently provide specific guidelines for the assignment of an additional diagnosis of Z40.-, for other types of prophylactic surgery. However, consideration will be given to expanding this standard in the future to address other scenarios where surgery is considered prophylactic.

Therefore, for this scenario assign the neoplastic bone disease as the principal diagnosis and a code from Z40.- is not currently required.

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Eighth Edition FAQs Part 1: ACS 0048 *Condition onset flag*

Q:

Where a patient with chronic obstructive pulmonary disease develops pneumonia during the episode of care, what COF would be assigned to the pneumonia code?

A:

A COF of 1 should be assigned to the pneumonia code as this condition arose during the episode of admitted patient care.

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Eighth Edition FAQs Part 1: ACS 0020 *Bilateral/multiple procedures* – skin lesions

Q:

If one lesion is excised but the histopathology report indicates that there was more than one morphological type in the excised tissue, how many times should the ACHI code be assigned?

A:

The ACHI code should be assigned as many times as the procedure is performed. Where one lesion is excised, the procedure code should be assigned once only, regardless of the number of morphological types reported.

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Eighth Edition FAQs Part 1: Hernia

Q:

If there is a causal link documented between a previous surgical procedure and an incisional hernia, can external cause codes also be assigned?

A:

Where there is documentation of a specific surgical procedure that has caused an incisional hernia, assign Y83._ as an additional code and Y92.22 *Health service area* for the place of occurrence (refer ACS 2001 *External cause code use and sequencing* and Coding Matters September 2005 Volume 12, Number 2, updated June 2013). See also ACS 1904 *Procedural complications*.

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Eighth Edition FAQs Part 1: Procedure for McRoberts Manoeuvre

Q:

In the workshop presentation there was an exercise scenario that included McRoberts manoeuvre, a type of assisted delivery, for which no procedure code was assigned. Should the ACHI code 90477-00 **[1343]** *Other procedures to assist delivery* be assigned in addition to O83 *Other assisted delivery*?

A:

A national guideline to mandate the assignment of an ACHI code for McRoberts manoeuvre does not currently exist. The assignment of an ACHI code for McRoberts manoeuvre is similar to a previous query about assigning an ACHI code for spontaneous vertex delivery, for which current advice directs that “the assignment of the procedure code is optional as directed by jurisdictional guidelines.”

This advice will be considered along with the requirement to assign intervention codes for both McRoberts manoeuvre and spontaneous vertex delivery in a future edition of ICD-10-AM and ACS. (refer Coding Q&A Oct 2010 McRoberts manoeuvre and Q&A Dec 2011 Intervention code for spontaneous vertex delivery).

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Eighth Edition FAQs Part 1: Imaging services

Q:

In the workshop presentation there were some scenarios where codes were assigned for imaging services such as CT and MRI guidance, where they were performed in association with other procedures. Even though these were done under anaesthetic should they be coded?

A:

As per ACS 0042 *Procedures normally not coded*, codes from ACHI Chapter 20 *Imaging services* should only be coded in certain circumstances, such as where cerebral anaesthesia is required in order for the procedure to be performed. The scenarios in the recent Eighth Edition Education should not have assigned codes for CTs and MRIs.

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Eighth Edition FAQs Part 1: High flow nasal cannula (HFNC)

Q:

Can high flow nasal cannula be used for adults as well as neonates?

A:

Yes, as per the Q&A for High Flow Cannula published in December 2011.

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Eighth Edition FAQs Part 1: ACS 0020 *Bilateral/multiple procedures* – skin lesions code title

Q:

If the codes for excision of separate skin lesions are assigned as many times as they are performed during a visit to theatre, why is the plural still in the code title, as in lesions (s)?

A:

It is acknowledged that the presence of the plural in the 'Excision of lesion(s) of skin and subcutaneous tissue' codes is misleading following the changes to ACS 0020 Bilateral/multiple procedures. It was not possible to update the code titles to remove the 's' for Eighth Edition due to time limits imposed by the production cycle. It will, however, be updated for the Ninth Edition of ACHI.

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Eighth Edition FAQs Part 1: ACS 0402 *Cystic fibrosis* - tune up

Q:

When a patient is admitted to hospital for several days for CF ‘tune up’, what principal diagnosis code should be assigned?

A:

Patients with CF typically require several admissions to hospital to improve (‘tune up’) their health level. A CF ‘tune up’ involves the provision of intravenous antibiotics and intensive chest physiotherapy in order to minimise the risk of recurrent lung infections or other worsening symptoms. During the hospital stay, investigations such as lung function, x-ray or sputum culture may also be performed. A ‘tune up’ is considered an integral part of the management of patients with CF and therefore appropriate code(s) from E84.- should be assigned, as per ACS 0001 *Principal diagnosis* and ACS 0402 *Cystic fibrosis*.

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Ref No: TN565 | Published On: 17-Oct-2013 | Status: Retired | Retired On: 30-Jun-2015

Eighth Edition FAQs Part 1: ACS 0402 *Cystic fibrosis* - nasal polyps

Q:

When nasal polyps or pancreatic insufficiency are documented as manifestations of cystic fibrosis (CF), which E84.- *Cystic fibrosis* code should be assigned?

A:

The current structure of the CF codes in ICD-10, the parent classification of ICD-10-AM, is limited. It is not clear which E84.- code should be assigned to reflect CF with nasal polyps or pancreatic insufficiency. Options to improve the classification of CF are being proposed internationally where these two manifestations are classified as otorhinolaryngological and exocrine pancreatic manifestations of CF respectively. As these options are currently not available in ICD-10-AM these manifestations should both be assigned to E84.8 *Cystic fibrosis with other manifestations*. It is inappropriate to assign E84.0 *Cystic fibrosis with pulmonary manifestations* or E84.1 *Cystic fibrosis with intestinal manifestations* for these manifestations (see also revised Q&A for Cystic fibrosis published June 2013).

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Ref No: TN565 | Published On: 17-Oct-2013 | Status: Retired | Retired On: 15-Dec-2014

Eighth Edition FAQs Part 1: Sunburn

Q:

In the workshop presentation there was an exercise scenario that included sunburn caused by a home solarium. Is it really sunburn when it isn't caused by the sun?

A:

Clinical advice confirmed that burns caused by other sources of ultraviolet radiation, such as tanning beds and therapeutic ultraviolet radiation, should be classified in the same way as sunburn. Enhancements were made to the ICD-10-AM Alphabetic Index in Errata 1, June 2013, to ensure the correct classification of burns from ultraviolet radiation.

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Eighth Edition FAQs Part 1: Catheterisation in a neonate:

Q:

Should a code be assigned for each episode of catheterisation in a neonate?

A:

A code for each type of catheterisation in a neonate should be assigned once only, regardless of the number of times it is performed. This instruction has been clarified in ACS 1615 *Specific interventions for the sick neonate* in the second errata to Eighth Edition.

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Eighth Edition FAQs Part 1: Resistance to antimicrobial and antineoplastic drugs

Q:

Can the code for resistance to antineoplastic drugs be used where there is resistance to cytotoxic drugs?

A:

Z07 *Resistance to antineoplastic drugs* is used where there is documentation of resistance, non-responsiveness and refractive properties of neoplasms to antineoplastic drugs (including cytotoxic drugs). This code should not be assigned for non-neoplastic conditions.

The second errata to Eighth Edition will amend the inclusion term at Z07 and the 'Use additional code' note at the beginning of Chapter 1, and a 'Use additional code' note will be added at the beginning of Chapter 2 to reflect this advice.

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Viral hepatitis

Viral hepatitis

Patients with chronic viral hepatitis are often asymptomatic or may have abnormal liver function tests (LFTs). An indication of chronic viral hepatitis is a raised level of alanine transaminase (ALT) and/or aspartate aminotransferase (AST), in the absence of other causes of liver inflammation such as alcohol, non-alcoholic fatty liver disease. Generally, patients with chronic viral hepatitis are followed up 6-12 monthly with blood tests. Six monthly ultrasounds are recommended for surveillance of hepatocellular carcinoma (primary liver cancer) in all patients with cirrhosis, and in some patients with chronic HBV infection in the absence of cirrhosis.

Generally, after recovery from an infection with an organism, a person will develop antibodies to the pathogenic organism. Antibodies to certain infectious diseases can also be produced by vaccination. In these vaccinated people, future blood tests demonstrating the antibodies will indicate past infection or immunisation. Detection of antibodies does not indicate active infection; this is confirmed by detecting the virus in the blood. A person with detectable virus in their blood may or may not manifest symptoms but is potentially infectious and the virus can be transmitted to others.

It is important to understand the distinction between a person who has an active infection (at risk of transmission of infection to others and disease progression) and a person whose antibody results indicate past infection or immunisation to an infectious disease (not an infection risk, and usually not at risk of disease progression). The role of antibody tests in distinguishing between disease status and past infection varies depending on the infection. In some situations, testing for viral nucleic acid (DNA or RNA) is required to determine if actual infection is present.

Hepatitis A

Transmission within families is common. In developing countries, the usual source of infection is faecal contamination of drinking water.The hepatitis A virus (HAV) is detected by two antibody tests:

1. IgM antibody: positive result indicates recent infection. 2. IgG antibody (anti-HA): positive result indicates past infection (previous exposure to HAV) or immunity through vaccination.

Hepatitis B

Most people who are infected with HBV as adolescents or adults do not develop symptoms and clear infection spontaneously - they make a full recovery and are left with immunity for life. However, following acute infection, a small minority (approximately 5%) of patients will progress to a chronic infection.

In contrast, most of the global burden of chronic hepatitis B results from mother to infant transmissions or infection in early childhood, in high prevalence countries. Newborn babies of mothers who have hepatitis B (HBsAg positive) are at risk of infection and should receive HBV vaccination and immunoglobulin (within 12 hours of birth and complete a full HBV vaccination schedule). People who are infected with HBV as infants or in early childhood are often asymptomatic, but usually progress to chronic HBV infection.

There are two categories of tests used to diagnose and manage HBV infection:

1. serological assays: enzyme immunoassay (EIA) detects specific antibody(ies) to HBV and antigen(s) and includes HBsAg, anti-HBs, HBeAg, anti-HBe, anti-HBcAg.

2. molecular assays: detect and/or quantify the amount of viral nucleic acid (HBV DNA [deoxyribonucleic acid]). Tests are divided into two types:

- qualitative assays: detects presence or absence of HBV DNA
- quantitative assays: measures the amount of HBV DNA ('viral load') in serum (this is the preferred testing method and includes polymerase chain reaction (PCR) and transcription-mediated amplification (TMA) assays).

Antiviral therapy is used to treat patients with HBV infection, with the current aim of treatments to suppress virus replication and prevent progression of liver disease (EASL 2012). Spontaneous clearance of HBV infection may occur without treatment. This is common in adults following acute infection, but can also occur in people with chronic HBV infection. Resolution of HBV infection is rare with current treatment. Resolved HBV infection is defined as 'previous HBV infection without further virologic, biochemical or histological evidence of active virus or disease' (Lok & McMahon 2009, p. 4).

Hepatitis C

The majority of patients (60-70%) with acute HCV infection will progress to a chronic infection. Spontaneous viral clearance after acute HCV infection occurs without treatment in 30-40% of people, usually within the first 6 months after infection.

There are two categories of tests used to diagnose and manage HCV infection:

1. serological assays: enzyme immunoassay (EIA) detects specific antibody to HCV (anti-HCV) 2. molecular assays: detect and/or quantify the amount of viral nucleic acid (HCV RNA [ribonucleic acid]). Tests are divided into three types:

- qualitative assays: detects presence or absence of HCV RNA
- quantitative assays: measures the amount of HCV RNA ('viral load') in serum. This is usually by polymerase chain reaction (PCR).
- genotype assay: there are 6 main genotypes of HCV. Choice and duration of antiviral treatment, as well as likelihood of response is strongly related to the infecting genotype.

Antiviral therapy is used to treat patients with HCV infection, with the aim of virological cure. Therapy is for a defined time period, usually 24 or 48 weeks. HCV infection is considered to be successfully treated when SVR (sustained virological response) is attained. SVR is defined as the absence of HCV RNA in serum 24 weeks after discontinuing therapy (Ghany et al. 2009, p. 1341).

Hepatitis D

Testing for HDV involves serology for hepatitis D antibodies (anti-HDV). However, this does not allow determination of active infection or prior exposure. Hepatitis D virus RNA testing has only limited availability in research settings.

Hepatitis E

It is endemic in South-East Asia, countries of the Soviet region, India, mid-east Africa and Central America. Large outbreaks are usually spread by contaminated water. Direct person to person

spread can occur but is less common. The normal course of infection is an acute and a relatively benign illness. Whereas, HEV in pregnancy can cause fulminant hepatic failure, particularly in the third trimester, with mortality rates of 15-25%.

It was previously thought that HEV is *never* a chronic infection. However, it has been recently recognised that hepatitis E may result in chronic infection, particularly in immunosuppressed individuals such as organ transplant recipients (Kamar et al. 2012, p. 6).

Ackowledgements:

The NCCC would like to thank Dr Mark Douglas, Associate Professor Simone Strasser and Associate Professor Stuart Roberts for their invaluable contribution to updating viral hepatitis in the classification system.

References:

European Association for the Study of the Liver (EASL) 2012, 'EASL Clinical Practice Guidelines: Management of chronic hepatitis B virus infection', *Journal of Hepatology*, vol. 57, pp. 167-185.

Ghany, MG, Nelson, DR, Strader, DB, Thomas, DL and Seeff, LB 2011, 'An Update on Treatment of Genotype 1 Chronic Hepatitis C Virus Infection: 2011 Practice Guideline by the American Association for the Study of Liver Diseases', *Hepatology*, vol. 54, no. 4, pp. 1433-1444.

Kamar, N, Bendall, R, Legrand-Abravanel, F, Xia, N, Ijaz, S, Izopet, J and Dalton, HR 2012, 'Hepatitis E', *The Lancet*, vol. 11, pp. 1-12.

Lok, ASF and McMahon, BJ 2007, Chronic Hepatitis B, *Hepatology*, vol. 50, no. 3, pp. 1-36.

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Principal diagnosis assignment for syndromes

Q:

Where a patient is admitted for treatment of a particular component of a syndrome, should a code for the syndrome or the particular component, be assigned as the principal diagnosis?

A:

Where a patient presents for management of a component of a previously diagnosed syndrome, a code for the component should be assigned as the principal diagnosis. Where ICD-10-AM:

- provides a specific code for the underlying syndrome, assign this code as an additional diagnosis (refer ACS 0001 *Principal diagnosis, Problems and underlying conditions*).
- does not provide a specific code for the underlying syndrome, refer to ACS 0005 *Syndromes* for instruction regarding assignment of additional diagnosis codes.

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Obstetric principal diagnosis and delivery outcome codes

Q:

What is the appropriate principal diagnosis and outcome of delivery code to assign in the following scenario:

Mother admitted to hospital after delivering Twin 1 by breech extraction in the ambulance on the way to hospital, then delivers Twin 2 by emergency caesarean section?

A:

O84.82 *Multiple delivery by combination of methods* should be assigned as the principal diagnosis and assign Z37.2 *Twins, both liveborn* as the outcome of delivery code.

Z39.03 *Postpartum care after unplanned, out of hospital delivery* should also be assigned to indicate that Twin 1 was delivered prior to admission. As this is an exception to the guidelines in ACS 1548 *Postpartum condition or complication* for assigning a code from Z39.0- *Postpartum care and examination* immediately after delivery as an additional diagnosis, the standard will be reviewed for inclusion of this scenario in a future edition.

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Insertion of fiducial markers into the lung percutaneously

Q:

What is the best procedure code to assign for insertion of fiducial markers into the lung percutaneously?

A:

Fiducial markers are metal markers implanted into a lesion or soft tissue as a radiographic reference point for provision of external beam radiotherapy or radiosurgery. When used to treat lung cancer, the markers are inserted into the lesion and its adjacent sites through needles, using a percutaneous approach. This procedure technically resembles that of CT guided biopsy of lung (Sotiropoulou et al., 2013).

Currently there is no specific code in ACHI to classify insertion of fiducial markers into lung. Given the procedure is technically similar to a CT guided biopsy, NCCC considers the best fit code to be 38812-00 **[550]** *Percutaneous needle biopsy of lung*. This code can be accessed via index pathway:

Puncture

- lung 38812-00 **[550]**

Please note that 38456-02 **[558]** *Other procedures on lung or pleura, intrathoracic approach* is not an appropriate code for this procedure as this intervention code is for lung procedures performed via an open intrathoracic approach.

The NCCC will consider improvements to the classification of fiducial markers implantation for a future edition of ACHI.

References:

Sotiropoulou, E, Georgiadi, V, Stathochristopoulou, I, Stathopoulos, K, Salvaras, N and Thanos, L (2013), International Hospital Equipment & Solutions: CT-guided fiducial implantation in radiosurgery of extracranial parenchymal cancer, accessed: 12 February 2013, available: http://www.ihe-online.com/feature-articles/ct-guided-fiducial-implantation-in-radiosurgery-of-extracranial-parenchymal-cancer/.

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Pressure injury

Q:

What is the correct code to assign for a pressure injury, documented as ‘suspected deep tissue injury: depth unknown’ or ‘unstageable pressure injury: depth unknown’?

A:

In 2009, new definitions and a six stage classification for pressure injury were developed by the American National Pressure Ulcer Advisory Panel (NPUAP) and European Pressure Ulcer Advisory Panel (EPUAP). Australia and other Asia Pacific countries adopted this new classification of pressure injuries in the ‘Pan Pacific Clinical Guideline for the Prevention and Management of Pressure Injury (Abridged Version)’ (AWMA 2012).

The new clinical guideline uses the term ‘pressure injury’ for the synonymous terms pressure ulcer, decubitus ulcer and bedsore; and has added two new stages of pressure injury to the existing four stage classification for those pressure injuries where it is not possible to specify the depth, namely:

- Suspected deep tissue injury: depth unknown
- Unstageable pressure injury: depth unknown.

‘Unstageable pressure injury: depth unknown’ is defined as:

Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV (NPUAP & EPUAP 2009; NPUAP 2013).

‘Suspected deep tissue injury: depth unknown’ is defined as:

Purple or maroon localised area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment (NPUAP & EPUAP 2009; NPUAP 2013).

Currently there is no specific code in ICD-10-AM to classify ‘suspected deep tissue injury: depth unknown’ and ‘unstageable pressure injury: depth unknown’, however a proposal to update ICD-10 in line with the new guidelines has been submitted to the WHO ICD-10 Update and Revision Committee (WHO-URC).

In the interim, clinical advice confirms that L89.9 *Decubitus ulcer and pressure area, unspecified* should be assigned when either of these two new stages of pressure injury are documented.

References:

National Pressure Ulcer Advisory Panel (NPUAP) (2013), NPUAP Pressure Ulcer Stages/Categories, accessed: 6 March 2013, available: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/. National Pressure Ulcer Advisory Panel (NPUAP) and European Pressure Ulcer Advisory Panel (EPUAP) (2009), International Guideline: Pressure Ulcer Treatment Technical Report, accessed: 6 March 2013, available: http://www.npuap.org/wp-content/uploads/2012/03/Final-2009-Treatment-Technical-Report1.pdf. Australian Wound Management Association (AWMA) (2012), Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury (Abridged Version), accessed: 6 March 2013, available: http://www.awma.com.au/publications/2012_AWMA_Pan_Pacific_Abridged_Guideline.pdf.

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Spontaneous premature rupture of membranes

Q:

Could the NCCC please clarify the coding of ‘premature rupture of membranes’, including whether there is a requirement for the word ‘spontaneous’ to be specified?

A:

Premature rupture of membranes (PROM), also known as pre-labour rupture of membranes, is ‘the spontaneous rupture of the amniotic sac before the onset of labour’ (Mosby, 2009). PROM can occur at term, that is, at or beyond 37 completed weeks of gestation, or preterm (PPROM), before 37 completed weeks of gestation, which can pose a significant risk for morbidity and mortality in both the mother and the fetus, and is a major cause of preterm delivery (Jazayeri, 2011).

The appropriate code for both term and preterm PROM is assigned following the index pathway:

Rupture, ruptured

- membranes (spontaneous)

- - premature

As ‘spontaneous’ is not an essential modifier it does not need to be specified in order to assign a code for premature rupture of membranes, however it is implicit in the condition.

A code from O42 *Premature rupture of membranes* should not be assigned where membranes are ruptured artificially.

NCCC notes that a public submission has been submitted requesting index entries for ‘pre-labour rupture of membranes’. This will be considered along with other index entries for PROM and PPROM for a future edition of ICD-10-AM.

References:

Jazayeri, A (2011), Premature rupture of membranes, Medscape reference, accessed: 11 February 2013, available: http://emedicine.medscape.com/article/261137-overview.

Mosby (2009), Mosby’s Medical Dictionary, 8th edn, accessed: 11 February 2013, available: http://medical-dictionary.thefreedictionary.com/premature+rupture+of+membranes.

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Rusch balloon catheter for cervical ectopic pregnancy bleeding

Q:

What is the correct code to assign for management of bleeding from a cervical ectopic pregnancy using a Rusch balloon catheter?

A:

Cervical ectopic pregnancy is the rarest type of ectopic pregnancy, occurring in approximately 1 in 9,000 pregnancies. Initial presentation is usually profuse, painless vaginal bleeding. While it is potentially a life threatening condition, it can be treated conservatively following an early diagnosis by ultrasound.

Cervical bleeding resulting from an ectopic pregnancy can be treated using a Rusch catheter. The catheter is placed in the cervix and inflated with saline to create a balloon which places pressure on the blood vessels.

As ACHI does not contain a specific code for the insertion or replacement of Rusch catheters to control cervical bleeding, the appropriate code to assign for both insertion and replacement is 35618-03 **[1278]** *Other procedures on cervix* following the index pathway:

Procedure

- cervix NEC 35618-03 **[1278]**

The addition of index entries for Rusch balloon catheter for control of cervical bleeding will be considered for a future edition of ACHI.

Bibliography:

Kirk, E and Bourne, T (2009), Diagnosis of ectopic pregnancy with ultrasound, *Best Practice and Research Clinical Obstetrics and Gynaecology*, Vol. 23, No. 4, pp. 501-508. Heer, J, Chao, D and McPheeters, R (2012), Cervical ectopic pregnancy, *West Journal of Emergency Medicine*, Vol. 13, No. 1, pp. 125-126.

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Transvenous abdominis plane (TAP) blocks

Q:

What is the correct code assignment for TAP blocks?

A:

A transversus abdominis plane (TAP) block is a regional block of the abdominal wall which is primarily used in surgeries involving the lower abdominal wall, such as bowel surgery, appendicectomy, hernia repair and gynaecological surgery. TAP blocks are also used for postprocedural pain and, less commonly, other pain management.

TAP blocks can be administered via an injection or as a continuous or intermittent infusion, using either surface anatomy landmarks or ultrasound guided technique to deposit local anaesthetic into the tissue plane between the internal oblique and the transversus abdominis.

Assign codes for TAP blocks as follows:

- for **operative anaesthesia** – 92510-XX **[1909]** *Regional block, nerve of trunk* using index pathways: *Administration/nerve/for/operative anaesthesia/trunk Anaesthesia/conduction/regional block/nerve of/trunk Block/nerve/for/operative anaesthesia/trunk Injection/nerve/for/operative anaesthesia/trunk*
- for **postprocedural analgesia** following initiation in theatre or recovery -- 92517-01 **[1912]** *Management of regional block, nerve of trunk* using index pathways: *Analgesia/postprocedural/management of/regional block/nerve of/trunk Management/block/postprocedural/regional/trunk*
- for **pain management anaesthesia** – 90022-00 **[63]** *Administration of anaesthetic agent around other peripheral nerve* using the index pathway: *Administration/nerve/peripheral*

The addition of index entries for transversus abdominis plane (TAP) blocks will be considered for a future edition of ACHI.

Bibliography:

Webster, K (2008), The Transversus Abdominis Plane (TAP) block: abdominal plane regional anaesthesia, *Update in Anaesthesia*, Vol. 214, pp. 24-29.

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Cystic fibrosis (1 of 3)

Q:

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

A:

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 this 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.

More than one code from E84.- *Cystic fibrosis* should be used if the patient presents with multiple manifestations of CF."

Therefore, for the above scenario assign the following codes:

E84.8 *Cystic fibrosis with other specified manifestations*

J33.9 *Nasal polyp, unspecified*

E84.0 *Cystic fibrosis with pulmonary manifestations*

J47 *Bronchiectasis*

K86.8 *Other specified diseases of pancreas.*

When cystic fibrosis meets the criteria for code assignment as per ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*, all manifestations should be coded regardless of whether they meet ACS 0002.

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for implementation 01 July 2013.

Ref No: TN474 | Published On: 15-Jun-2013 | Status: Retired | Retired On: 30-Jun-2015

Cystic fibrosis (2 of 3)

Q:

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.

> 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?

A:

If cystic fibrosis or its manifestations do not meet the criteria for code assignment as per the guidelines in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*, 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.

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Ref No: TN474 | Published On: 15-Jun-2013 | Status: Retired | Retired On: 30-Jun-2015

Cystic fibrosis (3 of 3)

Q:

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.-?

A:

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 the relationship between the condition and CF should be verified with the clinician.

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Ref No: Q2739 | Published On: 15-Jun-2013 | Status: Retired | Retired On: 30-Jun-2013

Total knee replacement with patellofemoral joint replacement

Q:

What is the correct code to assign when patellofemoral joint replacement/resurfacing is performed with total knee replacement (TKR)?

A:

If the patellofemoral joint is found to be significantly diseased during a total knee replacement procedure, it is resurfaced and the original width of the patella is recreated (Palmer Cross, 2012). Clinical advice confirms that total replacement arthroplasty (joint resurfacing) of PF joint performed in conjunction with TKR should be considered as part of a TKR procedure.

Therefore, the correct code to assign for total replacement arthroplasty of patellofemoral joint performed in conjunction with TKR is:

49518-00 **[1518]** *Total arthroplasty of knee, unilateral*

or

49519-00 **[1518]** *Total arthroplasty of knee, bilateral* as appropriate.

When a total replacement arthroplasty of the patellofemoral joint is performed on its own, assign 49534-01 **[1518]** *Total replacement arthroplasty of patellofemoral joint of knee*.

Reference:

Palmer, S and Cross, M (2012), Total knee arthroplasty, accessed: 28/03/2013, available: http://emedicine.medscape.com/article/1250275.

Published 15 June 2013,
for implementation 01 July 2013.

Ref No: Q2789 | Published On: 15-Dec-2012 | Status: Retired | Retired On: 30-Jun-2019

Endoscopic clipping of a bleeding duodenal arteriovenous malformation

Q:

What is the correct code to assign for endoscopic clipping of a bleeding duodenal arteriovenous malformation (AVM)?

A:

Clinical advice confirms that the procedure for endoscopic clipping of a bleeding duodenal arteriovenous malformation (AVM) is similar to endoscopic clipping of bleeding duodenal ulcer in technique, complexity and resource use.

Therefore, the correct code to assign for endoscopic clipping of a bleeding duodenal AVM is 90296-00 **[887]** *Endoscopic control of peptic ulcer or bleeding*.

NCCC will consider improvements to ACHI to reflect this advice for a future edition.

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for implementation 01 January 2013.

Ref No: Q2665 | Published On: 15-Dec-2012 | Status: Retired | Retired On: 30-Jun-2019

Transvaginal oocyte retrieval (TVOR)

Q:

What is the appropriate code to use for transvaginal oocyte retrieval (TVOR) where no oocytes were retrieved?

A:

Transvaginal oocyte retrieval (TVOR) is a procedure performed under a light anaesthetic as part of the in-vitro fertilisation (IVF) program. An ultrasound probe is inserted into the vagina to visualise the ovaries, then using ultrasound guidance, a needle penetrates the vaginal wall into the ovarian follicles and aspirates the follicular fluid. An egg is not always obtained from each follicle.

The correct code to assign for TVOR irrespective of whether an oocyte has been retrieved is:

13212-00 **[1297]** *Transvaginal ovarian retrieval*

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Ref No: Q2706 | Published On: 15-Dec-2012 | Status: Retired | Retired On: 30-Jun-2019

Unknown primary with neoplasm site default in Alphabetic Index

Q:

When certain morphologies have a site default code in the Alphabetic Index but the coding scenario is a known secondary with clinical documentation of 'unknown primary', should the primary site be coded to C80.- *Malignant neoplasm without specification of site* or should the clinical coder be guided by the default site in the index? Examples include:

Adenocarcinoma

- parietal cell (M8214/3) -- see Neoplasm, stomach, malignant

Carcinoma

- renal (cell) (M8312/3) C64

Melanoma (malignant) (M8720/3) C43.9

A:

Clinical coders should not presume the primary site of these types of neoplasms based on the default site codes listed in the Alphabetic Index. These index defaults indicate that certain morphological types of cancer are **usually** of a particular site eg. stomach, kidney or skin; however this should not override clinician documentation that the primary site is unknown.

Clinical advice also confirms that, in those rare circumstances, where such neoplasms are documented as having an unknown primary they should be coded as such ie. an unknown primary.

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Ref No: Q2714 | Published On: 15-Dec-2012 | Status: Retired | Retired On: 30-Jun-2019

Diabetes mellitus and eradicated cataract

Q:

Is E1-.39 **Diabetes mellitus with other specified ophthalmic complications* the correct code to use for diabetes mellitus with history of cataract eradicated by previous surgery? If so, does the assignment of E1-.39 in this scenario count towards the criteria for assignment of E1-.71 **Diabetes mellitus with multiple microvascular and other specified nonvascular complications*?

A:

Current clinical advice confirms that surgery to remove a cataract in a patient with DM **does eradicate the ophthalmic complication**, therefore E1-.39 **Diabetes mellitus with other specified ophthalmic complications* **should not** be assigned. And consequently, eradicated cataract **does not** contribute to the allocation of E1-.71 **Diabetes mellitus with multiple microvascular and other specified nonvascular complications*.

Please note: The final DM education material which was placed on the NCCC website (posted June 2012) includes this advice, however the material distributed at the Diabetes Workshops did not (as these were conducted before we were made aware of the updated clinical advice).

Please refer to ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia, 7. Eradicated conditions and DM* (1 July 2012) for revised instructions and examples which reflect current clinical advice.

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Ref No: Q2648 | Published On: 15-Dec-2012 | Status: Retired | Retired On: 30-Jun-2019

Low birth weight and prematurity

Q:

Should low birth weight always be coded in conjunction with prematurity in the birth episode and subsequent episodes of care?

A:

ACS 1618 *Low birth weight and gestational age* is not explicit about whether codes should be assigned for both birth weight and gestational age in all episodes of care, however the note at P07 *Disorders related to short gestation and low birth weight, not elsewhere classified* in the Tabular List states:

"*Note:* When both birth weight and gestational age are available, priority of assignment should be given to gestational age."

This note instructs that codes for both birth weight and gestational age should be assigned when the documentation is available and that priority of code assignment should be given to P07.2- *Extreme immaturity* and P07.3- *Other preterm infants* over P07.0- *Extremely low birth weight* and P07.1- *Other low birth weight*.

Clinical advice confirms that the guidance provided in the Tabular List is appropriate for the birth episode, however low birth weight is usually not significant in subsequent neonatal admissions and therefore should not be routinely assigned. A code for low birth weight should only be assigned in a subsequent episode of care if it meets ACS 0002 *Additional diagnoses*.

NCCC will review ACS 1618 *Low birth weight and gestational age* and clarify the note at P07 *Disorders related to short gestation and low birth weight, not elsewhere classified* in the Tabular List for a future edition of ICD-10-AM and ACS.

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Ref No: Q2685 | Published On: 15-Dec-2012 | Status: Retired | Retired On: 30-Jun-2019

Open reduction and internal fixation of frontal sinus fracture

Q:

What is the correct procedure code to assign for open reduction with internal fixation of a frontal sinus fracture?

A:

Published literature and clinical advice received from the Australian and New Zealand Association of Oral and Maxillofacial Surgeons, indicates that the frontal sinuses are a pair of cavities in the frontal bone of the skull. Due to their location, any fractures involving the frontal bone that require surgery are compound by nature as they involve the underlying frontal sinus and in more severe cases the dura and brain.

Therefore, the correct ACHI code to assign for open reduction with internal fixation of fracture of the frontal sinus is 39609-02 **[25]** *Reduction of compound skull fracture* following the index pathway:

Reduction

- fracture (bone) (with cast) (with splint)

- - skull (closed) (comminuted)

- - - open (comminuted) (compound) 39609-02 **[25]**

- - - - with

- - - - - internal fixation 39609-02 **[25]**

NCCC will revise the classification of open reduction with internal fixation of fracture of the frontal sinus for a future edition of ACHI. This will include a review of the includes note 'frontal sinus' at block **[1365]** *Reduction of fracture of nasal bone* and the index entries *Elevation, bone fragments, sinus, frontal* and *Elevation, fracture, sinus, frontal* which currently assign 41737-00 **[389]** *Other intranasal procedures on frontal sinus*.

Bibliography:

Bradley Strong, E (2008), Frontal sinus fractures, *Operative Techniques in Otolaryngology-Head and Neck Surgery*, Vol. 19, No. 2 , pp. 151-160.Navarro Vila, C, Asensio, R, Coll, M, Vila, I, Acero, J, Navarro Cuellar, C and Ochandiano, S (2011), Indications and treatment of frontal sinus fractures, *International Journal of Oral and Maxillofacial Surgery*, Vol. 40, No. 10, p. e18.Tedaldi, M, Ramieri, V, Foresta, E, Cascone, P and Iannetti, G (2010), Experience in the Management of Frontal Sinus Fractures, *Journal of Craniofacial Surgery*, Vol. 21, No. 1, pp. 208-210.Chaaban, M, Conger, B and Woodworth, B (2012), *Endoscopic Management of Frontal Sinus Fractures, Otolaryngoogyl Head and Neck Surgery*, Vol. 147, No. 2, Supp. P109.

Published 15 December 2012,
for implementation 01 January 2013.

Ref No: Q2691 | Published On: 15-Dec-2012 | Status: Retired | Retired On: 30-Jun-2019

Postictal state

Q:

What is the correct code to assign for a patient who is admitted for postictal state following an epileptic seizure? Specifically what is the correct code assignment for postictal state characterised by confusion?

A:

The postictal state is described as being the abnormal condition that occurs between the end of an epileptic seizure and the return to the baseline condition, or the interictal state. A patient admitted in a postictal state may have a number of symptoms and signs, including focal deficits (such as aphasia and hemiplegia) or diffuse cerebral dysfunction (such as delirium and psychosis). The postictal state may be further complicated by injuries or secondary medical conditions.

When assigning codes for postictal state, codes for both the specific manifestation(s) and epilepsy should be assigned, in accordance with the guidelines in ACS 0001 *Principal diagnosis*.

Where postictal state is documented without further specification, assign G40.90 *Epilepsy, unspecified, without mention of intractable epilepsy*.

For confusion in the postictal state, assign F05.8 *Other delirium* following the index pathway:

Confusion, confused

- epileptic F05.8

Also assign a code for the epilepsy.

NCCC will consider improvements to the index for ‘postictal state’ for a future edition of ICD-10-AM.

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for implementation 01 January 2013.

Ref No: Q2751 | Published On: 15-Dec-2012 | Status: Retired | Retired On: 30-Jun-2019

Follicular non-Hodgkin lymphoma

Q:

What is the correct code to assign for follicular non-Hodgkin lymphoma?

A:

Follicular lymphoma is a specific type of non-Hodgkin lymphoma classified to category C82 *Follicular lymphoma* in ICD-10-AM. Assign an appropriate neoplasm and morphology code for follicular non-Hodgkin lymphoma by following the index pathway:

Lymphoma

- follicular

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

Bibliography:

Cancer Council NSW (2011), Understanding Non-Hodgkin Lymphoma, accessed: September 2012, available: http://www.cancercouncil.com.au/1496/cc-publications/understanding-cancer-series/understanding-non-hodgkin-lymphoma/understanding-non-hodgkins-lymphoma/?pp=1718 American Cancer Society (2012), Non-Hodgkin Lymphoma, accessed September 2012, available: http://www.cancer.org/Cancer/Non-HodgkinLymphoma/DetailedGuide/non-hodgkin-lymphoma-what-is-non-hodgkin-lymphoma

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for implementation 01 January 2013.

Ref No: Q2757 | Published On: 15-Dec-2012 | Status: Retired | Retired On: 30-Jun-2019

Intramucosal adenocarcinoma/carcinoma of the colon

Q:

What is the correct morphology behaviour code to assign for intramucosal carcinoma or adenocarcinoma of the colon?

A:

The first layer of the bowel wall referred to as the mucosa consists of the surface epithelium, lamina propria and muscularis mucosa. Intramucosal adenocarcinoma/carcinoma refers to carcinoma confined to these layers of the bowel wall and is **usually** in situ.

For documentation of intramucosal adenocarcinoma/carcinoma of the colon without further qualification, the coder should, in the first instance, verify the correct morphology behaviour code with the clinician. Where clinical clarification is not possible, assign one of the following morphology codes as appropriate:

M8140/2 *Adenocarcinoma in situ NOS*

M8010/2 *Carcinoma in situ NOS*

The NCCC will consider indexing improvements for intramucosal carcinoma/adenocarcinoma of the colon in a future edition of ICD-10-AM.

Bibliography:

Edge, SB, Byrd, DR, Compton, CC, Fritz, AG, Greene, Fl, and Dotti, A (2009), *AJCC Cancer Staging Manual*, 7th edn, Springer, New York. Ingledew, PA (2012), *LearnOncology.CA: On-line Integrated Oncology Education Modules for Medical Students*, accessed: September 2012, available: http://learnoncology.ca/wordpress/oncology-modules/colorectal-cancer/staging/. Farmer, J, Munro, S and Hawkins, N (2007), *Minimum Dataset for Colorectal Cancer*, accessed: September 2012, available: http://www.med.unsw.edu.au/crcweb.nsf/resources/Path/$file/Guidlines+for+Colorectal+Cancer+Reporting+1st+Ed+August+2007.pdf.

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Ref No: TN440 | Published On: 15-Dec-2012 | Status: Retired | Retired On: 30-Jun-2019

The diabetic foot

The diabetic foot is a complication of diabetes often requiring extended hospitalisation for successful treatment (weeks or months). It is characterised by an infected ulcer over a weight-bearing area of the foot, where a number of other factors contribute to the breakdown of the skin and underlying connective tissues and even involvement of the neighbouring bone. The presence of diabetic peripheral sensory neuropathy can result in a painless lesion and possibly develop from total unawareness of injury to the foot due to insensitivity to heat or other form of injury. Compromised circulation decreasing the capacity for response to antibiotics due to poor oxygenation and access of the antibiotics to the ulcerated area. Excessive 'loading' of parts of the foot already subject to breakdown because of poor quality tissue damaged by the diabetic process is an important contributing factor and might be due to changes in gait following amputations to the same or other foot with similar combinations of diabetic complications.

Typically the diabetic foot features an ulcer which does not respond to 'aggressive' traditional treatments with antibiotics, etc and such condition is the leading cause of lower limb amputation in medical practice and patients undergoing such need for amputation have an increased risk of death within five years.

Classification of diabetic foot

Please refer to ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision.

The text below reinforces the guidelines in ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia, 6. Diabetic foot* and clarifies the sequencing of codes for diabetic foot.

Assign E1-.73 **Diabetes mellitus with foot ulcer due to multiple causes* when:

- 'diabetic foot' is documented in the clinical record, or
- the criteria specified in ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia, 6. Diabetic foot* are met.

Additional codes for the specific complications of DM or IH should be assigned in accordance with Rule 4a and Rule 4b.

Sequencing of codes for diabetic foot should be determined by:

- ACS 0001 *Principal diagnosis*, with particular attention to:
- the 'after study' principle
- *Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis*
- *Two or more diagnoses that equally meet the definition for principal diagnosis*
- ACS 0002 *Additional diagnoses*.

Ref No: Q2791 | Published On: 15-Dec-2012 | Status: Retired | Retired On: 30-Jun-2019

Long term use of insulin

Q:

When should Z92.22 *Personal history of long term (current) use of other medicaments, insulin* be assigned? Is it appropriate to assign Z92.22 when insulin treatment is initiated during the admission with the intent of treatment to be ongoing at the time of discharge?

A:

Follow the instruction in the Tabular List at E11, E13 and E14 which states, “Use additional code (Z92.22) to identify current pre-admission or ongoing insulin treatment” to assign Z92.22 Personal history of long term (current) use of other medicaments, insulin.

Therefore, Z92.22 **should be assigned** with codes from category E11, E13* and E14 (and not E10) where insulin treatment is ongoing, that is long-term not short term.

Z92.22 **should not be assigned** where insulin treatment is:

- initiated during the current episode - even if the intention is that the insulin treatment will be ongoing at the time of discharge
- used to control diabetes mellitus during an episode of care (eg. postoperatively)
- used to treat Type 1 diabetes mellitus as this is standard treatment for Type 1 diabetes mellitus.

Revision of the wording of the use additional code instruction at categories E11, E13* and E14 will be considered for a future edition of ICD-10-AM.

This advice has a minor modification to correspond with an update in a subsequent edition ofICD-10-AM/ACHI/ACS.

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Ref No: Q2722 | Published On: 15-Dec-2012 | Status: Retired | Retired On: 01-Jul-2017

Failed trial of labour and failure to progress

Q:

What is the difference between failed trial of labour and failure to progress?

A:

Current clinical advice regarding these terms provided the following information:

Failure to progress (in labour) - is a description rather than a diagnostic term, therefore, where possible, coders should assign a code for the underlying condition resulting in the 'failure to progress'. The patient must be in an active phase of labour (ie. cervix is dilated to >= 4cms and regular contractions are occurring with or without ruptured membranes), before failure to progress can be established. Underlying causes may include cephalopelvic disproportion, fetal malpresentation, incoordinate uterine action (primary uterine inertia or secondary uterine inertia), cervical dystocia or maternal exhaustion. The clinician will consider why labour is not progressing, make a diagnosis and then use interventions such as amniotomy and/or augmenting labour with oxytocins.

In the absence of documentation of an underlying cause for 'failure to progress' clinical advice indicates that the correct code to assign is O62.9 *Abnormalities of forces of labour, unspecified* following the index pathway:

Failure, failed

- to

- - progress (in labour) NEC O62.9

Failed trial of labour - is also a description rather than a diagnostic term, therefore coders should assign, where possible, a code for the underlying condition resulting in a caesarean birth after trial of labour (TOL). A trial of labour can be undertaken because of potential problems due to small maternal size, large fetal size or for patients who have had a previous caesarean section to see if a vaginal delivery can be achieved. Other terminology used to describe this type of trial of labour include 'trial of scar', VBAC (Vaginal Birth after Caesarean) attempt or 'trial of vaginal birth after Caesarean' (TOVBAC). Trials of labour fail because women fail to progress, usually because of fetal malpresentation, cephalopelvic disproportion or fetal distress. Conditions that may result from a failed trial of labour include uterine rupture or fetal distress. See also ACS 1506 *Malpresentation, disproportion and abnormality of maternal pelvic organs*.

In the absence of documentation of an underlying cause for 'failed trial of labour' clinical advice indicates that the correct code to assign is O66.4 *Failed trial of labour, unspecified* following the index pathway:

Failure, failed

- trial of labour (with subsequent caesarean section) O66.4

The NCCC will consider indexing improvements for additional terms under failed trial of labour in a future edition of ICD-10-AM.

This advice supersedes advice published in *Coding Matters*, March 2009 (Volume 15, Number 4), *Failure to progress in labour*, which will be retired from 31 December 2012.

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Ref No: Q2621 | Published On: 15-Dec-2012 | Status: Retired | Retired On: 01-Jul-2017

Staphylococcal pneumonia with sepsis

Q:

What is the correct code assignment for staphylococcal pneumonia with sepsis?

A:

Staphylococcal pneumonia with sepsis is classified to J15.2 *Pneumonia due to staphylococcus,* by following the index pathway:

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

- in (due to)

- - staphylococcus J15.2

Additional codes for sepsis should be assigned according to the guidelines within ACS 0110 *Sepsis, severe sepsis and septic shock*.

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Ref No: Q2646 | Published On: 15-Dec-2012 | Status: Retired | Retired On: 01-Jul-2017

Suspected drink spiking

Q:

Where a patient presents to hospital for suspected drink spiking, is it appropriate to assign Z03.6 *Observation for suspected toxic effect from ingested substance* as the principal diagnosis, with relevant symptom codes and associated external cause codes for drug and alcohol as additional codes?

Also, can Z03.6 *Observation for suspected toxic effect from ingested substance* be assigned if there are bloods taken and/or urine is tested, or is it to be assigned for 'observation' only?

A:

Patients with suspected drink spiking may present as a variety of different scenarios and coders should be guided by the appropriate standards, including ACS 0001 *Principal diagnosis* and ACS 0012 *Suspected conditions*.

ACS 0001 *Principal diagnosis, Codes from the Z03.0-Z03.9 series, medical observation and evaluation for suspected diseases and conditions* states:

"An observation code is not to be used on a record with additional related codes. If symptoms related to the suspected condition are noted, then the symptom codes should be assigned, not code Z03.-."

Therefore, a code from category Z03 should only be assigned where drink spiking is suspected but there are no symptoms documented, no treatment is required and no supporting evidence for the drink spiking is found during the admission.

External cause codes may be assigned as appropriate (see ACS 0012 *Suspected conditions*).

Obtaining blood and urine samples does not preclude assignment of a code from category Z03, unless they indicate the presence of a drug that confirms drink spiking.

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Ref No: Q2718 | Published On: 15-Dec-2012 | Status: Retired | Retired On: 01-Jul-2017

Mesh erosion

Q:

Mesh erosion is a complication associated with surgical mesh devices used to repair pelvic organ prolapse and stress urinary incontinence. What is the correct diagnosis code for vaginal mesh erosion and what is the correct procedure code for excision of vaginal mesh?

A:

Surgical mesh implantation is commonly used in surgical repair of pelvic organ prolapse (POP) or stress urinary incontinence (SUI). Surgical mesh can be placed in the anterior/posterior vaginal wall, or vaginal apex to create more pelvic support in an effort to reduce the recurrence of prolapse. Mesh erosion (also called exposure, extrusion or protrusion) occurs when the mesh fails to remain in place and erodes through the vaginal wall or, less likely, into other adjacent organs such as the bladder or urethra, causing pain, infection, ulceration of tissue overlying the mesh and other mesh related complications.

Therefore, the most appropriate diagnosis code for mesh erosion is by selecting a mechanical complication code(s) from the category T83.- *Complications of genitourinary prosthetic devices, implants and grafts*, as appropriate, for example T83.4 *Mechanical complication of other prosthetic devices, implants and grafts* in genital tract for vaginal mesh erosion, T83.1 *Mechanical complication of other urinary devices and implants* for mesh erosion involving the bladder.

In addition, assign external cause codes:

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

Y92.22 *Health service area*

Clinical advice indicates that excision of vaginal mesh usually involves partial removal of the mesh that has extruded or the part underlying an ulcer and the surrounding tissues. Total removal of surgical implanted mesh is usually impossible and rarely indicated. Currently there is no specific code in ACHI for this procedure. In cases where ‘excision of vaginal mesh’ is documented, assign:

35557-00 **[1282]** *Excision of lesion of vagina*

92116-00 **[1900]** *Removal of other device from genital tract*

by following the index pathways:

Excision

- lesion(s)

- - vagina 35557-00 **[1282]**

and

Removal

- device

- - genitourinary NEC 92116-00 **[1900]**


IHACPA

Mesh erosion involving the bladder and/or urethra is considered a more serious complication and it requires various corrective surgeries such as cystoscopy, partial cystectomy, depending on the extent of the erosion. Therefore, appropriate intervention codes should be assigned according to the procedure(s) performed.

NCCC will consider improvements to the classification for excision of mesh for a future edition of ACHI.

Bibliography:

Schorge, JO, Schaffer, JI, Pietz, J, Halvorson, LM, Hoffman, BL, Bradshaw, KD and Cunningham, FG (2008), Williams Gynecology, McGraw-Hill, New York.

U.S Food and Drug Administration (2011), Urogynecologic surgical mesh: Update on the safety and effectiveness of Transvaginal Placement for Pelvic Organ Prolapse, accessed: 13/09/2012, available: http://www.fda.gov/downloads/MedicalDevices/Safety/AlertsandNotices/UCM262760.pdf.

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Ref No: Q2736 | Published On: 15-Dec-2012 | Status: Retired | Retired On: 01-Jul-2017

Conventions used in the Tabular List of Diseases

Could clarification be provided on how to apply the principle of translating medical statements into code, where there are inclusion terms and excludes notes as in the following scenarios:

Q:

Excludes notes - type 1 and type 2

There is an excludes note at K56.1 *Intussusception* that directs the coder to K38.8 *Other specified diseases of appendix* for the condition 'intussusception of appendix', where it is listed as an inclusion term. Can both these codes be assigned in order to translate the medical statement? (refer *Coding Matters*, March 2008 (Volume 14, Number 4))

A:

The instruction in the *Conventions used in the Tabular List of Diseases*, regarding translating medical statements into code, applies primarily to excludes notes and the principles of multiple condition versus single condition coding. The concept of multiple coding outlined in ACS 0001 *Principal Diagnosis* and 0002 *Additional Diagnoses*, highlights common areas where multiple codes are required to reflect multiple concepts such as aetiology and manifestation, specifying infectious and toxic agents, neoplasm morphology etc.

The previous advice regarding 'Intussusception of appendix' in *Coding Matters*, March 2008 (Volume 14, Number 4) *Type 2 Excludes notes* is correct. It highlights that the excludes note at K56.1 *Intussusception* is a 'type 2' excludes note and should be followed ie. you might think 'it' goes here but it doesn't. K38.8 *Other specified diseases of appendix* is the only code required to classify 'intussusception of appendix' and its assignment is supported in the Alphabetic Index. The concept has been classified to K38.8 and there are not multiple concepts to translate.

If the Alphabetic Index is followed correctly, K38.8 is assigned and a coder would not even be aware there is an excludes note at K56.1.

Q:

Postprocedural complications - haemorrhage/haematoma

Code titles for T82.8, T83.8, T84.8 and T85.8 (complications of devices, implants and grafts) do not include haemorrhage and/or haematoma; however 'Haemorrhage due to cardiac and vascular prosthetic devices, implants and grafts' is listed as an inclusion term. Should T81.0 *Haemorrhage and haematoma complicating a procedure, not elsewhere classified* be assigned to translate the medical statement where the wound haematoma meets ACS 0002 and is a complication of a procedure such as insertion of a pacemaker generator? (refer *Coding Matters*, September 2009 (Volume 16, Number 2))

A:

To classify a haemorrhage/haematoma due to or associated with prosthetic implants, devices and grafts assign one of the following codes as appropriate:

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

T83.8 *Other complications of genitourinary prosthetic devices, implants and grafts*

T84.8 *Other complications of internal orthopaedic prosthetic devices, implants and grafts*

T85.81 *Other complications due to nervous system device, implant and graft*

T85.88 *Other complications of internal prosthetic device, implant and graft, NEC*

There doesn't need to be a cause and effect relationship stated between the haemorrhage/haematoma and the device, implant or graft.

Assignment of T81.0 *Haemorrhage and haematoma complicating a procedure, not elsewhere classified* is not correct for a haemorrhage/haematoma complicating the insertion of a prosthetic device as this is a 'not elsewhere classified' code in category T81 *Complications of procedures, not elsewhere classified*.

This is supported by the:

- Alphabetic Index,
- note at T81 which excludes "specified complications classified elsewhere, such as: complications of prosthetic devices, implants and grafts",
- note at T81.0 which excludes "haemorrhage due to or associated with prosthetic devices, implants and grafts"; and
- advice in ACS 1904 *Procedural complications*, which states:

"Where the complication relates to a prosthetic device, implant or graft, such as a cardiac valve, look up the lead term 'Complication(s)' and then by the device (if known and listed) or by the subterm of 'prosthetic device, implant or graft'."

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

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for implementation 01 January 2013.

Ref No: Q2728 | Published On: 15-Dec-2012 | Status: Superseded | Superseded On: 15-Jun-2016 | Superseded By: Q2903

Diagnosis code assignment for admission for insulin pump

Q:

What is the principal diagnosis when a patient with diabetes mellitus and background retinopathy is admitted for connection of an insulin pump?

A:

The NCCC acknowledges there may be inconsistency in practice and published advice regarding the assignment of ‘Z’ codes versus condition code as principal diagnosis. A recent attempt by NCCC to consolidate advice regarding the assignment of ‘Z’ codes as principal or additional diagnoses featured a number of outstanding queries reflecting different scenarios and episodes of care. However the feedback received in response to the discussion paper provided no definitive outcome to the issue for inclusion in Eighth Edition ICD-10-AM, and ongoing evaluation is required to determine changes for a future edition.

In the interim, follow the principles of the coding advice published by the NCCH (2008) which states:

Drug delivery devices

A drug delivery device is a piece of equipment used to administer pharmacological substances. An ambulatory, external infusion pump is a type of drug delivery device that is attached to a vascular access device to infuse substances over long periods. The pump is computerised to allow the administration of a prescribed dose and rate of medication over a defined time period. External drug delivery devices may also be attached to venous catheters (without reservoirs) - for example, a Hickman’s line - or other, nonvascular catheters for administration of pharmacological agents via other routes - for example, for the subcutaneous administration of insulin (via an insulin pump).

.....

Classification

Where patients are admitted for adjustment, management, fitting or removal of a drug delivery device, ... assign:

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

.....

Following these guidelines, the NCCC advises that the correct disease code assignment for admission for insulin pump in a patient with diabetes mellitus is Z45.1 *Adjustment and management of drug delivery device* followed by a code for the diabetes mellitus.

Therefore, for the scenario cited, the correct code assignment is:

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

E1-.31 **Diabetes mellitus with background retinopathy*

Education on the use of the pump is provided to the patient prior to admission. During the admission the pump is initiated and insulin is administered via the pump. Ongoing education is provided and the patient is observed for several hours due to risk of hypoglycaemia or hyperglycaemia and to ensure that the subcutaneous cannula inserted as part of the initiation is correctly sited and patent.

The reason for the admission is the connection of the insulin pump; therefore Z45.1 is assigned as the principal diagnosis code. E1-.31 is assigned as an additional code as per ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia, Rule 1* which states that diabetes mellitus should always be coded.

(See also the advice published in *Coding Matters*, September 2007 (Volume 14, Number 2) for guidelines on the assignment of ACHI codes for insulin pumps).

Reference:

National Centre for Classification in Health (2008): Coding Matters: Vascular Access Devices, Venous Catheters and Drug Delivery Devices, Vol. 15, No. 1.

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for implementation 01 January 2013.

Ref No: Q2792 | Published On: 15-Dec-2012 | Status: Retired | Retired On: 30-Jun-2015

Very Long Chain Acyl-CoA Dehydrogenase (VLCAD) deficiency

Q:

What is the correct code to assign for Very Long Chain Acyl-CoA Dehydrogenase (VLCAD) deficiency?

A:

Very Long Chain Acyl-CoA Dehydrogenase (VLCAD) deficiency is a rare genetic disorder in which the metabolism of long-chain fatty acids is disrupted due to impaired production of VLCAD enzyme, which catalyses the initial step of mitochondrial oxidation of long chain fatty acids.

Clinical advice confirms that VLCAD deficiency clearly fits into the category of disorders of fatty acid metabolism, therefore the correct code assignment is E71.3 *Disorder of fatty-acid metabolism*, following the index pathway:

Disorder

- fatty acid metabolism E71.3

NCCC will consider improvements to the Tabular List and Alphabetic Index for this condition for a future edition of ICD-10-AM.

Bibliography:

National Centre for Biotechnology Information (NCBI), U.S. (2011): *Very Long-Chain Acyl-Coenzyme A Dehydrogenase Deficiency,* accessed: 29 August 2012, available: http://www.ncbi.nlm.nih.gov/books/NBK6816.

Published 15 December 2012,
for implementation 01 January 2013.

Ref No: Q2731 | Published On: 15-Dec-2012 | Status: Retired | Retired On: 30-Jun-2015

Acquired redundant colon

Q:

What is the correct code assignment for acquired redundant colon?

A:

A redundant colon is an anatomical variant and consists of extra loops making it longer than normal. Clinical advice confirms that redundant colon can be congenital or acquired. An **acquired redundant colon** typically occurs in adults over the age of 60 with risk factors such as an enlarged colon and intestinal pseudo obstructions, a bowel blockage caused by nerve or muscle problems affecting the flow of food, liquid and air through the intestines with contributing factors such as constipation, chronic laxative abuse, long standing immobility, dietary deficiencies, toxicity in the colon and the presence of pathogenic organisms.

The appropriate code to assign for acquired redundant colon is K63.8 *Other specified diseases of intestine* following the index pathway:

Deformity

- colon

- - acquired K63.8

Clarification should be sought from the clinician if the documentation does not specify whether it is an acquired or congenital redundant colon.

When clarification from the clinician is not possible, assign Q43.89 *Other specified congenital malformations of intestine* by following the index pathway:

Redundant

- colon (congenital) Q43.89

The NCCC will consider indexing improvements for redundant colon in a future edition of ICD-10-AM.

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for implementation 01 January 2013.

Ref No: Q2759 | Published On: 15-Dec-2012 | Status: Retired | Retired On: 30-Jun-2015

Levator ani syndrome

Q:

What is the correct code to assign for levator ani syndrome? Is levator ani syndrome synonymous with proctalgia fugax?

A:

Clinical advice indicates that levator ani syndrome (LAS) and proctalgia fugax are **not the same condition** although both are associated with anorectal pain, painful spasms of the anus/rectum and both belong to a group of conditions called functional anorectal disorders, which is a subclassification of functional gastrointestinal disorders (Drossman et al. 2006).

Clinical advice confirms that the correct code to assign for levator ani syndrome is K59.4 *Anal spasm*, by following the index pathway:

Spasm(s), spastic, spasticity

- anus, ani (reflex) (sphincter) K59.4

or

Spasm(s), spastic, spasticity

- rectum (sphincter) K59.4

The NCCC will consider improvements to the Alphabetic Index for levator ani syndrome in a future edition of ICD-10-AM.

Reference:

Drossman, DA, Corazziari, E, Delvaux, M, Spiller, RC, Talley, NJ, Thompson, WG and Whitehead, WE (Eds) (2006), *Rome III: The Functional Gastrointestinal Disorders*, 3rd edn, Degnon Associates, Inc., McLean, Virginia.

Published 15 December 2012,
for implementation 01 January 2013.

Ref No: Q2657 | Published On: 15-Dec-2012 | Status: Retired | Retired On: 30-Jun-2015

Removal of testicular implant

Q:

What is the correct code to use for removal of testicular implant (prosthesis)?

A:

Saline filled testicular implants are used in men who suffer testicular absence, agenesis, atrophy, or have had surgery to remove one or both testis(es). The implants are also used in gender realignment surgery. They have been widely shown to reduce the psychological impact from a loss or absence of a testicle. The implant may be removed due to infection, extrusion of the implant or dissatisfaction with the cosmetic appearance.

ACHI does not provide a specific code for the removal of testicular implant/prosthesis. The appropriate code to use is 37604-00 **[1172]** *Exploration of scrotal contents, unilateral* or 37604-01 **[1172]** *Exploration of scrotal contents, bilateral* following the index pathway:

Incision

- scrotum (unilateral) 37604-00 **[1172]**
- - bilateral 37604-01 **[1172]**

NCCC will consider improvements for this procedure for a future edition of ACHI.

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for implementation 01 January 2013.

Ref No: Q2784 | Published On: 15-Dec-2012 | Status: Retired | Retired On: 30-Jun-2015

Choroidal neovascularisation

Q:

What is the correct diagnosis code for choroidal neovascularisation?

A:

Choroidal neovascularisation is a neovascular response to breaks in Bruch's membrane, a deep layer in the retina, resulting in a neovascular membrane forming under the retina (Dr Ralph Higgins, personal communication, September 2012). The new vessels when formed in the macula area of the retina leak fluid and blood leading to scar tissue formation and severe visual loss.

It may occur as an idiopathic entity or in association with wet age related macular degeneration (wet AMD), extreme (high) myopia, ocular trauma, ocular histoplasmosis and inflammatory disease of choroid and retina.

Clinical advice confirms that it is a choroidal disease that secondarily involves the retina once the neovascular membrane has broken through to the retinal layers. The correct diagnosis code for choroidal neovascularisation is H31.8 *Other specified disorders of choroid* following the index pathway:

Disease, diseased

- choroid

- - specified NEC H31.8

NCCC will consider indexing improvements for choroidal neovascularisation in a future edition of ICD-10-AM.

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for implementation 01 January 2013.

Ref No: Q2752 | Published On: 15-Dec-2012 | Status: Retired | Retired On: 30-Jun-2015

Paravertebral or paraspinal neuroblastoma

Q:

What is the correct code assignment for paravertebral and/or paraspinal neuroblastoma?

A:

Neuroblastoma is a solid tumour that begins in primitive nerve cells of the sympathetic nervous system - nerves that run alongside the spinal cord and those in the medulla of the adrenal gland. It is predominantly a childhood cancer and most commonly starts in the adrenal glands and presents in the abdomen. However, tumours can also form in the ganglia near the spine, in the chest, neck or pelvis. The sympathetic nervous system is part of the autonomic nervous system of the body.

Therefore the correct neoplasm code to assign for a paravertebral or paraspinal neuroblastoma is C47.9 *Peripheral nerves and autonomic nervous system, unspecified* following the index pathway for malignant primary site in the *Table of Neoplasms* at:

- spine, spinal (column)

- - nerve (root)

Morphology code M9500/3 *Neuroblastoma, NOS* should also be assigned.

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

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for implementation 01 January 2013.

Ref No: TN445 | Published On: 15-Dec-2012 | Status: Retired | Retired On: 30-Jun-2015

Trichoadenoma

Q:

What is the correct morphology code to assign for Trichoadenoma?

A:

Trichoadenoma is a rare benign follicular tumour, often found on the face or buttock.

ICD-O (International Classification of Diseases for Oncology) does not contain a morphology code for Trichoadenoma and clinical advice confirms that the most appropriate morphology code to assign in this case is M8100/0 *Trichoepithelioma*.

Assign a code for the site of the neoplasm by following the index pathway in the Table of Neoplasms at *Neoplasm, skin, benign*.

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

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for implementation 01 January 2013.

Ref No: Q2695 | Published On: 15-Dec-2012 | Status: Retired | Retired On: 30-Jun-2015

ACS 0604 *Stroke* - Coding of sequelae of CVA with deficits not meeting ACS 0002 *Additional diagnoses*

Q:

In Example 2 in ACS 0604 *Stroke* there is an instruction to code the hemiparesis even though it wasn't treated. How would the hemiparesis meet ACS 0002 if no treatment is given?

A:

NCCC confirms previous advice published by NCCH in *Coding Matters* (2002) which states:

"Patients who have had a previous stroke and are left with residual deficits should have these conditions coded when they meet the criteria for an additional diagnosis (ACS 0002 *Additional diagnoses*)."

Example 2 of ACS 0604 *Stroke*, indicates that an additional code for hemiparesis should be assigned. The example is not explicit about how it meets ACS 0002 *Additional diagnoses*, however, clinical coders should be guided by the advice cited above and make a determination on whether a deficit meets ACS 0002 by review of the entire clinical record.

Example 2 of ACS 0604 will be clarified for a future edition of the Australian Coding Standards.

Reference:

National Centre for Classification in Health (2002), *Coding Matters: 10-AM Commandments*, Vol. 9, No. 2.

Published 15 December 2012,
for implementation 01 January 2013.

Ref No: Q2671 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 30-Jun-2019

Z09 *Follow-up examination after treatment for conditions other than malignant neoplasms*

Q:

Is it appropriate to assign Z09.0 *Follow-up examination after surgery for conditions other than malignant neoplasms* where there has been a previous biopsy? In addition, where there are multiple treatment modalities for a condition and the patient is admitted for follow-up, which code from category Z09 *Follow-up examination after treatment for conditions other than malignant neoplasms* should be assigned?

A:

When assigning Z09.0 *Follow-up examination after surgery for conditions other than malignant neoplasms*, a previous biopsy does not meet the criteria for assignment of this code, as a biopsy is diagnostic and not considered surgical treatment. The correct code to assign from this category for a follow-up examination after multiple treatment modalities (when there is no recurrence of disease) is Z09.7 *Follow-up examination after combined treatment for other conditions*.

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: Q2684 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 30-Jun-2019

Stroke with hemiplegia

Q:

ACS 0604 Stroke, 1. Current, Sequelae (late effects) states:

> "While the patient is receiving continuing treatment, regardless of the period of time elapsed since the stroke, assign a code from categories I60-I64 (cerebrovascular diseases) with any applicable deficit codes (eg hemiplegia)."

Given the above, should a code be assigned for hemiplegia where a patient is admitted for treatment of a stroke but the hemiplegia has resolved prior to admission?

A:

For the scenario cited, the hemiplegia should not be coded as the deficit (hemiplegia) is not an 'applicable' deficit when it has resolved and does not meet the criteria for assignment as per ACS 0002 *Additional diagnoses*.

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for implementation 01 July 2012.

Ref No: Q2714 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 30-Jun-2019

Diabetes mellitus and additional specific codes

Q:

A code is assigned for diabetes mellitus with peripheral vascular disease (PVD) - the PVD does not meet the criteria for ACS 0002 *Additional diagnoses*. If there is more information about the PVD (eg PVD with rest pain), can a specific PVD code be assigned as an additional code (eg I70.22 *Atherosclerosis of arteries of extremities with rest pain*)?

A:

Please refer to ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision. Following ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia, Rule 4b* complications of diabetes classified outside of category E09-E14 are assigned only when that condition meets the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*. Therefore, if the PVD itself does not meet criteria for coding, an additional code to add specificity for PVD should not be assigned.

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: Q2715 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 30-Jun-2019

Diabetes mellitus and macular degeneration

Q:

Should E1-.34 *_Diabetes mellitus with other retinopathy_* be assigned in addition to H35.3 *Degeneration of macula and posterior pole* in a patient with macular degeneration and diabetes mellitus?

A:

The NCCC sought current clinical advice which confirmed that there is no association between diabetes mellitus and macular degeneration. Therefore, assignment of E1-.34 *_Diabetes mellitus with other retinopathy_* following the index entry *Diabetes, with, maculopathy* is not appropriate for macular degeneration with diabetes mellitus.

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for implementation 01 July 2012.

Ref No: Q2715 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 30-Jun-2019

Diabetes mellitus and carpal tunnel syndrome

Q:

Is there further clinical advice regarding the following *Coding Matters* advice (2006, Volume 13, No 3)?

> "The NCCH was asked to clarify whether carpal tunnel syndrome in a patient with diabetes should be assigned E1-.41 *Diabetes Mellitus with diabetic mononeuropathy* as carpal tunnel syndrome can be regarded as a mononeuropathy. Clinical advice received by the NCCH on this issue indicates that it is still under deliberation and no consensus has been achieved.
>
> **Classification**
>
> Therefore, until further clinical advice is received, carpal tunnel syndrome in a patient with diabetes should not be coded to diabetic mononeuropathy."

A:

The NCCC sought current clinical advice which confirmed that there is no association between diabetes mellitus and carpal tunnel syndrome. Therefore, assignment of E1-.41 *Diabetes mellitus with diabetic mononeuropathy* is not appropriate for diabetes mellitus and carpal tunnel syndrome.

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Ref No: Q2701 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 30-Jun-2019

Diabetes mellitus with multiple microvascular complications

Q:

Using ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision, what are the correct codes to assign for the following scenario:

Scenario: Patient admitted for acute kidney failure and also has NIDDM (meeting ACS 0002 *Additional diagnosis*) and retinopathy (not meeting ACS 0002 *Additional diagnosis*).

A:

Please refer to the rules in ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision.In the scenario cited, the correct code assignment applying ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision is:

N17.9 *Acute kidney failure, unspecified*

E11.29 *Type 2 diabetes mellitus with other specified kidney complication*

E11.31 *Type 2 diabetes mellitus with background retinopathy*

E11.71 *Type 2 diabetes mellitus with multiple microvascular and other nonvascular complications*

The acute kidney failure (N17.9) is assigned as the principal diagnosis as it meets ACS 0001 *Principal diagnosis*. The complications of diabetes - acute kidney failure (E11.29) and retinopathy (E11.31) - classified to category E09-E14 are coded to reflect the severity of the diabetes (refer to ACS 0401, *Rule 4a*). The presence of both acute kidney failure and retinopathy qualifies the coding of E11.71 which is sequenced as an additional code (refer to ACS 0401, 4.1 *DM with multiple microvascular and other nonvascular complications*). Retinopathy (H35.0) is not coded as it does not meet ACS 0002 *Additional diagnoses* (refer to ACS 0401, *Rule 4b*).

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for implementation 01 July 2012.

Ref No: TN428 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 30-Jun-2019

ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* workshop FAQs: Diabetic foot

Please refer to ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision.

Q:

With reference to the criteria for coding diabetic foot (ACS 0401, *6. Diabetic foot*) does amputee status meet the criteria at Category 2d when the amputation was due to an injury/trauma not related to diabetes mellitus complications?

A:

Clinical advice confirmed that amputee status of the lower limb, regardless of what caused the amputation, contributes to the criteria for diabetic foot as specified in ACS 0401, *6. Diabetic foot, Category 2d*. This is because prior amputation presents increased risk of contralateral foot lesion (eg ulcer) and other complications (eg excessive loading) associated with diabetic foot.

Q:

With reference to the criteria for coding diabetic foot (ACS 0401, *6. Diabetic foot*) does an ulcer and/or infection of lower limb (not foot) - for example ulcer of calf - meet the criteria at Category 1?

A:

Clinical advice confirmed that the Category 1 of the diabetic foot criteria (ACS 0401, *6. Diabetic foot*) is limited to ulcer and/or infection of the foot region (including heel and toes).

Q:

L97.0 *Ulcer of foot* should not be assigned for foot ulcer in addition to E11.73 *Type 2 diabetes mellitus with foot ulcer due to multiple causes* following ACS 0401, *Rule 6*. However, can L97.8 *Ulcer of lower limb, other sites* or L97.9 *Ulcer of lower limb, unspecified* be assigned for ulcer of lower limb (not foot) in addition to E11.73?

A:

L97.8 *Ulcer of lower limb, other sites* or L97.9 *Ulcer of lower limb, unspecified* may be assigned, in addition to E11.73, for an ulcer of the lower limb (not foot region: foot, heel, toes) if the ulcer meets ACS 0002 *Additional diagnoses* in its own right.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS

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ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* workshop FAQs: Specific examples from 2012 Diabetes Mellitus Workshop Material: *Example 14*

Please refer to ACS 0401 Diabetes mellitus and intermediate hyperglycaemia - 1 July 2012 revision.

Q:

In *Example 14*, why isn't I70.23 *Atherosclerosis of arteries of extremities with ulceration* assigned given that the peripheral vascular disease meets *Rule 4b*?

> "**EXAMPLE 14**
>
> Patient with a history of Type 2 diabetes mellitus, peripheral vascular disease and peripheral neuropathy was admitted for treatment of a left foot ulcer. The foot ulcer was treated with daily dressings. Diabetic educator spoke to the patient in relation to their ongoing insulin medication. The vascular surgeon reviewed the patient's peripheral vascular disease and decided that the patient was unfit for surgery."

A:

The final code assignment for *Example 14* is:

- E11.73 *Type 2 diabetes mellitus with foot ulcer due to multiple causes*
- E11.51 *Type 2 diabetes mellitus with peripheral angiopathy, without gangrene*
- E11.42 *Type 2 diabetes mellitus with diabetic polyneuropathy*
- Z92.22 *Personal history of long term (current) use of other medicaments, insulin*

While the PVD meets *Rule 4b*, I70.23 A*therosclerosis of arteries of extremities with ulceration* is not assigned following *Rule 6*, which instructs that multiple codes should not be assigned when the DM code identifies the elements documented in the diagnosis: the PVD is identified in E11.51 and the ulcer is identified in E11.73.

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Ref No: TN428 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 30-Jun-2019

ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* workshop FAQs: Eradicated conditions and diabetes mellitus

Please refer to ACS 0401 Diabetes mellitus and intermediate hyperglycaemia - 1 July 2012 revision.

Q:

If a patient with diabetes mellitus has had a vascular reconstruction procedure for PVD should a Z code be added to indicate the previous surgery even though the PVD is not eradicated?

A:

ACS 0401, *7. Eradicated conditions and DM* advises that a vascular reconstruction procedure may eradicate a manifestation of peripheral arterial disease, such as an ulcer, but does not eradicate the peripheral arterial disease. DM with peripheral arterial disease should be coded with Z95.8 *Presence of other cardiac and vascular implants and grafts* or Z95.9 *Presence of cardiac and vascular implants and grafts, unspecified* to indicate the status of the previous surgery.

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Ref No: TN428 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 30-Jun-2019

ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* workshop FAQs: Specific examples from 2012 Diabetes Mellitus Workshop Material: *Scenario J*

Please refer to ACS 0401 Diabetes mellitus and intermediate hyperglycaemia - 1 July 2012 revision.

Q:

In Scenario J, could I70.23 Atherosclerosis of arteries of extremities with ulceration be assigned according to Rule 4b?

> "**Scenario J** -
>
> This 67 year old male presented for below knee amputation as treatment of foot ulcer. Also has Type 2 DM with PVD and neuropathy."

A:

The final code assignment for *Scenario J* is:

- E11.73 *Type 2 diabetes mellitus with foot ulcer due to multiple causes*
- E11.51 *Type 2 diabetes mellitus with peripheral angiopathy, without gangrene*
- E11.40 *Type 2 diabetes mellitus with unspecified neuropathy*

Rule 4b specifies that conditions classified outside of category E09-E14 should only be assigned when the condition meets ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*. In *Scenario J*, there is no evidence that PVD met ACS 0001 or ACS 0002, therefore I70.23 *Atherosclerosis of arteries of extremities with ulceration* was not assigned.

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for implementation 01 July 2012.

Ref No: TN428 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 30-Jun-2019

ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* workshop FAQs: Documentation of diabetes mellitus

Please refer to ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision.

Q:

Can you refer to previous admissions to inform code assignment for diabetes mellitus? How far back in the clinical record can you go for information? Do you use past admissions to gather information about complications of DM to assign codes from E1-.7- **Diabetes mellitus with multiple complications*?

A:

The following statement is included in the *Introduction* to the *Australian Coding Standards* (ACS):

“It is assumed that coding decisions are not made solely based on information provided on the clinical record front sheet and/or discharge summary (or a copy of same) but that analysis of the entire clinical record is performed before code assignment.”

Therefore, previous admissions and correspondence can be used to inform assignment of diabetes mellitus codes. However, previous admissions and correspondence should not be used:

- to assign diabetes mellitus if it has not been documented in the current admission.
- to inform the assignment of diabetes mellitus codes which have contributing conditions which may no longer be relevant or where criteria has changed over previous editions of the classification, eg hypertension being used to assign a code for features of insulin resistance.

Q:

Are nurses considered clinicians when it comes to documentation for clinical coding? What documentation is sufficient to warrant coding of DM? Specifically, should a code for DM be assigned by virtue of a nurse checking a ‘tick box’ on a form such as a pre-admission check list?

A:

The *Introduction* to the *Australian Coding Standards, How to use this document* contains the following guideline:

“The term ‘clinician’ is used throughout the document and refers to the treating medical officer but may refer to other clinicians such as midwives, nurses and allied health professionals. In order to assign a code associated with a particular clinician’s documentation, the documented information must be appropriate to the clinician’s discipline.”

The NCCC supports this guideline and maintains that documentation by any clinician can be used to determine conditions that should be coded. However, clinical coders should also be guided by the following from the *Introduction* to the *Australian Coding Standards*:

“If a clinical record is inadequate for complete, accurate coding, the clinical coder should seek more information from the clinician. When a diagnosis is recorded for which there is no supporting documentation in the body of the clinical record, it may be necessary to consult with the clinician before assigning a code.”

While ACS 0401, *Rule 1* specifies that DM should always be coded, general coding and abstraction guidelines should still be followed.

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for implementation 01 July 2012.

Ref No: TN428 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 30-Jun-2019

ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* workshop FAQs: Diabetes mellitus and day only admissions

Please refer to ACS 0401 Diabetes mellitus and intermediate hyperglycaemia - 1 July 2012 revision.

Q:

Does diabetes mellitus have to be coded for day only admissions, in particular day only dialysis admissions?

A:

There is no exception to the rule that diabetes mellitus should be coded when documented. Therefore, diabetes mellitus should be coded when documented in same day admissions.

Dialysis admissions

The issue of whether to code diabetes, or any other additional diagnosis, when dialysis episode coding is autogenerated is unique. The following advice was published in Coding Matters, September 2008:

Q:

In day only dialysis admissions, should codes be assigned for any additional diagnoses, eg CKD, diabetes etc?

A:

As most day only dialysis admissions are autogenerated, it is difficult to assign additional diagnosis codes when the full record is not available at the time of the coding process. Therefore, for day only admissions for dialysis, only assign Z49.1 *Extracorporeal dialysis* for extracorporeal dialysis or Z49.2 *Other dialysis* for peritoneal dialysis together with the appropriate procedure code. Additional diagnosis codes should only be assigned if the conditions meet ACS 0002 *Additional diagnoses*."
(Coding Matters, Volume 15, Number 2, September 2008)

Further to the Coding Matters advice above, ACS 0001 *Principal diagnosis, Problems and underlying conditions* states:

"If a patient presents with a problem, and the underlying condition is known at the time of admission, and only the problem is being treated, then the problem should be assigned as the principal diagnosis code. The underlying condition should be sequenced as an additional diagnosis code."

Therefore, it is more accurate to state:

"... Additional diagnosis codes should be assigned if the conditions meet the criteria for code assignment as per the guidelines in ACS 0001 *Principal diagnosis, Problems and underlying conditions* or ACS 0002 *Additional diagnoses*".

However, as most day only dialysis admissions are coded using autogenerated software, it is difficult to assign additional diagnosis codes for specific patients. In addition the full record is not always available at the time of the patient's admission to inform the coding process. The NCCC recognises these system issues and accepts, for now, that it will not be possible for many hospitals to comply with ACS 0001 *Principal diagnosis, Problems and underlying conditions* and ACS 0002 *Additional diagnoses* for these episodes.

This advice supersedes the previous advice published in Coding Matters, September 2008 (Volume 15, Number 2), Day only admissions and additional diagnoses, which will be retired on 30 June 2012.

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Ref No: TN428 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 30-Jun-2019

ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* workshop FAQs: Diabetes mellitus with features of insulin resistance

Please refer to ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision.

Q:

If a patient previously had conditions (such as obesity or characteristic dyslipidaemia) which qualified them for assignment of E1-.72 **Diabetes mellitus with features of insulin resistance* but in a more recent episode of care no longer has those qualifying conditions (because they are no longer obese or their dyslipidaemia is controlled by medication) do they still qualify for the assignment of E1-.72 **Diabetes mellitus with features of insulin resistance*?

A:

Clinical advice confirmed that if conditions which previously contributed to the assignment of E1-.72 **Diabetes mellitus with features of insulin resistance* (such as obesity or characteristic dyslipidaemia) are no longer current, then these conditions should no longer be considered as contributing to the criteria for assignment of E1-.72 **Diabetes mellitus with features of insulin resistance*.

Q:

Can test results alone be used to identify characteristic dyslipidaemia in order to assign E1-.72 **Diabetes mellitus with features of insulin resistance*?

A:

No, test results alone cannot be used to identify elevated fasting triglycerides or depressed HDL-cholesterol, as per the guidelines in ACS 0010 *General abstraction guidelines, Test results*. The following guidelines which are also represented in ACS 0401, *3. DM and IH with features of insulin resistance* and ACS 0401, *Figure 1* should be followed in order to identify “characteristic dyslipidaemia”:

1. if there is clinician documentation of “dyslipidaemia/hypercholesterolaemia/high cholesterol/ hyperlipidaemia”, then seek confirmation that levels of either “elevated fasting triglycerides” (=1.7 mmol/L) or “depressed HDL-cholesterol” (male =1.03, female =1.29) meet the required values for characteristic dyslipidaemia in order to assign E1-.72 **Diabetes mellitus with features of insulin resistance.*

2. if there is NO clinician documentation of dyslipidaemia/hypercholesterolaemia/high cholesterol/ hyperlipidaemia, then clinician documentation of both “elevated fasting triglycerides” (=1.7 mmol/L) and “depressed HDL-cholesterol” (male =1.03, female =1.29) is required - test results can only be used to confirm the levels meet the required values for characteristic dyslipidaemia in order to assign E1-.72 **Diabetes mellitus with features of insulin resistance.*

Q:

Are there specific diagnostic criteria for characteristic dyslipidaemia for the Indigenous Australian population?

A:

Clinical advice confirmed that there are no population specific criteria for characteristic dyslipidaemia for use in Australia.

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: TN428 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 30-Jun-2019

ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* workshop FAQs: Gestational diabetes mellitus (GDM)

Please refer to ACS 0401 Diabetes mellitus and intermediate hyperglycaemia - 1 July 2012 revision.

Q:

This advice has been deleted from ACS 0401 - 1 July 2012:

> "Gestational diabetes may recur in a subsequent pregnancy and when this occurs, assign a code for gestational diabetes, with Z87.5 Personal history of complications of pregnancy, childbirth and the puerperium." *(Source, ACS 0401, Seventh Edition, 1 July 2010, Gestational diabetes mellitus)*

Is the advice still valid?

A:

This advice was removed from ACS 0401 to standardise the assignment of Z87.5 Personal history of complications of pregnancy, childbirth and the puerperium in line with ACS 2112 Personal history. Z87.5 Personal history of complications of pregnancy, childbirth and the puerperium should only be assigned according to the guidelines in ACS 2112 Personal history.See also ACS 0401, 2. Specific classification principles for DM and IH, DM and IH in pregnancy, childbirth and the puerperium.

This advice has a minor modification to correspond with an update in a subsequent edition ofICD-10-AM/ACHI/ACS.

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for implementation 01 July 2012.

Ref No: TN448 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 01-Jul-2017

Influenza A (H3N2)

Q:

What is the correct code to assign for influenza A (H3N2)?

A:

To classify influenza type A (H3N2) assign the appropriate code from category J10 *Influenza due to other identified influenza virus*. J09 *Influenza due to identified avian influenza virus* (which is to be renamed *Influenza due to certain identified influenza virus* for ICD-10-AM Eighth Edition) should not be assigned for influenza type A (H3N2). Previous advice from NCCH (2010, p. 9) instructed that this code should only be assigned for influenza virus types A (H1N1) (swine flu) and (H5N1) (avian influenza) and that additional virus strains may only be classified to this code upon recommendation from WHO. At this time WHO has not recommended this code be assigned for influenza type A (H3N2).For more information see http://www.who.int/influenza/surveillance_monitoring/updates/en/.

Reference:

National Centre for Classification in Health 2010, *Coding Matters: Swine flu with pneumonia*, Vol. 17, No. 1, p. 9.

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: Q2678 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 01-Jul-2017

Coding a resuscitation intervention with cardiac arrest

Q:

If patient has a cardiac arrest and resuscitation is performed should procedure codes for nonmechanical or cardiopulmonary resuscitation be assigned?

A:

The NCCC advises that procedure codes for nonmechanical or cardiopulmonary resuscitation performed after cardiac arrest should not be assigned as per the principle in ACS 0016 *General procedure guidelines* which states:

> "Many procedures may meet the above AIHW definition of a clinical intervention but if they are routine in the treatment of the diagnosis being coded, it may not be necessary to code them. For example, many nursing procedures may require 'specialised training' but these procedures are not coded."

The NCCC will consider adding 92042-00 **[1889]** *Nonmechanical methods of resuscitation* and 92052-00 **[1890]** *Cardiopulmonary resuscitation* to ACS 0042 *Procedures normally not coded* for a future edition of the ACS.

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: Q2727 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 01-Jul-2017

Spinal dural tear during spinal surgery

Q:

What is the correct code assignment for a spinal dural tear during spinal surgery?

A:

The appropriate codes to assign for a dural tear occurring during spinal surgery are:

T81.2 *Accidental puncture and laceration during a procedure, not elsewhere classified*

T09.3 *Injury of spinal cord, level unspecified* (following the index pathway: *Laceration, meninges, spinal*)

Y60.0 *Unintentional cut, puncture, perforation or haemorrhage during surgical operation*

Y92.22 *Health service area*

Where damage to the nerve roots is documented, an appropriate injury code should be assigned following the index pathway: *Injury, nerve, spinal, root*.

Code also any associated cerebrospinal fluid leak from the spinal puncture.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: Q2783 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 01-Jul-2017

Administration of Anti-D

Q:

Is it appropriate to assign Z29.1 *Prophylactic immunotherapy* and 92173-00 **[1884]** *Passive immunisation with Rh(D) immunoglobulin* for administration of Anti-D in admissions where the obstetric patient is Rhesus negative?

A:

Anti-D is usually produced from the plasma of selected Rhesus (D) negative donors. It is administered to obstetric patients who are Rhesus (D) negative to prevent their babies from developing haemolytic disease of the newborn. If an obstetric patient requires injection of Anti-D during an admission, assign Z29.1 *Prophylactic immunotherapy* and 92173-00 **[1884]** *Passive immunisation with Rh(D) immunoglobulin*.

This is consistent with advice previously published by NCCH. ACS 0302 *Blood transfusions* and advice relating to the assignment of codes from block **[1893]** *Administration of blood and blood products* and block **[1884]** *Immunisation* has been flagged for review in a future edition.

This advice supersedes the previous advice published in Coding Q&A, April 2011 for *Administration of Anti-D* which will be retired on 30 June 2012.

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: Q2741 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 30-Jun-2015

Interposition graft of femoro-popliteal graft

Q:

What is the correct code to assign for a reoperation of a femoro-popliteal bypass graft involving the removal of a stenosed section of the bypass vessel and replacement with a new piece of graft, or 'interposition graft', using saphenous vein harvested from the same leg?

A:

An interposition graft of a femoro-popliteal bypass graft in the scenario cited refers to the removal and replacement of a stenosed segment of a femoro-popliteal bypass graft using harvested saphenous vein graft. Assign the appropriate procedure code by following the index pathway:

Bypass

- arterial

- - with

- - - vein

- - - - femoro-popliteal (below knee anastomosis) 32742-00 **[711]**

- - - - - above knee anastomosis 32739-00 **[711]**

In addition, assign 35202-00 **[763]** *Access for reoperation of arteries or veins of neck, abdomen or limb* to indicate the procedure is a reoperation following previous surgery on the vessels, using the index pathways:

Access, accessing

- for reoperation of artery or vein

- - limb 35202-00 **[763]**

or

Reoperation

- vein

- - limb 35202-00 **[763]**

Improvements to the Tabular List for the reoperation code will be considered for a future edition of ACHI.

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: Q2714 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 30-Jun-2015

Diabetes mellitus and chronic kidney disease

Q:

If E1-.22 **Diabetes mellitus with established diabetic nephropathy* is assigned should a code from category N18.- *Chronic kidney disease* also be assigned (following the *Use additional code* instruction at E1-.22) if the chronic kidney disease itself does not meet ACS 0002 *Additional diagnoses*?

A:

Please refer to ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision.

When E1-.22 **Diabetes mellitus with established diabetic nephropathy* is assigned, the instruction *Use additional code to identify the presence of chronic kidney disease (N18.-)* should be followed. The chronic kidney disease should be documented but does not have to meet ACS 0002 *Additional diagnoses*.

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: Q2716 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 30-Jun-2015

Diabetic foot not documented as the principal diagnosis or reason for admission

Q:

When the criteria for diabetic foot are met, yet diabetic foot is not documented as the principal diagnosis or reason for admission, how should the codes E1-.73 and the additional codes for the specific complications be sequenced?

A:

Please refer to the rules in ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision.

When the criteria for coding diabetic foot are met (as specified in ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision), codes should be sequenced according to ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*.

If the criteria for diabetic foot is met and the 'diabetic foot' diagnosis itself meets ACS 0001 *Principal diagnosis*, assign E1-.73 **Diabetes with foot ulcer due to multiple causes* first followed by any codes for the specific complications assigned according to ACS 0401, *Rule 4a* and *Rule 4b*.

If the criteria for diabetic foot are met, but the 'diabetic foot' diagnosis itself does not meet ACS 0001 *Principal diagnosis*, then assign E1-.73 **Diabetes with foot ulcer due to multiple causes* as an additional diagnosis.

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: Q2693 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 30-Jun-2015

CVA deficit of facial droop

Q:

What code should be assigned for facial droop following a stroke?

A:

Facial ‘droop’ following a stroke is paralysis of one side of the face, and is also referred to as facial hemiplegia. ICD-10 does not have a specific code for ‘facial droop/hemiplegia’, therefore assign a code from category G81 *Hemiplegia* as appropriate.

NCCC will consider a more specific classification of facial hemiplegia for a future edition of ICD-10-AM.

Reference:

Stedman’s Medical Dictionary, 2006, 28th edn, Lippincott Williams & Wilkins

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: TN409 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 30-Jun-2013

Fat graft in spinal surgery

Q:

Should an additional procedure code be assigned to classify fat graft performed during spinal surgery?

A:

Small fat grafts are commonly used in various spinal surgeries, in theory, to prevent adhesion between the dura and the overlying muscle. Although in some instances, a large fat graft is used to seal dural tears or to repair postoperative cerebrospinal fluid leaks. Small fat grafts are usually harvested locally without additional incisions. However, for a larger graft, the fat may be obtained from the lateral thigh or abdominal wall. Clinical advice confirms that fat grafts are usually a minor component of spinal surgery, therefore it is not necessary to assign an additional code to specify the graft.

This is also consistent with ACS 0016 *General procedure guidelines, Procedure components* which states “Do not code procedures which are individual components of another procedure”.

To classify larger fat grafts where fat is harvested from a separate site, assign 45018-04 **[1666]** *Procurement of fat for graft via separate incision*. This is consistent with the assignment of fat grafts in block 23 *Cranioplasty*.Amendments to the Tabular List have been incorporated in ACHI Eighth Edition to reflect this advice.

Reference:

Perry, B (2000), Cerebrospinal fluid leaks following spinal or posterior fossa surgery: use of fat grafts for prevention and repair, accessed: 11 April 2012, available:http://www.medscape.com/viewarticle/405621_3.

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: Q2756 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 30-Jun-2013

Diabetes mellitus and fixed or persistent proteinuria

Q:

What is the correct code assignment for diabetes mellitus with fixed or persistent proteinuria?

A:

Please refer to the rules in ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision.

Where diabetes mellitus with fixed or persistent proteinuria is documented, the correct codes to assign are:

E1-.22 **Diabetes mellitus with established diabetic nephropathy*

N39.1 *Persistent proteinuria, unspecified*

Follow the index pathway *Diabetes, with, proteinuria, fixed* or *Diabetes, with, proteinuria, persistent* to assign

E1-.22 (ACS 0401, *Rule 1* and *Rule 3*).

N39.1 *Persistent proteinuria, unspecified* is assigned in accordance with ACS 0401, *Rule 4b*.

Follow the code also instruction at E1-.22 to assign a code for chronic kidney disease (N18.-) only if chronic kidney disease is documented (see also ACS 1438 *Chronic kidney disease*).

Note: The NCCC sought clinical advice regarding the classification of 'fixed' proteinuria, given that 'fixed' is not specified in the Index under the lead term *Proteinuria*. Clinicians' advice indicated that while the term 'fixed proteinuria' was not in common use, it should be classified to N39.1 *Persistent proteinuria, unspecified*.

The NCCC will add an index entry for *Proteinuria, fixed* in ICD-10-AM Eighth Edition.

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: Q2662 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 30-Jun-2013

Condition onset flag for conditions occurring while patient is on leave

Q:

Is the following advice published in *Coding Matters*, June 2010 (Volume 17, Number 1) correct?:

> "**Condition onset flag for conditions occurring while patient is on leave Q. 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**
>
> **.A.**
>
> 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 '1' assigned."

A:

The Australian Institute of Health Welfare (AIHW) defines an admitted episode of patient care (METeOR identifier 268956) as:

> "The period of admitted patient care between a formal or statistical admission and a formal or statistical **separation**, characterised by only one care type. This treatment and/or care provided to a patient during an episode of care can occur in hospital and/or in the person's home (for **hospital-in-the-home** patients)"

AIHW further defines a leave period (METeOR identifier 327156) as:

> "Leave period is a temporary absence from hospital, with medical approval for a period no greater than seven consecutive days."

These definitions support the previously published advice quoted below:

> "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 '1' assigned."

In addition the NCCC also sought confirmation from The Australian Commission on Safety and Quality in Health Care (ACSQHC) regarding the previously published advice above. ACSQHC works in partnership with AIHW to facilitate an informative and functional national system of information that enhances the safety and quality of health care. ACSQHC endorsed this advice on the basis that an episode of admitted patient care should include all periods where the patient is under the responsibility of the health care provider.

This includes periods of authorised leave and hospital in the home. However, it does not include periods of unauthorised leave where the health care provider is not responsible for the patient.


IHACPA

A primary purpose of the condition onset flag (COF) is to provide insight into conditions which arise during the episode of care to facilitate review of trends and patterns of complications, with a view to informing prevention strategies. It is not necessarily indicative of an error arising in hospital. Therefore, it is important to identify conditions which arise while a patient is on authorised leave to determine if they are preventable in the future.

It should also be noted that linking the COF to specific codes such as the ICD-10-AM external cause of morbidity and mortality code Y92.22 *Health service area* does not necessarily indicate error. For example, Y92.22 is often applicable in subsequent admissions for treatment of complications of previous admissions or where a patient is transferred from another hospital to treat a postoperative complication. A COF of 2 is correct against Y92.22 in these scenarios.

ACS 0048 *Condition onset flag* is currently under review for Eighth Edition and will include this advice.

This advice supersedes advice published in *Coding Matters*, June 2010 (Volume 17, Number 1), *Condition onset flag for conditions occurring while patient is on leave*, which will be retired from 30 June 2012.

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for implementation 01 July 2012.

Ref No: Q2704 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 30-Jun-2013

Osteophyte, facet joint

Q:

What code should be assigned for an osteophyte of the facet joint? The Index assigns M25.7- *Osteophyte*. However, there is a note in the Tabular List at M20-M25 which "*Excludes*: joints of the spine (M40-M54)".

A:

An osteophyte is the formation of a smooth bony outgrowth or spur which can occur in various bony sites, including the facet joints of the vertebrae. In the facet joints, osteophyte formation is the body's response to the degeneration of the cartilage lining of the joints as part of the normal wear and tear of the spine due to ageing and the disease process of osteoarthritis.

Clinical advice confirmed that osteophyte of facet joint should be classified to category M47 *Spondylosis* not M25.7- *Osteophyte*.

This is supported in the classification where the note ("*Excludes*: joints of the spine (M40-M54)") at category M20-M25 *Other joint disorders* applies to all codes in that range and indicates that disorders of spinal joints are classified to category M40-M54 *Dorsopathies*.

Therefore, to correctly classify osteophyte of the facet joint, use the lead term ***Osteoarthritis***, follow the "see also" reference to ***Spondylosis*** and select the appropriate code under this lead term.

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

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: Q2765 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 30-Jun-2013

Succinic semialdehyde dehydrogenase (SSADH) deficiency

Q:

What is the correct code to assign for succinic semialdehyde dehydrogenase (SSADH) deficiency?

A:

Succinic semialdehyde dehydrogenase (SSADH) deficiency is a rare disease that is inherited as an autosomal recessive trait in which the metabolism of gamma-aminobutyric acid (GABA) is disrupted.

SSADH deficiency leads to various neurological and neuromuscular disorders including mild to severe mental retardation, psychomotor retardation, and delays in language and speech development. Initial findings may include hypotonia, ataxia, and episodes of uncontrolled seizures. SSADH deficiency affects males and females in equal numbers with approximately 350 cases being diagnosed throughout the world. A diagnosis of SSADH deficiency is made based upon urine organic profiling or blood amino acid analysis.

NCCC agrees with the suggested code of E72.8 *Other specified disorders of amino-acid metabolism*, following the index pathway:

Disorder (of)

- metabolism NEC

- - amino-acid NEC

- - - specified NEC E72.8

Or

Disorder (of)

- amino-acid

- - metabolism NEC

- - - specified NEC E72.8

Bibliography:

National Organisation for Rare Diseases (NORD) (2012), *Succinic Semialdehyde Dehydrogenase Deficiency*, accessed: 12/6/12, available: http://www.rarediseases.org/rare-disease-information/rare-diseases Pediatric Neurotransmitter Disease Association (PND) (2007), *What is Succinic Semialdehyde Dehydrogenase Deficiency?*, accessed: 12/6/12, available: http://www.pndassoc.org/site/c.iuLWJdMRKpH/b.856323/k.E8FA/Succinic_Semialdehyde_Dehydrogenase_Deficiency_SSADH.htm

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: Q2780 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 30-Jun-2013

Vaginal vault suspension

Q:

Can you please advise what code should be assigned when a vaginal vault suspension (also documented as 'uterosacral vault suspension') is performed vaginally?

A:

Prolapse of the vaginal vault is caused by a weakening of the support structures in the pelvic region including muscles, ligaments and fascia. It can occur following a hysterectomy or with the uterus in place. Vaginal vault suspension procedures, or colpopexies, can be divided into abdominal, laparoscopic and vaginal approaches.

There are a variety of vaginal approach procedures involving fixation to various aspects of the pelvis such as the uterosacral, iliococcygeus and sacrospinous ligaments. Sacrospinous ligament suspension is one of the most commonly performed vaginal approach procedures.

The correct code to assign for a vaginal vault suspension performed vaginally is 35568-00 **[1285]** *Sacrospinous colpopexy* following the index pathway:

Colpopexy

- sacrospinous 35568-00 **[1285]**

or

Repair

- vagina NEC

- - by sacrospinous colpopexy 35568-00 **[1285]**

The NCCC will consider improvements to the code assignment for these procedures for a future edition of ACHI.

Bibliography:

Davila, G 2011, *Vaginal Vault Suspension*, Medscape Reference, accessed 21/05/12 http://emedicine.medscape.com/article/1848619-overview#a01, Lentz, G, Lobo, R, Gershenson, D and Katz, V 2012, *Comprehensive Gynaecology*, 6th edn, Elsevier Mosby, Philadelphia.

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: Q2670 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 30-Jun-2013

Excisional biopsy

Q:

When an excisional biopsy is performed should this procedure be coded to excision of lesion or biopsy?

A:

An excisional biopsy is the total removal of a lesion for examination and is most often used to diagnose skin lesions. The major advantage of excisional biopsy is that it provides the pathologist with the entire lesion and minimises the chance that a cancer in part of the lesion would be missed. In contrast, an incisional biopsy involves removal of only a portion of the lesion for pathological examination and is used when the size or location of the tumour prohibits its complete excision. This technique is also used when a needle biopsy does not provide adequate information for a diagnosis to be made.

Therefore, when an excisional biopsy is performed select the appropriate code under the lead term *Excision*.

The NCCC will consider improvements to the Alphabetic Index for this procedure for a future edition of ACHI.

Reference:

Britannica Online Academic Edition, *Biopsy*, accessed 18/4/2012, http://www.britannica.com/

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: Q2726 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 30-Jun-2013

Musculoskeletal chest pain

Q:

What is the correct code to assign for musculoskeletal chest pain? Other index entries of similar type chest pain eg. *Pain, rib* and *Pain, anterior wall* are coded to R07.3 *Other chest pain*.

A:

The correct code assignment for musculoskeletal chest pain is R07.3 *Other chest pain*, by following the index pathway:

Pain(s)

- chest

- - specified NEC R07.3

This is consistent with other international classifications.

The NCCC will consider improvements to the Alphabetic Index for *musculoskeletal chest pain* for a future edition of ICD-10-AM.

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: Q2729 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 30-Jun-2013

Haglund's deformity

Q:

According to research Haglund's deformity can also be an acquired condition (pump bump) yet ICD-10-AM only provides a code for Haglund's osteochondrosis (juvenile). When a patient is admitted with an acquired Haglund's deformity is it correct to assign M21.67 *Other acquired deformities of ankle and foot* via the index entry *Deformity, ankle (acquired)*?

A:

The term 'Haglund's' is used to describe two different conditions:

- Haglund's osteochondrosis, or juvenile os tibiale externum osteochondrosis, is an abnormal growth at the inner aspect of the foot, on or near the navicular bone.
- Haglund's deformity, also known as Haglund's disease, disorder or syndrome, is an acquired condition in which there is a painful bony enlargement of the posterior heel, with or without bursitis.

The condition is also referred to as 'pump bump' as it is caused by repetitive impingement of the retrocalcaneal bursa, often due to pressure from the backs of pump style shoes.

For this reason it commonly occurs at the end of the second or third decade, mainly in females and is often bilateral.

However the condition may occur in both sexes and at any age.

ICD-10 classifies Haglund's osteochondrosis to M92.6 *Juvenile osteochondrosis of tarsus* but does not classify acquired Haglund's deformity. The NCCC agrees that the correct code to assign for acquired Haglund's deformity is M21.67 *Other acquired deformities of ankle and foot*. The following index pathway should be used:

Deformity

- heel (acquired) M21.67

The NCCC will consider improvements to the Alphabetic Index and Tabular List for this condition in a future edition of ICD-10-AM.

Bibliography:

American College of Foot and Ankle Surgeons (2009), *Foot Health Facts*, accessed: 3/5/12, available: http://www.foothealthfacts.org/footankleinfo/haglunds-deformity.htm van Sterkenburg, MN, de Leeuw, PA and van Dijk, CN (2011), 'Endoscopic calcaneoplasty', *Minimally Invasive Surgery of the Foot and Ankle*, vol.4, pp.299-313.

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: Q2675 | Published On: 15-Jun-2012 | Status: Retired | Retired On: 30-Jun-2013

Blue rubber bleb naevus syndrome

Q:

What is the correct code to assign for blue rubber bleb naevus syndrome (BRBNS)?

A:

Blue rubber bleb naevus syndrome (BRBNS) also referred to as Bean syndrome, is a rare congenital disorder commonly characterised by cutaneous and gastrointestinal venous malformations, however lesions have also been known to occur in other body organs.

Clinical advice confirmed that BRBNS is a venous malformation not a vascular tumour, therefore the correct code assignment is:

Q27.8 *Other specified congenital malformations of peripheral vascular system*

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

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: Q2692 | Published On: 15-Dec-2011 | Status: Retired | Retired On: 30-Jun-2019

Recurrence of transitional cell carcinoma (TCC) of the bladder

Q:

When a previously resected TCC of the anterior wall of the bladder represents with a recurrence in the dome of the bladder, what is the correct neoplasm code to assign? Following ACS 0237 *Recurrence of malignancy* would you assign C67.3 *Malignant neoplasm of anterior wall of bladder* or C67.1 *Malignant neoplasm dome of bladder* as the principal diagnosis?

A:

ACS 0237 *Recurrence of malignancy* states:

> *"If the primary malignancy previously eradicated has recurred, assign a code for the original primary site using the appropriate code from C00-C75. Code also any secondary sites mentioned."*

Clinical advice also confirms that, for the scenario cited, this is usually considered a recurrence of the primary bladder tumour and not as two primary invasive bladder tumours or a secondary tumour. Therefore, the correct code to assign in this scenario is C67.3 *Malignant neoplasm of the anterior wall of the bladder*.

However, if there is any uncertainty concerning code assignment then confirmation should be sought from the clinician, as per the guidelines in ACS 0010 *General abstraction guidelines*.

Published 15 December 2011,
for implementation 01 January 2012.

Ref No: Q3005 | Published On: 15-Dec-2011 | Status: Retired | Retired On: 30-Jun-2019

Morphology codes

Q:

Does the sentence in ACS 0233 *Morphology* - “If a morphological diagnosis contains two histological terms which have different M codes, select the highest number as it is usually more specific” apply to a morphological diagnosis from one biopsy or two biopsies taken at different times for a recurrent tumour?

A:

The statement cited in the question above applies to one histological sample which describes a neoplasm using more than one histological term for which there are separate morphology codes. It does not apply to multiple histological diagnoses from different timeframes or different episodes of care, even if in reference to the same tumour.

Published 15 December 2011,
for implementation 01 January 2012.

Ref No: Q2653 | Published On: 15-Dec-2011 | Status: Retired | Retired On: 01-Jul-2017

Intervention code for spontaneous vertex delivery

Q:

Should 90467-00 **[1336]** *Spontaneous vertex delivery* be assigned when this is the only procedure that occurs in a delivery episode?

A:

The NCCC has considered this issue at length and confirms that the advice published in Coding Matters October 1998, Vol. 5, No. 2 is no longer applicable. The advice stated “the assignment of 90467-00 **[1336]** *Spontaneous vertex delivery* duplicates the diagnosis code O80 and need not be used with this code.

“In Seventh Edition, the concept within O80 *Single spontaneous delivery* was broadened to include single spontaneous breech delivery.

Consequently assigning 90467-00 **[1336]** can no longer be considered duplication of O80, therefore, the assignment of 90467-00 **[1336]** *Spontaneous vertex delivery* is optional as directed by jurisdictional coding guidelines.

NCCC will consider improvements for spontaneous vertex delivery in a future edition of ICD-10-AM and ACS.

Published 15 December 2011,
for implementation 01 January 2012.

Ref No: Q2638 | Published On: 15-Dec-2011 | Status: Retired | Retired On: 01-Jul-2017

Diabetes mellitus with peripheral vascular disease

Q:

Can chronic venous insufficiency, and/or varicose veins with diabetes mellitus be coded to diabetes mellitus with peripheral vascular disease (E1-.51 or E1-.52)?

A:

While it can be argued that peripheral vascular disease (PVD) is definitionally inclusive of varicose veins and chronic venous insufficiency, these conditions with diabetes mellitus should not be classified to diabetes mellitus with peripheral vascular disease (E1-.51 or E1-.52). Clinical advice states that categories E1-.5- are intended for **arterial** complications of diabetes mellitus.

The NCCC will consider indexing improvements for chronic venous insufficiency, and/or varicose veins with diabetes mellitus in a future edition of ICD-10-AM.

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for implementation 01 January 2012.

Ref No: TN262 | Published On: 15-Dec-2011 | Status: Superseded | Superseded On: 15-Jun-2016 | Superseded By: Q2953

High flow nasal cannula

Q:

What is the correct code to assign for high flow nasal cannula?

A:

High flow nasal cannula (HFNC), more commonly referred to as 'High flow' is a novel means of respiratory support, introduced as an alternative to noninvasive ventilation (NIV) as it delivers air and oxygen at flow rates greater than those traditionally used with a nasal interface (Groves & Tobin, 2007; Shoemaker et al. 2007). HFNC is more than simple oxygen enrichment as it involves the administration of ventilatory support (Australia and New Zealand Intensive Care Society, 2011, personal communication). HFNC allows sufficient warmth and high levels of humidification to breathing gas and permits higher flow rates from nasal cannula devices to be applied to patients (Dysart et al., 2009). This form of respiratory support is generally referred to as high flow therapy (HFT) (Dysart et al., 2009). Clinical advice from the Australian and New Zealand Neonatal Network and published literature defines HFNC as the administration of (heated and humidified) oxygen or blended oxygen and air via nasal cannula at flow rates of >1L/min (A/Prof Peter Marshall, personal communication, 2011; Wilkinson et al. 2011). HFNC is used on patients ranging in ages from preterm infants to adults who receive flow rates ranging from 2-40L/min for respiratory support in a variety of conditions (Dysart et al., 2009).

Uses of HFNC:

- **Newborns:** management of respiratory distress or apnoea and weaning from invasive forms of respiratory support.
- **Paediatrics:** used in typical situations that might have otherwise required intubation or CPAP. Diseases such as viral bronchiolitis, bacterial pneumonia and reactive airway disease are being treated with HFNC.
- **Adults:** used in a variety of clinical care settings and benefits patients suffering from respiratory diseases such as type 1 (hypoxic) respiratory failure, pulmonary oedema, chronic obstructive pulmonary disease (COPD) and acute respiratory distress syndrome (ARDS) (Australian and New Zealand Intensive Care Society, 2011; Dysart et al., 2009; Thoracic Society of Australia and New Zealand, 2011).

HFNC should be identified by the clinician as a specific respiratory therapy and administered via intranasal prongs at:

- 1L / minute or more for neonates (generally 2-7 L/ min)
- 4L / min or more for infants and young children (generally 4-12L/min)
- 20-40L / min for adults (generally 30L/min)

(A/Prof Peter Marshall, personal communication, 2011; Australia and New Zealand Intensive Care Society, personal communication, 2011)

When 'high flow', high flow therapy or high flow nasal cannula is documented in the clinical record, assign a code from block 570 *Noninvasive ventilatory* support following the index pathways:

Management (of)

- airway

- - with ventilatory support -- see Management, ventilatory support

...

- ventilatory support (nonintubated) – *see block* **[570]**

Ventilation

- noninvasive

- - mask ventilation (NIMV) -- see block **[570]**

- - pressure ventilation (NIPV) -- see block **[570]**

NCCC will consider indexing improvements for a future edition of ACHI.

References:

Dysart, K, Miller, TL, Wolfson, MR and Shaffer, TH (2009), Research in high flow therapy: Mechanisms of action, Respiratory Medcine, Vol. 103, No. 10, pp. 1400-1405. Groves, N and Tobin, A (2007), High flow nasal oxygen generates positive airway pressure in adult volunteers, Australian Critical Care, Vol. 20, pp. 126-131. Shoemaker, MT, Pierce, MR, Yoder, BA and DiGeronimo, RJ (2007), High flow nasal cannula versus nasal CPAP for neonatal respiratory disease: a retrospective study, Journal of Perinatology Vol. 27, pp. 85-91. Wilkinson, DJC, Andersen, CC and Holberton, J (2008), Should High Flow Nasal Cannula Be Used For Respiratory Support In Preterm Infants?, Neonatalogy Today, Vol. 3, No. 8, pp. 1-5.

Published 15 December 2011,
for implementation 01 January 2012.

Ref No: Q2745 | Published On: 15-Dec-2011 | Status: Retired | Retired On: 30-Jun-2015

Hypertension due to acute kidney disease

Q:

Can I15.0 *Renovascular hypertension* and I15.1 *Hypertension secondary to other kidney disorders* be caused by acute kidney disease? When can I15.0 and I15.1 be assigned?

A:

Hypertension can arise due to acute kidney disease, therefore I15.0 *Renovascular hypertension* and I15.1 *Hypertension secondary to other kidney disorders* can be assigned as per the guidelines in ACS 0925 *Hypertension and related conditions* which states, “Assign these codes when hypertension is stated to be ‘due to’ or ‘secondary to’ another condition.”

Therefore, I15.0 may be assigned when hypertension is documented as being due to a renovascular disorder, such as renal artery stenosis and I15.1 may be assigned when hypertension is documented as being due to a kidney disorder NEC, such as nephrotic syndrome due to poststreptococcal glomerulonephritis.

The *Use additional code* note at I15.0 and I15.1 should be followed in those instances where the presence of chronic kidney disease is also documented.

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Ref No: Q2760 | Published On: 15-Dec-2011 | Status: Retired | Retired On: 30-Jun-2015

Coding of basal cell papilloma/seborrhoeic keratosis

Q:

We have received advice that basal cell papilloma and seborrhoeic keratosis are synonymous terms and the use of the different wording can be based on the surgeon's preference.

Could you advise if we should code L82 *Seborrhoeic keratosis* or D23.- with M8050/0 *Papilloma NOS*?

There is no indexed pathway to reach code L82 using 'papilloma' as the lead term.

A:

The terms basal cell papilloma and seborrhoeic keratosis may be synonymous and used interchangeably, however, they are classified separately in ICD-10. Therefore, NCCC advises that code assignment should be based on the documentation in the histology report.

NCCC will consider submitting a proposal to the WHO Update Reference Committee (URC) about this issue so it can be considered in a future update of ICD-10 or ICD-11.

Published 15 December 2011,
for implementation 01 January 2012.

Ref No: Q2664 | Published On: 15-Dec-2011 | Status: Retired | Retired On: 30-Jun-2015

Procedures on the left atrial appendage (LAA)

Q:

What are the correct codes for the following procedures?

- Ligation of the left atrial appendage (LAA)
- Percutaneous occlusion of the left atrial appendage (LAA)

A:

Thrombus formation in the left atrial appendage (a muscular pouch arising from the left atrium) is a major risk factor for stroke in patients with atrial fibrillation. Ligation and occlusion of the left atrial appendage (LAA) are procedures used to prevent emboli, as an alternative to oral anticoagulopathy.

Ligation of the LAA involves many techniques, including, creating an “endoloop”, suturing, clipping or stapling of the atrial appendage.

Occlusion of the LAA is usually performed via a catheter, crossing the inter-atrial septum and using a guidewire to advance the device into the left atrium which is then deployed into the LAA.

The NCCC sought clinical advice which confirms that while the techniques used in this procedure may be similar to those used for closure of an atrial septal defect, it is not the correct code to assign. Clinical advice also confirmed that in the absence of a specific code for this procedure, the appropriate code to assign is:

38456-13 **[606]** *Other intrathoracic procedures on atrium without cardiopulmonary bypass*

or

38653-01 **[606]** *Other intrathoracic procedures on atrium with cardiopulmonary bypass*, as appropriate, following the index pathway:

Procedure

- atrium, heart (intrathoracic) (without cardiopulmonary bypass) NEC 38456-13 **[606]**
- - with cardiopulmonary bypass 38653-01 **[606]**

Any additional procedures, such as the following, should also be assigned:

38203-00 **[667]** *Left heart catheterisation*

55118-00 **[1942]** *2 dimensional real time transoesophageal ultrasound of heart*

38209-00 **[665]** *Cardiac electrophysiological study,<= 3 catheters* or

38212-00 **[665]** *Cardiac electrophysiological study, >= 4 catheters*

The NCCC will consider creating new codes for these procedures in a future edition of ACHI.

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for implementation 01 January 2012.

Ref No: Q2627 | Published On: 15-Dec-2011 | Status: Retired | Retired On: 30-Jun-2013

Healthcare associated *Staphylococcus aureus* bacteraemia (HA SAB) (1 of 2)

Q:

Should Y95 *Nosocomial condition* be assigned in addition to U90.0 *Healthcare associated Staphylococcus aureus bacteraemia*, or is it implicit in U90.0?

A:

There is no requirement to assign Y95 *Nosocomial condition* in addition to U90.0 *Healthcare associated Staphylococcus aureus bacteraemia*. U90.0 is an additional code which already specifies 'healthcare associated' and thereby makes the assignment of Y95 unnecessary.

The NCCC will consider adding an excludes note at Y95 in a future edition of ICD-10-AM to make this explicit.

Published 15 December 2011,
for implementation 01 January 2012.

Ref No: Q2738 | Published On: 15-Dec-2011 | Status: Retired | Retired On: 30-Jun-2013

Morphology code for C94.6 *Myelodysplastic and myeloproliferative disease, not elsewhere classified?*

Q:

What is the correct morphology code to assign with C94.6 *Myelodysplastic and myeloproliferative disease NEC*?

A:

The correct morphology code to assign with C94.6 *Myelodysplastic and myeloproliferative disease, not elsewhere classified* is M9989/3 *Myelodysplastic syndrome NOS*.

The NCCC will amend the index entry for ICD-10-AM Eighth Edition for C94.6 *Myelodysplastic and myeloproliferative disease, not elsewhere classified* to include the correct morphology code.

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for implementation 01 January 2012.

Ref No: Q2650 | Published On: 15-Dec-2011 | Status: Retired | Retired On: 30-Jun-2013

Closed reduction of acetabulum

Q:

What is the correct code to assign for closed reduction of the acetabulum?

A:

The acetabulum is part of the pelvis, specifically, the socket of the ball-and-socket hip joint. Acetabular fractures have conventionally been treated with open reduction and internal fixation (ORIF). However, the procedure is often associated with significant blood loss, infection, lengthy operative times and neurovascular complications (Crowl Kahler, 2002). More recently a less invasive alternative to the conventional treatment has been closed (percutaneous) reduction and fixation, facilitated by image guided surgical navigation (Crowl Kahler, 2002).

Currently there is no specific code in ACHI for this procedure, therefore, 90552-00 **[1491]** *Other repair of hip* should be assigned for this procedure, following the index pathway:

Repair

- hip NEC 90552-00 **[1491]**

The NCCC does not endorse the assignment of 47501-00 **[1486]** *Open reduction of fracture of acetabulum with internal fixation* as it is not an open reduction. Code 47498-00 **[1479]** *Internal fixation of fracture of acetabulum* cannot be assigned due to the *excludes note* which specifies 'that with reduction of fracture'.

However, NCCC will consider modifying the instructional notes at 47498-00 **[1479]** so that this code may be assigned in the future.

Reference:

Crowl, A and Kahler, D (2002), Closed Reduction and Percutaneous Fixation of Anterior Column Acetabular Fractures, *Computer Aided Surgery*, vol.6, no. 1, pp 169-178.

Published 15 December 2011,
for implementation 01 January 2012.

Ref No: Q2682 | Published On: 15-Dec-2011 | Status: Retired | Retired On: 30-Jun-2013

Aspiration of peritonsillar abscess

Q:

What is the correct code to assign for aspiration of peritonsillar abscess?

A:

The correct code assignment for ‘aspiration of peritonsillar abscess’ is 41807-00 **[409]** *Incision and drainage of peritonsillar abscess*, by following the index pathway:

Drainage

- abscess

- - peritonsillar 41807-00 **[409]**

or

Incision

- peritonsillar abscess 41807-00 **[409]**

The NCCC will consider improvements to the Tabular List and Alphabetic Index for this procedure for a future edition of ACHI.

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for implementation 01 January 2012.

Ref No: Q2717 | Published On: 15-Dec-2011 | Status: Retired | Retired On: 30-Jun-2013

Coding of multiple radiotherapy sessions

Q:

When radiotherapy is performed multiple times during an episode of care could you advise if it should be coded only once or should a code be assigned for each treatment?

In Fifth Edition, radiotherapy was coded only once according to ACS 0020 *Multiple/bilateral procedures* which stated “procedures performed without anaesthesia should be coded once only”.

However, following updates to ACS 0020 in Sixth Edition, radiotherapy appears to fall under classification point (1)

> “A procedure which is repeated during the episode of care should be coded as many times as it is performed.”

Also ACS 0229 *Radiotherapy* does not specify whether the procedure code for radiotherapy should be assigned only once or for each treatment.

A:

It was not intended that the Sixth Edition amendments to ACS 0020 *Bilateral/multiple procedures* would alter coding practice with respect to the number of times radiotherapy is coded during an episode of care. The instruction in ACS 0020 regarding classification of the same procedure repeated during the episode of care, provides ‘Examples of exceptions to this rule’ so it cannot be considered an exhaustive list. Therefore, similarly to chemotherapy, dialysis and blood transfusions, where the same procedure code applies, assign the procedure code for radiotherapy once only.

The NCCC will consider amending ACS 0020 Bilateral/multiple procedures and ACS 0229 *Radiotherapy* to specifically address coding of multiple radiotherapy sessions for a future edition of ICD-10-AM.

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for implementation 01 January 2012.

Ref No: TN355 | Published On: 15-Dec-2011 | Status: Retired | Retired On: 30-Jun-2013

Open door laminoplasty

Q:

What is the correct code assignment for ‘open door’ laminoplasty, performed for cervical stenosis with myelopathy?

A:

A cervical laminoplasty is performed to repair a restricted spinal canal. The procedure creates more space for the spinal cord and nerve roots immediately relieving the pressure. This method is sometimes called an ‘open door’ laminoplasty, because the back of the spine is made to swing open like a door.

The correct code to assign for cervical open door laminoplasty is the appropriate code from Block **[46]** *Decompression of cervical spinal cord*, by following the index pathway *Decompression, spinal, cord, cervical*.

NCCC will consider indexing ‘open door’ laminoplasty for a future edition of ACHI.

Reference:

The State of Queensland (Queensland Health) (2011), *Cervical Laminoplasty*, accessed: 16/11/2011, available: http://www.health.qld.gov.au/consent/documents/neurosurgery_16.pdf.

Published 15 December 2011,
for implementation 01 January 2012.

Ref No: Q2674 | Published On: 15-Dec-2011 | Status: Retired | Retired On: 30-Jun-2013

Multiple skin biopsies

Q:

What is the correct code assignment for multiple skin (punch) biopsies performed on:

1. Separate skin lesions (eg. skin lesion of face and back)

2. Same lesion (eg. multiple biopsies of single lesion of nose)

A:

ACS 0020 *Bilateral/multiple procedures* states:

> *"ACHI generally refers to organs, diseases and sites using the singular tense. This is done for consistency and ease of updating? examples includes wart(s), skin tag(s), biopsy/biopsies, lesion(s)."*

For the scenarios cited:

1. **Multiple (punch) biopsies of skin lesions on separate skin lesions**: code as many times as it is performed

2. **Multiple (punch) biopsies of the same lesion**: code once only.

The NCCC will consider amending Point 5 (skin or subcutaneous lesion removal) in ACS 0020 *Bilateral/multiple procedures* in a future edition of ACS.

Published 15 December 2011,
for implementation 01 January 2012.

Ref No: Q2676 | Published On: 15-Dec-2011 | Status: Retired | Retired On: 30-Jun-2013

Prophylactic salpingo-oophorectomy

Q:

What is the correct principal diagnosis to assign in the following scenarios?

a) Bilateral salpingo-oophorectomy (BSO) performed prophylactically due to risk of ovarian cancer after being found to have the BRCA2 gene fault on predictive gene testing

b) Bilateral salpingo-oopherectomy performed prophylactically due to a family history of ovarian cancer

A:

a) Prophylactic BSO due to risk of ovarian cancer

The correct principal diagnosis to assign when a bilateral salpingo-oophorectomy is performed prophylactically due to risk of ovarian cancer is Z40.01 *Prophylactic surgery for risk-factors related to malignant neoplasms, ovary*, following the index pathway:

Prophylactic

- surgery

- - for risk factors related to malignant neoplasm

- - - ovary Z40.01

b) Prophylactic BSO due to family history of ovarian cancer

The correct principal diagnosis to assign when a prophylactic bilateral salpingo-oopherectomy is performed due to a family history of ovarian cancer is Z40.01 *Prophylactic surgery for risk-factors related to malignant neoplasms, ovary* with the addition of Z80.4 *Family history of malignant neoplasm of genital organs*, to specify the risk factor (family history of ovarian cancer), following the index pathway noted in scenario 1.

There is a principle for prophylactic surgery in ACS 1204 *Plastic surgery, prophylactic mastectomy*, which states:

> *"When the reason for the prophylactic mastectomy can be assigned a code (eg fibrocystic disease, family history, this should be sequenced as the principal diagnosis (even if all evident disease has been previously resected). Z40.00 Prophylactic surgery for risk-factors related to malignant neoplasm, breast or Z40.8 Other prophylactic surgery should be assigned as an additional diagnosis."*

However, this principle should not be followed for prophylactic BSO in the scenarios cited. The principal diagnosis to assign in these instances is the appropriate code from Z40.0- *Prophylactic surgery for risk-factors related to malignant neoplasms* to indicate the organ being removed. Risk factors noted to be related to the prophylactic organ removal should be assigned as additional diagnoses, as appropriate.

ACS 1204 *Plastic surgery* will be reviewed for Eighth Edition, with the 'prophylactic' part of this ACS removed and the creation of a general standard for prophylactic surgery which standardises the sequencing guidelines for prophylactic organ removal.

Published 15 December 2011,
for implementation 01 January 2012.

Ref No: Q2639 | Published On: 15-Jun-2011 | Status: Retired | Retired On: 01-Jul-2017

ACS 0002 *Additional diagnoses* and newborn conditions (1 of 2)

Q:

In what circumstances should conditions noted on the examination of a newborn be coded? Previous advice published in Coding Matters (Vol 17, No 1), stated:

> "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"

Is this advice current?

A:

Conditions noted on a newborn examination should be assessed on an individual basis and coded if they meet the criteria in ACS 0002 *Additional diagnoses*. The condition should be coded if therapeutic treatment is commenced, a diagnostic procedure is performed or the condition warrants increased clinical care and/or monitoring. If a condition is significant enough to warrant review/evaluation by a clinician, in the admitted episode of care, then it has met the criterion of 'increased clinical care and/or monitoring' and a code should be assigned.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

Published 15 June 2011,
for implementation 01 July 2011.

Ref No: Q2639 | Published On: 15-Jun-2011 | Status: Retired | Retired On: 01-Jul-2017

ACS 0002 *Additional diagnoses* and newborn conditions (2 of 2)

Q:

Do conditions in a newborn that warrant review/evaluation by a clinician or referral for an external opinion meet the criteria for coding under ACS 0002 *Additional diagnoses*?

A:

Advice in part **1** is based on the application of ACS 0002 *Additional diagnoses* and should be applied to any condition in a newborn requiring review/evaluation by a clinician. Coders should be guided by the documentation in the clinical record. Therefore, a code should be assigned for a condition that is referred for an external opinion.

Published 15 June 2011,
for implementation 01 July 2011.

Ref No: Q2696 | Published On: 15-Jun-2011 | Status: Retired | Retired On: 30-Jun-2013

Insertion of gold seeds/fiducial markers into prostate

Q:

What is the correct code to assign for insertion of gold seeds/fiducial markers into prostate?

A:

Gold seeds can be inserted into the prostate for different purposes:

- to mark a tumour in preparation for radiotherapy, in which case the seeds are not radioactive. This is known as insertion of fiducial markers, or
- for radiotherapy, where the seeds contain radioactive material. This is known as brachytherapy.

ACHI code 37227-00 **[1160]** *Implantation of brachytherapy applicator, prostate* was created in Seventh Edition as part of the MBS updates. It is the correct code to assign for insertion of gold seeds into the prostate for brachytherapy, following index pathways:

Implant, implantation -- *see also Insertion*

- applicator for brachytherapy (catheters) (needles)

- - prostate 37227-00 **[1160]** ...

- radioactive seed (brachytherapy)

- - prostate 37227-00 **[1160]**

Or

Insertion

- applicator for brachytherapy (catheters) (needles)

- - prostate 37227-00 **[1160]** ...

- catheter

- - prostate, for brachytherapy 37227-00 **[1160]**

In addition to 37227-00 **[1160]** also assign 15338-00 **[1792]** *Brachytherapy, prostate*.

However, if insertion of fiducial markers/gold seeds are inserted into the prostate to mark a tumour in preparation for radiotherapy, assign 90395-00 **[1170]** *Other procedures on prostate* as per previous published advice in Coding Matters September 2009, Vol. 16, No. 2.

The NCCC will create a new code for insertion of fiducial markers into the prostate in preparation for radiotherapy in a future edition of ACHI.

Published 15 June 2011,
for implementation 01 July 2011.

Ref No: Q2661 | Published On: 15-Jun-2011 | Status: Retired | Retired On: 30-Jun-2013

McCall’s Culdoplasty

Q:

What is the appropriate code assignment for McCall’s culdoplasty?

A:

The NCCC sought clinical advice which confirmed that a McCall’s culdoplasty, or similar procedure, is routinely performed with a vaginal hysterectomy to prevent enterocele formation and vaginal vault prolapse or to repair an existing enterocele.

Therefore, a McCall’s culdoplasty performed with a vaginal hysterectomy is a component of the procedure and should not be coded, as per ACS 0016 *General procedure guidelines, Procedure components*, which states:

> *‘Do not code procedures which are individual components of another procedure. These components would usually be considered a routine or inherent part of the more significant procedure being performed.’*

However, when McCall’s culdoplasty is performed independently of a vaginal hysterectomy the correct code assignment is 35571-00 **[1283]** *Repair of posterior vaginal compartment, vaginal approach.*

Published 15 June 2011,
for implementation 01 July 2011.

Ref No: Q2651 | Published On: 15-Apr-2011 | Status: Retired | Retired On: 01-Jul-2017

Intraoperative serosal tear

Q:

What is the correct code assignment for an intraoperative serosal tear which is treated by oversewing the splenic flexure?

A:

Splenic flexure is the left flexure of the colon as it bends at the junction of the transverse and descending segments of the colon, near the spleen (Mosby's medical dictionary, 8th edition, 2009).

For the above scenario assign the following codes as per the guidelines in ACS 1904 *Procedural complications*:

T81.2 *Accidental puncture and laceration during a procedure, not elsewhere classified*

S36.59 *Injury of other and multiple parts of colon*

Y60.0 *Unintentional cut, puncture, perforation or haemorrhage during surgical operation*

Y92.22 *Health service area*

The index pathways are:

Complications (from) (of)

- accidental puncture or laceration during procedure T81.2

and

Injury *(see also specified injury type)* T14.9

- colon S36.50

- - specified site NEC S36.59

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for implementation 01 May 2011.

Ref No: Q2628 | Published On: 15-Apr-2011 | Status: Retired | Retired On: 30-Jun-2015

Stenosis of coronary artery of less than or equal to 50%

Q:

What are the guidelines for coding of stenosis of the coronary artery if it is documented as 50% or less, without further confirmation of disease?

A:

ACS 0941 *Arterial disease* states:

"**Stenosis**

Stenosis is a quantitative anatomical term and often refers to atherosclerosis. The terms 'stenosis' and 'obstruction' are equivalent (eg 60% stenosis = 60% obstruction). Complete stenosis results in occlusion. (See also *Obstruction*)

Classification

If over 50% of stenosis of a coronary artery is documented without further information, a code from category I25.1- *Atherosclerotic heart disease* should be assigned. If it is evident from cardiac catheterisation or angiogram results that the stenosis is due to a thrombus (and the patient has not progressed to an AMI), assign I24.0 *Coronary thrombosis not resulting in myocardial infarction*. In the latter case, where the patient progresses to a myocardial infarction, assign a code from category I21 *Acute myocardial infarction*."

According to this standard, if:

- there is documentation of over 50% stenosis of a coronary artery, assign a code from I25.1- *Atherosclerotic heart disease*.
- This is based on clinical advice that >50% stenosis is considered significant and would warrant coding as atherosclerosis.
- test results confirm that stenosis is due to a thrombus, assign code I24.0 *Coronary thrombus not resulting in myocardial infarction* or a code from category I21.- *Acute myocardial infarction*.
- If coronary obstruction/stenosis of less than or equal to 50% is documented without further confirmation of disease:
- assign a code for the sign or symptom that was the reason for admission, unless

a procedure was performed for atherosclerosis, then assign I25.1- *Atherosclerotic heart disease* (as specified in ACS 0941 *Arterial disease, Procedures performed for atherosclerosis*).

The NCCC has flagged ACS 0941 *Arterial disease* for review in a future edition of ICD-10-AM/ACHI/ACS with particular attention to the classification of stenosis and review of the 50% rule.

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for implementation 01 May 2011.

Ref No: Q2666 | Published On: 15-Apr-2011 | Status: Retired | Retired On: 30-Jun-2015

DRIL procedure

Q:

What is the correct code for DRIL procedure? Is it necessary to assign additional codes for procurement of vein and/or ligation of artery?

A:

Distal revascularisation-interval ligation (DRIL) can be performed to treat access-induced ischaemia or ischaemic steal syndrome (ISS) where there is direct artery to vein communication following placement of an arteriovenous bridge graft/shunt or creation of an arteriovenous fistula (AVF). ISS following haemodialysis is a complication of AV access, occurring mainly in patients with diabetes with multiple previous AVFs. The DRIL procedure enables the clinician to maintain functional haemodialysis access while relieving distal ischaemia.

The DRIL procedure involves:

Creation of a bypass from the proximal to the distal end of the anastomotic arterial site. This can be done using an autogenous vein (eg great saphenous vein, cephalic vein) or synthetic material (eg polytetrafluoroethylene (PTFE) or Dacron grafts).

This bypass restores antegrade blood flow to the hand while maintaining the functioning dialysis access.

Ligation of the native artery just distal to the AV access but proximal to the distal bypass graft anastomosis.

The ligation addresses steal syndrome by preventing blood flow reversal from the affected hand.

Therefore, the correct code to assign for DRIL procedure is:

32763-00 **[711]** *Other arterial bypass using vein* (if a vein is used for the bypass)

Or

32763-01 **[712]** *Other arterial bypass using synthetic material* (if material such as polytetrafluoroethylene (PTFE) is used for the graft).

Following the index pathway:

Bypass

- arterial

- - with (using)

- - - synthetic material 32763-01 **[712]**

- - - vein 32763-00 **[711]**

- - - - specified site NEC 32763-00 **[711]**

An additional code should be assigned for the procurement of the vein if not procured from the same arm on which the DRIL procedure is being performed, as per the note at block **[711]** *Arterial bypass graft using vein*:


IHACPA

Code also when performed:

- procurement of vein from arm or leg (32760-00 **[730]**) except when vein is procured from same arm or leg on which bypass or graft is performed - omit code

The ligation should not be coded as instructed in the excludes note at block **[697]** *Interruption of artery*:

Excludes:

that with any other vascular procedure - omit code

Reference:

Hubbard, J, Markel, K, Bendick, P and Long, G, (2009), Distal Revascularizaton - Interval Ligation (DRIL) for the Treatment of Dialysis Access Steal, *Journal of Diagnostic Medical Sonography,* Vol. 25, No. 316 (originally published online 12 October 2009).

Published 15 April 2011,
for implementation 01 May 2011.

Ref No: Q2660 | Published On: 15-Apr-2011 | Status: Retired | Retired On: 30-Jun-2015

Chemical angioplasty of carotid artery

Q:

What is the correct code assignment for a chemical angioplasty of carotid artery for carotid artery spasm?

A:

Chemical angioplasty of carotid artery spasm involves intra-arterial infusion of chemical vasodilators such as paperverine, nicardipine or verapamil. The infusion of the chemical agent is performed by inserting a guiding catheter through a peripheral artery (femoral or iliac artery) and lasts for 15 - 60 minutes.

The correct code assignment for this procedure is 35317-00 **[741]** *Percutaneous peripheral arterial or venous catheterisation with administration of thrombolytic or chemotherapeutic agents by continuous infusion*, following the index pathway:

Administration (around) (of)-- *see also Injection*

- agent (to)

- - chemotherapeutic -- *see Chemotherapy*

Infusion -- *see also Administration*

- agent (to)

- - arrest haemorrhage via surgical peripheral catheterisation -- *see Embolisation, blood vessel, transcatheter, by site*

- - chemotherapeutic -- *see Chemotherapy*

Chemotherapy -- *see also Pharmacotherapy*

- via surgical peripheral arterial or venous catheterisation (open) 35320-00 **[741]**

- - percutaneous (continuous infusion) 35317-00 **[741]**

Cerebral angiogram is commonly performed during this procedure and should be coded if performed under cerebral anaesthesia, as per the guidelines in ACS 0042 *Procedures normally not coded*.

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for implementation 01 May 2011.

Ref No: Q2677 | Published On: 15-Apr-2011 | Status: Superseded | Superseded On: 15-Jun-2012 | Superseded By: Q2783

Administration of Anti-D

Q:

Is it appropriate to assign Z29.1 *Prophylactic immunotherapy* and 92173-00 **[1884]** *Passive immunisation with Rh(D) immunoglobulin* for administration of Anti-D in admissions where the obstetric patient is Rhesus negative?

A:

Anti-D is produced from the plasma of selected Rhesus (D) negative donors. It is administered to obstetric patients who are Rhesus (D) negative to prevent their babies from developing haemolytic disease of the newborn.

If an obstetric patient requires injection of Anti-D during an admission, assign Z29.1 *Prophylactic immunotherapy* and 92173-00 **[1884]** *Passive immunisation with Rh(D) immunoglobulin*.

This is consistent with advice previously published by NCCH and is reinforced by ACS 0302 *Blood transfusions which states that the administration of blood and blood products should be coded whenever performed.*

Published 15 April 2011,
for implementation 01 May 2011.

Ref No: Q2632 | Published On: 15-Apr-2011 | Status: Retired | Retired On: 30-Jun-2013

Thickened endometrium

Q:

What is the correct code assignment for thickened endometrium?

A:

Clinical advice states that “the term *thickened endometrium* is usually applied to the appearance of the post menopausal endometrium where it exceeds 4mm in thickness. This is not a diagnosis, but requires a hysteroscopy and DC to see what the histology is. If the histology shows *cystic glandular hyperplasia* or normal endometrium, it could be treated with oral progestogens or the Mirena®) device. More serious causes would be *adenomatous hyperplasia* or *atypical endometrial hyperplasia*, when hysterectomy is usually indicated” Roger Pepperell, O G Clinician (personal communication, 8 September 2010).

When a diagnosis of *thickened endometrium* meets the criteria for code assignment as per ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*, eg treatment using oral progestogens or the Mirena® device is commenced, first check the histology for a more specific diagnosis such as *cystic glandular hyperplasia* (N85.0), *adenomatous hyperplasia* (N85.1) or *atypical endometrial hyperplasia* (N85.1). However, if the histology reveals normal endometrium assign N85.9 *Noninflammatory disorders of the uterus, unspecified*.

The NCCC will consider improvements to the classification of *thickened endometrium* for a future edition of ICD-10-AM.

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for implementation 01 May 2011.

Ref No: Q2643 | Published On: 15-Apr-2011 | Status: Retired | Retired On: 30-Jun-2013

Pipelle aspiration of endometrium

Q:

What is the correct code to assign for Pipelle aspiration of endometrium?

A:

Pipelle aspiration is a means of non-invasively sampling the endometrium without cervical dilation or anaesthesia. It involves inserting a flexible polypropylene suction cannula (thin long tube with a plunger at one end), known as a Pipelle de Cornier aspiration device, into the uterine cavity and aspirating endometrial tissue.

The current code choices in ACHI for this procedure do not accurately reflect the nature of the procedure. While there are arguments supporting the use of the codes for *diagnostic hysteroscopy, curettage of uterus without dilation and biopsy of endometrium*, we suggest that the hysteroscopy code (35630-00 **[1259]** *Diagnostic hysteroscopy*) remains the best choice because it:

- provides continuity with previous advice, and
- classifies this biopsy procedure with other biopsies which is helpful for data analysis

The NCCC will consider indexing improvements for *Pipelle aspiration of the endometrium* in a future edition of ACHI.

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for implementation 01 May 2011.

Ref No: TN163 | Published On: 15-Apr-2011 | Status: Retired | Retired On: 30-Jun-2013

Duration of pregnancy

Q:

a) When assigning duration of pregnancy codes does 37 completed weeks of pregnancy mean 36 weeks plus 7 days or 37 weeks plus 7 days?

b) Should there be a code in category O09 *Duration of pregnancy* for pregnancies with duration greater than 37 completed weeks?

A:

a) 37 completed weeks is equal to 36 weeks plus 7 days. Any duration of pregnancy less than 37 completed weeks is deemed premature. Thus, 36 weeks and 6 days is premature. A pregnancy at or after 37 completed weeks is known as term pregnancy.

The NCCC is aware that the code title of O09.5 *Duration of pregnancy 34 - 36 completed weeks* is misleading as 36 completed weeks is equal to 35 weeks plus 7 days. This will be amended to *Duration of pregnancy 34 - in ICD-10-AM Eighth Edition.*

b) The duration of pregnancy codes were developed by the Obstetrics and Gynaecology CCCG specifically to identify, through the codes, the duration of pregnancy for a specific group of high risk pregnancies. These high risk pregnancies are abortions (includes threatened abortion), early onset of labour, fetal death in utero, premature rupture of membranes and threatened premature labour. A code for the duration of pregnancy greater than 37 completed weeks is not necessary since the absence of a code from O09 Duration of pregnancy with these high risk pregnancies indicates that the condition occurred at term.

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for implementation 01 May 2011.

Ref No: TN184 | Published On: 15-Oct-2010 | Status: Retired | Retired On: 30-Jun-2019

McRoberts manoeuvre

Q:

If there is documentation that a McRoberts manoeuvre has been performed during delivery, which code should be assigned O80 *Single spontaneous delivery* or O83 *Other assisted single delivery*?

A:

McRoberts manoeuvre is performed for shoulder dystocia (sometimes documented as ‘impacted’ or ‘difficult’ shoulders). Delivery of the shoulders is facilitated by flexing the mother’s hips to increase the pelvic diameter. Clinical advice confirms that when this manoeuvre is performed during delivery assign O83 *Other assisted single delivery*.

Shoulder dystocia must be documented before assigning O66.0 *Labour and delivery affected by shoulder dystocia*, as this technique is sometimes employed prophylactically in anticipation of a potential shoulder dystocia.

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for implementation 01 November 2010.

Ref No: Q2631 | Published On: 15-Oct-2010 | Status: Retired | Retired On: 30-Jun-2019

Fetoscopic tracheal balloon occlusion

Q:

What is the correct intervention code to assign for fetoscopic tracheal balloon occlusion?

A:

Fetoscopic tracheal occlusion (FETO) is a minimally invasive antepartum procedure performed to treat severe congenital diaphragmatic hernia (CDH), which is associated with a high rate of neonatal death due to pulmonary hypoplasia.

“Temporary tracheal occlusion is a technique which prevents the normal efflux of foetal lung fluid, which enhances positive pressure in the growing lungs and promotes lung growth (Harrison et al. 2003). Originally, occlusion occurred by placement of an occlusion clip around the trachea via open hysterotomy. However, due to the high rate of preterm delivery and irreversible damage to the laryngeal nerve and trachea, and difficulty for reversal, fetoscopic tracheal occlusion using a detachable balloon has been developed (Harrison et al.1998). The detachable balloon can be placed via one fetobronchoscopic port and deflation at birth aids an easier reversal. This minimally invasive technique may improve postnatal survival in patients with severe CDH and may be used in conjunction with postnatal management strategies.” (ASERNIP-S, 2005)

The correct code to assign for FETO is 90464-00 **[1332]** *Correction of fetal defect*, following the index pathway:

Correction-- *see also Repair*

- fetal defect (intrauterine) 90464-00 **[1332]**

or

Procedure

- fetal, in utero

- - therapeutic 90464-00 **[1332]**

The NCCC has flagged *Antepartum repair procedures* for review in a future edition of ACHI.

Reference:

Australian Safety and Efficacy Register of New Interventional Procedures-Surgical, 2005, Horizon Scanning Technology Prioritising Summary - Fetoscopic tracheal occlusion using a detachable balloon, Canberra, Australia.

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for implementation 01 November 2010.

Ref No: Q2613 | Published On: 15-Oct-2010 | Status: Retired | Retired On: 30-Jun-2019

Depression due to a medical condition

Q:

Is it appropriate to assign F06.33 *Organic depressive disorder* for documentation of depression due to a medical condition?

A:

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IVTR®) states:

> "In DSM-III-R, the Mental Disorders Due to a General Medical Condition and the Substance-Induced Disorders were called 'organic' disorders and were listed together in a single section...DSM-IV eliminates the term organic and distinguishes those mental disorders that are due to a general medical condition from those that are substance induced and those that have no specific etiology...
>
> The essential feature of Mood Disorder Due to a General Medical Condition is a prominent and persistent disturbance in mood that is judged to be due to the direct physiological effects of a general medical condition. The mood disturbance may involve depressed mood; markedly diminished interest or pleasure; or elevated, expansive, or irritable mood."

Therefore, it is appropriate to assign F06.33 Organic depressive disorder for documentation of depression due to a medical condition, by following the index pathway:

Disorder

- mood

- - due to (secondary to)

- - - general medical condition F06.3-

The underlying condition may also be assigned as per ACS 0001 Principal diagnosis, Problems and underlying conditions.

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Ref No: TN184 | Published On: 15-Oct-2010 | Status: Retired | Retired On: 01-Jul-2017

Postpartum haemorrhage and retained placenta and membranes, without haemorrhage

Q:

What is the difference between?

O72.0 *Third-stage haemorrhage*

O72.2 *Delayed and secondary postpartum haemorrhage*andO73.0 *Retained placenta without haemorrhage*

O73.1 *Retained portions of placenta and membranes, without haemorrhage*

A:

The two groups of codes, O72.- and O73.- include the concept of retained placenta (see index below) and are distinguished by the presence (O72.-) or absence (O73.-) of haemorrhage. The term 'without haemorrhage' is an essential modifier in the Alphabetic Index, so it has to be documented, before assigning O73.0 or O73.1.

Retention, retained

- placenta (total) (with haemorrhage) O72.0

- - without haemorrhage O73.0

- - portions or fragments (with haemorrhage) O72.2

- - - without haemorrhage O73.1

In ICD-10-AM the default code for retained placenta, not further specified is O72.0 *Third-stage haemorrhage*, which is consistent with ICD-10.

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for implementation 01 November 2010.

Ref No: Q2617 | Published On: 15-Oct-2010 | Status: Retired | Retired On: 01-Jul-2017

Postoperative pain

Q:

What is the correct code to assign for a patient admitted with postoperative pain related to a total knee replacement performed 3 weeks previously? Is the correct code T81.8 *Other complications of procedures NEC*, as per Coding Matters Vol 7, No 3, December 2000 or T84.8 *Other complication of internal orthopaedic device, implants and grafts*?

A:

The Coding Matters advice cited above has been superseded by revisions to ACS 1904 *Procedural complications* and ACS 1807 *Pain diagnoses and pain management* procedures in ICD-10-AM/ACS, Sixth Edition.

Follow the current advice in ACS 1807, which states:

> "For classification of readmissions due to postprocedural pain, please refer to ACS 1904 *Procedural complications*."

ACS 1904 *Procedural complications*, states:

> "Where the complication relates to a prosthetic device, implant or graft, such as a cardiac valve, look up the main term 'Complication(s)' and then by the device (if known and listed) or by the subterm of 'prosthetic device, implant or graft'."

ICD-10-AM classifies procedural complications according to the type of procedure that was performed:

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

T83.8 *Other complications of genitourinary prosthetic devices, implants and grafts*

T84.8 *Other complications of internal orthopaedic prosthetic devices, implants and grafts*

T85.81 *Other complications due to nervous system device, implant and graft*

T85.88 *Other complications of internal prosthetic device, implant and graft, NEC*

Postprocedural complications classified to these codes include embolism, fibrosis, haemorrhage, pain, stenosis and thrombosis. Such complications may be related to the prosthetic device, implant or graft without having a direct cause and effect relationship documented. While it could be argued that pain is not caused directly by the device/implant/graft, the ICD convention essentially enforces this association by its structure. For consistency of application, this convention should be followed.

For the scenario cited follow the index pathway:

Complications

- orthopaedic

- - device, implant or graft

- - - specified NEC T84.8

or

Pain(s)

- due to device, implant or graft *(see also Complications, by site and type)*

- - joint prosthesis T84.8

Therefore, the correct code assignment for a patient readmitted with postoperative pain after a TKR, performed three weeks previously, is:

T84.8 *Other complications of internal orthopaedic prosthetic devices, implants and grafts*,

M25.56 *Pain in joint, lower leg* with external cause codes

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

Y92.22 *Health service area*.

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for implementation 01 November 2010.

Ref No: TN184 | Published On: 15-Oct-2010 | Status: Retired | Retired On: 01-Jul-2017

Severe sepsis in pregnancy, childbirth or the puerperium

Q:

If a patient has severe sepsis in pregnancy, childbirth or the puerperium, do you need to assign the O codes with the acute organ failure codes, eg O99.5 *Diseases of the respiratory system complicating pregnancy, childbirth and the puerperium* with the code for acute respiratory failure?

A:

ACS 1521 *Conditions complicating pregnancy* states:

> "Chapter 15 *Pregnancy, childbirth and the puerperium* contains two blocks of codes for complications related to pregnancy, O20-O29 *Other maternal disorders predominantly related to pregnancy* and O94-O99 *Other obstetric conditions, not elsewhere classified*. Conditions that are known to occur commonly in pregnancy have specific codes in O20-O29. To code other conditions complicating pregnancy (or being aggravated by the pregnancy or that are the main reason for obstetric care), a code from O98 *Maternal infectious and parasitic diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium* or O99 *Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium* is assigned, together with an additional code from the other chapters of ICD-10-AM to identify the specific condition."

Therefore, in the scenario detailed above, O99.5 *Diseases of the respiratory system complicating pregnancy, childbirth and the puerperium* should be assigned in addition to J96.0 *Acute respiratory failure*.

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Ref No: Q2629 | Published On: 15-Oct-2010 | Status: Retired | Retired On: 01-Jul-2017

Same day endoscopy (*Coding Matters* advice, June 2001)

Q:

Is the following advice in *Coding Matters* Vol 8, No 1, 10-AM Commandments, *Coding same day endoscopy* still valid?"

If no diagnosis (reason for admission) is recorded in the record and clinical advice is unavailable, assign Z01.8 *Other specified special examinations*."

A:

This advice is still valid. Z01.8 *Other specified examinations* may be assigned, in the absence of a diagnosis and where a reasonable attempt has been made to establish a diagnosis with the clinician.

ACS 0046 *Diagnosis selection for same day endoscopy* has been flagged for review for a future edition of ICD-10-AM/ACHI/ACS.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

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Ref No: Q2612 | Published On: 15-Oct-2010 | Status: Retired | Retired On: 30-Jun-2015

Resternotomy for valve replacement

Q:

Is 38640-00 **[664]** *Reoperation for other cardiac procedure, not elsewhere classified* intended to be used only when re-performing the same operation? Or can it be assigned, for example, when a resternotomy is performed for a heart valve replacement following a previous coronary artery bypass graft (CABG) operation?

ACS 0909 *Coronary artery bypass grafts* and ACS 0934 *Cardiac revision/reoperation procedures* indicate that the procedure code is assigned when re-performing the same procedure, but do not provide advice about reopening of the same site for another (new) procedure.

A:

A resternotomy performed for a valve replacement following a previous CABG is not considered a reoperation (redo) of a procedure. It is a reopening of a previous operative approach to perform a different procedure.

The classification advice in ACS 0909 *Coronary artery bypass grafts* and ACS 0934 *Cardiac revision/reoperation procedures* provides advice for the assignment of 38637-00 **[680]** *Reoperation for reconstruction of coronary artery graft* and 38640-00 **[664]** *Reoperation for other cardiac procedure NEC*, when it is necessary to 'redo' or revise the same cardiac procedure, either due to complication of the initial procedure or progression of the disease.

Code 38656-01 **[562]** *Reopening of thoracotomy or sternotomy site* cannot be assigned when a resternotomy is performed, as per the advice in ACS 0039 *Reopening of operative site*:

"These codes should not be used for a subsequent opening of the operative site for treatment of a recurrent or unrelated condition."

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Ref No: TN184 | Published On: 15-Oct-2010 | Status: Retired | Retired On: 30-Jun-2015

Premature rupture of membranes

Q:

When would O42.2 *Premature rupture of membranes, labour delayed by therapy* be assigned? Can this code also be assigned with a code from O42.0 or O42.1-?

A:

O42.2 *Premature rupture of membranes, labour delayed by therapy* should be assigned when drugs aimed at stopping contractions are administered. These drugs include:

- Calcium channel blockers (nifedipine)
- Prostaglandin synthetase inhibitors (indomethacin, ketorolacs, sulindac)
- Magnesium sulphate
- Beta-mimetics (terbutaline, ritodrine)

It should not be assigned when steroids are administered to a woman in preterm labour as this drug is given for the purpose of maturing the baby's lungs, to reduce breathing problems after birth. O42.2 can be assigned with O42.0 *Premature rupture of membranes, onset of labour within 24 hours*.

However the excludes notes at O42.1 *Premature rupture of membranes, onset of labour after 24 hours* precludes O42.2 from being assigned with O42.11 or O42.12.

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for implementation 01 November 2010.

Ref No: TN184 | Published On: 15-Oct-2010 | Status: Retired | Retired On: 30-Jun-2015

Mendelson’s syndrome

Q:

What is the correct external cause code to assign for Mendelson’s syndrome?

A:

Mendelson’s syndrome is an uncommon term used to describe bronchopulmonary diseases occurring as a result of aspiration of gastric contents during general anaesthesia, due to suppression of the laryngeal reflexes. It occurs predominantly in association with obstetric anaesthesia. If the pH of the aspirated fluid is less than 2.5 and the volume of aspirate is greater than 0.3 ml/kg of body weight (20-25 ml in adults), there is greater potential for that individual developing the syndrome.

Therefore, two external cause codes should be assigned for Mendelson’s syndrome, the appropriate external cause code from category Y48 *Anaesthetics and therapeutic gases* and W78 *Inhalation of gastric contents*, following the index pathway:

Inhalation

- gastric contents (with asphyxia, obstruction respiratory passage, suffocation) W78

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Ref No: Q2619 | Published On: 15-Oct-2010 | Status: Retired | Retired On: 30-Jun-2013

PTQ Injections

Q:

What is the correct code to assign for a PTQ injection performed for faecal incontinence?

A:

A new, minimally invasive, treatment for faecal incontinence involves the injection of a liquid material (PTQ Implant also known as Bioplastioque) into the anal sphincter. When injected in to the sphincter muscle it becomes solid and by its bulk improves sphincter function.

The correct code to assign for this procedure is 90344-01 **[929]** *Administration of other therapeutic agent to anorectal region*. Currently there is no suitable index entry look up for this procedure in ACHI. Improvements to the Alphabetic Index will be considered for this procedure for a future edition of ACHI.

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Ref No: Q2618 | Published On: 15-Oct-2010 | Status: Retired | Retired On: 30-Jun-2013

Type I and type II respiratory failure

Q:

What is the correct code to assign for type I and type II respiratory failure?

A:

Respiratory failure occurs when gas exchange at the lungs is sufficiently impaired to cause a drop in the levels of oxygen (hypoxaemia). This may occur with or without an increase in carbon dioxide levels (hypercapnia). Respiratory failure is divided into type I and type II.

Type I respiratory failure - involves low oxygen and normal or low carbon dioxide levels.

Type II respiratory failure - involves low oxygen, with high carbon dioxide

Both type I and type II respiratory failure may be either acute or chronic.

ICD-10-AM does not classify respiratory failure according to type I or II. It can only be specified by acute, chronic or unspecified. Therefore, the correct code assignment for respiratory failure (type I or type II) is by selecting the appropriate code from the following index pathway:

Failure, failed

- respiration, respiratory J96.9

- - acute J96.0

- - chronic J96.1

Changes are being considered internationally for the classification of type I and type II respiratory failure.

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Ref No: Q2623 | Published On: 15-Oct-2010 | Status: Retired | Retired On: 30-Jun-2013

Percutaneous aortic valve replacement

Q:

What is the correct code assignment for percutaneous aortic valve replacement? Should an additional code be assigned for the balloon valvuloplasty which is performed on the native valve prior to insertion of the bioprosthesis?

A:

Percutaneous aortic valve replacement has been practiced in Australia since 2008 and offers an alternative treatment for aortic valve disease when an open procedure is considered high risk. The Australian Safety and Efficacy Register of New Interventional Procedures-Surgical (ASERNIP-S) (2009) indicates there are two types of percutaneous heart valves (PHV) currently in use:

1. The **Cribier-Edwards** is a bioprosthetic valve composed of a stainless steel balloon expandable stent with an integrated unidirectional tri-leaflet valve made of equine pericardium.
2. The **CoreValve** is also a bioprosthetic valve, but in contrast to the Cribier-Edwards PHV is a self expanding aortic valve prosthesis.

Currently there is no specific code in ACHI for percutaneous aortic valve replacement, but a new code is being considered for a future edition. In the interim assign 38488-01 **[623]** *Replacement of aortic valve with bioprosthesis* following the index pathway:

Replacement

- valve

- - heart

- - - aortic

- - - - with

- - - - - bioprosthesis 38488-01 **[623]**

It is unnecessary to assign a separate code for the balloon valvuloplasty for the following reasons:

1. The valvuloplasty is a component of the overall valve replacement procedure -- see ACS 0016 *General procedure guidelines*: “Do not code procedures which are individual components of another procedure. These components would usually be considered a routine or inherent part of the more significant procedure being performed.”
2. Assigning two codes (valvuloplasty and valve replacement) gives the impression that 2 separate procedures were performed -- both significant -- when in fact one surgical ‘event’ occurred where these 2 procedures were performed.

Reference:

Australian Safety and Efficacy Register of New Interventional Procedures-Surgical, 2009, *Horizon Scanning Technology Prioritising Summary - Percutaneous aortic valve replacement*, Canberra, Australia.

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Ref No: TN184 | Published On: 15-Oct-2010 | Status: Retired | Retired On: 30-Jun-2013

Lymphoid/lymphomatoid granulomatosis

Q:

When assigning the morphology code in the ICD-10-AM index pathway below an error message occurs indicating that it is an invalid code:**Granulomatosis**- lymphoid (M9766/3) C83.8 - lymphomatoid (M9766/3) C83.8 What is the correct morphology code to assign?

A:

The following change was made as part of the WHO 2008 leukaemia/lymphoma updates to ICD-10-AM Seventh Edition, where *lymphoid/lymphomatoid granulomatosis* was reclassified from D47.7 *Other specified neoplasm of uncertain or unknown behaviour* to C83.8 *Other non-follicular lymphoma*. Following clinical advice, the morphology code was reclassified from M9766/1 *Angiocentric immunoproliferative lesion* to M9766/3 *Angiocentric immunoproliferative lesion*.

Granulomatosis- lymphoid (M9766/3) C83.8

- lymphomatoid (M9766/3) C83.8

While the above change was affected in the ICD-10-AM Alphabetic Index, 9766/3 was not included in the Seventh Edition Morphology of Neoplasms list in Appendix A of the ICD-10-AM Tabular List. As a result, this code was not included in the Electronic Code List (ECL) and its use created an error when assigned.

The states/territories have since been advised to amend their ECL to accept M9766/3 for the remainder of the Seventh Edition cycle and the NCCC will make the required changes to the ICD-10-AM Tabular List - Appendix A *Morphology of neoplasms* for Eighth Edition.

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Ref No: TN184 | Published On: 15-Oct-2010 | Status: Retired | Retired On: 30-Jun-2013

Delivery: condition onset flag

Q:

What ‘condition onset flag’ would be assigned if a code from category O80-O84 *Delivery* is assigned as an additional diagnosis?

A:

When a code from category O80-O84 is assigned as an additional diagnosis, assign a condition onset flag value of 2 *Condition not noted as arising during the episode of admitted patient care*.

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Ref No: Q2630 | Published On: 15-Oct-2010 | Status: Retired | Retired On: 30-Jun-2013

Personal history of familial adenomatous polyposis (FAP) (*Coding Matters* advice, September 2006)

Q:

Coding Matters Vol 13, No 2, September 2006, 10-AM Commandments, *Follow up examinations with detection of new conditions*, assigns 2 different codes for personal history of familial adenomatous polyposis (FAP) in the examples provided. In Example 1 Z86.0 *Personal history of other neoplasms* is assigned and in Example 2 Z87.12 *Personal history of colonic polyps* is assigned. Which is correct?

A:

In 10-AM Commandments, *Coding Matters* Vol 13, No 2, *Follow-up examinations with detection of new conditions*, Example 2 incorrectly assigned Z87.12 *Personal history of colonic polyps* for a personal history of FAP. The correct code is Z86.0 *Personal history of other neoplasms*, as per Example 1 of this Commandment.

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for implementation 01 November 2010.

Ref No: TN184 | Published On: 15-Oct-2010 | Status: Retired | Retired On: 30-Jun-2013

Patient controlled analgesia (PCA)

Q:

Should patient controlled analgesia (PCA) be coded?

A:

In ICD-10-AM Fifth Edition ACS 0031 *Anaesthesia* allowed for the decision to code intravenous PCA to be made at a local level if this data was required. However this entry was removed in Sixth Edition to reinforce the consistency of coded data at a national level. In Seventh Edition, subcutaneous and intravenous post procedural infusions were removed from the hierarchy of codes in ACS 0031 to reflect that intravenous PCA should not be coded. The neuraxial and regional block codes in block **[1912]** *Postprocedural analgesia* should continue to be assigned as per point 5 of ACS 0031.

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Ref No: TN184 | Published On: 15-Oct-2010 | Status: Retired | Retired On: 30-Jun-2013

Swan Ganz catheter

Q:

Should the insertion of Swan Ganz catheters be coded?

A:

A Swan Ganz or pulmonary artery catheter is used to monitor central cardiovascular pressures and should not be coded as per points 5 and 14 in ACS 0042 *Procedures normally not coded*:

> "**5. Catheterisation:**- **arterial or venous** (such as Hickman's, PICC, CVC) **except** cardiac catheterisation (blocks **[667]** and **[668]**), or surgical catheterisation (block **[741]**)**14. Monitoring: cardiac, electroencephalography (EEG), vascular pressure** except radiographic/video EEG monitoring >=24 hours."

Point 5 of ACS 0042 *Procedures normally not coded* will be revised in the ICD-10-AM errata to include Swan Ganz catheter.

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Postsurgery care after orthopaedic surgery

Q:

When orthopaedic surgery is performed at Hospital A (eg acute care) and transfers to Hospital B for post-surgery care, what is the correct code assignment at Hospital B?

A:

Follow the guidelines in ACS 2103 *Admission for convalescence/aftercare* which state:

> "When a patient is transferred from one hospital to another with a diagnosis of 'postoperative convalescence' and it is clear the patient is still receiving active treatment, assign as principal diagnosis code Z48.8 *Other specified surgical follow-up care*. The condition which required surgery should be an additional diagnosis code."

Therefore, the correct code assignment for the scenario cited is Z48.8 *Other specified surgical followup care* followed by the code for the condition which was treated by the orthopaedic surgery.

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Ref No: TN196 | Published On: 15-Jun-2010 | Status: Retired | Retired On: 30-Jun-2019

Administration of Haemaccel®

Q:

Should a code be assigned for infusion of Haemaccel®?

A:

Haemaccel® 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. Haemaccel® is a gelatin solution derived from cows, but is not a blood product. Although the code for infusion/transfusion of Haemaccel® 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 Haemaccel® (or similar plasma volume expander) when documented in the clinical record, except for neonates where the guidelines in ACS 1615 *Specific diseases and interventions related to the sick neonate* should be followed.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS

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Ref No: TN196 | Published On: 15-Jun-2010 | Status: Retired | Retired On: 30-Jun-2019

Place of occurrence for intentional (prescribed) drug overdoses

Q:

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

A:

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:

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

OR

Y92.24 *Place of occurrence, health service area, this facility*, where the adverse effect occurs as opposed to where the manifestation of the adverse effect occurs.

This advice has a minor modification to correspond with an update in a subsequent edition ofICD-10-AM/ACHI/ACS.

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Ref No: TN196 | Published On: 15-Jun-2010 | Status: Retired | Retired On: 01-Jul-2017

Anticoagulant monitoring

Q:

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?

A:

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."

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Adhesions

Q:

Should adhesions be coded in the following scenarios?

Adhesions noted at surgery but not divided as they pose a surgical risk - Dense adhesions of bowel to bladder at commencement of total abdominal hysterectomy (TAH). Adhesions not divided due to risk of bladder perforation. TAH performed.

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

Adhesions in this scenario do appear to meet ACS 0002, ie ‘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.

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Multiple trauma

Q:

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 ie no treatment, observation etc. Should they be coded?

A:

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".

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Diabetes with renal failure, unspecified

Q:

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?

A:

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 ...d*iabetes 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.

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Condition onset flag for conditions occurring while patient on leave

Q:

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.

A:

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 '1' assigned.

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Newborn conditions

Q:

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

A:

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.

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Cystic fibrosis

Q:

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.-?


IHACPA

A:

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.

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Bladder neck obstruction (BNO)

Q:

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?

A:

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.

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

Q:

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 [<>] (eg ischium [<>]) 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) <> (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 <> (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?

A:

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 <>, as per point 4 of the note at the Neoplasm Table of the ICD-10-AM Alphabetic Index.

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Food poisoning

Q:

What is the correct code assignment for gastroenteritis due to food poisoning? Is a T code always required?

A:

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

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Lexapro®

Q:

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

A:

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*.

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Stable Angina

Q:

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?

A:

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

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Swine flu with pneumonia

Q:

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

A:

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, ie 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 grippe (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.

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Endoluminal repair of an aortic dissection

Q:

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

A:

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.

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Duodenal switch

Q:

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

A:

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 anastamosed 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 ie 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]**

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Aspiration thrombectomy of the coronary artery

Q:

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

A:

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]**

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Cellulitis with superficial injuries

Q:

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?

A:

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.

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Admission for overnight video EEG

Q:

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

A:

The classification provides the following guidance in relation to video EEG monitoring: ACHI Tabular List “92011-00 **[1825]** *Video and radio-telemetered electroencephalographic [EEG] monitoringNote:* Only to be assigned for monitoring >= 24 hours”

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.

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Place of occurrence - highway (Errata 3, March 2009)

Q:

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*?

A:

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*.

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Vacuum assisted wound closure (VAC® dressings)

Q:

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

A:

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 **[1628]** *Nonexcisional debridement of skin and subcutaneous tissue* or 90686-00 **[1627]** *Nonexcisional debridement of burn*, as appropriate.

This has been indexed for ACHI Seventh Edition as follows:

Dressing

- vacuum 90686-01 **[1628]**

- - for burn 90686-00 **[1627]**

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Ref No: TN196 | Published On: 15-Jun-2010 | Status: Retired | Retired On: 30-Jun-2013

Hepatitis C cirrhosis

Q:

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.

A:

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*

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

Q:

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

A:

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.*

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Excision of hydrocele of the canal of Nuck

Q:

What is the correct code to assign for an excision of the canal of Nuck in an elderly woman?

A:

Hydrocele of the canal of Nuck is a rare condition in females. The canal of Nuck is the portion of the processus vaginalis within the inguinal canal, which normally undergoes obliteration during the first year of life. If obliteration fails in the distal portion of the canal, it may become distended with fluid, and results in a hydrocele of the canal of Nuck.

The correct code to assign for a laparoscopic excision of hydrocele of canal of Nuck is 35637-10 **[1299]** *Laparoscopic excision of lesion of pelvic cavity* following the index pathway:

Excision

- lesion(s)

- - pelvis

- - - cavity, female (laparoscopic) (pelvic peritoneum) 35637-10 **[1299]**

For excision of hydrocele of canal of Nuck via laparotomy assign 35713-14 **[1299]** *Excision of lesion of pelvic cavity* following the index pathway:

Excision

- lesion(s)

- - pelvis

- - - cavity, female (laparoscopic) (pelvic peritoneum) 35637-10 **[1299]**

- - - - via laparotomy 35713-14 **[1299]**

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Kidney transplant failure/kidney transplant status

Q:

A patient admitted to hospital is noted to have had a previous renal transplant which had failed and the patient was now requiring dialysis.

Should kidney transplant failure be assigned or kidney transplant status?

A:

Hyperacute rejections of transplanted kidneys are immediate and acute rejection is highest in the first three months after transplantation. However, acute rejection can also occur months to years after transplantation. Chronic transplant rejection is irreversible and cannot be treated effectively. When deciding whether to code kidney transplant failure or kidney transplant status the coder should attempt to determine, from the information in the clinical record, whether the failed transplant is chronic and irreversible or in an acute rejection phase.

Acute rejections will likely be the focus of the admission with the objective being the treatment of the rejection. For chronic irreversible kidney transplant rejection, the patient is likely to be on maintenance dialysis to treat the CKD stage 5.

Therefore, T86.1 *Kidney transplant failure and rejection* should only be assigned for acute kidney transplant rejections that meet the criteria for code assignment as per ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*.Z94.0 *Kidney transplant status* should be assigned as per the following advice in ACS 1438 *Chronic kidney disease, Kidney replacement therapy* which states:

“For patients who have received a kidney transplant and documentation pertaining to this status satisfies criteria for coding under ACS 0002, assign Z94.0 *Kidney transplant status* together with N18.3 *Chronic kidney disease, stage 3* or higher, as indicated by an eGFR level.”

Therefore, for a patient with a failed kidney transplant who is now requiring dialysis, as per the scenario cited, assign Z94.0 *Kidney transplant status* in addition to N18.5 *Chronic kidney disease, stage 5*.If it is impossible to determine whether the transplant rejection is acute or chronic, then the coder should seek clarification from the clinician.

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HALO ablation therapy

Q:

What is the correct code to assign for HALO ablation therapy of the oesophagus?

A:

HALO ablation therapy is used in the treatment of Barrett's oesophagus - a pre-cancerous condition caused by chronic acid reflux or gastro-oesophageal reflux disease (GORD).

Traditionally Barrett's oesophagus has been managed with frequent endoscopic biopsy surveillance to detect progression to cancer. Ablation, the use of energy, to remove this diseased layer of cells from the oesophagus offers treatment of the disease before it has the opportunity to progress to cancer. For most patients healthy tissue replaces the ablated tissue in three to four weeks.

The HALO system is a very specific type of ablation, in which heat energy is delivered in a precise and highly-controlled manner, to remove the layer of diseased oesophageal tissue, without damage to the normal underlying structures and allowing replacement by normal cells.

Assign 30478-19 **[856]** *Oesophagoscopy with other coagulation* for HALO ablation therapy of the oesophagus.

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Laser treatment of intranasal telangiectases

Q:

What is the correct code to assign for laser treatment of intranasal telangiectases, when performed both with and without endoscopy?

A:

The correct code to assign for endoscopic laser treatment of intranasal telangiectases is 52035-00 **[419]** *Endoscopic laser therapy of upper aerodigestive tract* following the index pathway:

Destruction

- lesion

- - intranasal

- - - by endoscopic laser 52035-00 **[419]**

For laser treatment of intranasal telangiectases, without endoscopy, assign 90130-00 **[374]** *Local destruction of intranasal lesion* following the index pathway:

Destruction

- lesion

- - intranasal 90130-00 **[374]**

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Repair of epigastric hernia

Q:

What is the correct code assignment for repair of an obstructed epigastric hernia?

A:

ICD-10-AM, as per the parent classification ICD-10, classifies an obstructed epigastric hernia to K43.0 *Ventral hernia with obstruction, without gangrene* following the index pathway:

Hernia, hernial

- - epigastric -- see Hernia, ventral – ventral

- - with

- - - obstruction K43.0

Category K43 *Ventral hernia*, has an includes note for *epigastric hernia*. ACHI is based on the Medicare Benefits Schedule (MBS), where terminology for hernias differs to that in ICD-10. To assign a code for a hernia repair, follow the index pathways provided in ACHI, for the type of hernia documented, not the code assigned by ICD-10-AM.

The correct code assignment for repair of an obstructed epigastric hernia is 30615-00 **[997]** *Repair of incarcerated, obstructed or strangulated hernia,* by following the index pathway:

Repair

- hernia

- - epigastric (with graft) (with prosthesis)

- - - incarcerated (obstructed) (with prosthesis) 30615-00 **[997]**

Ventral hernia is excluded at block **[997]**. A code from category **[996]** *Repair of other abdominal wall hernia* should only be assigned if a ventral or unspecified abdominal wall hernia is documented, which is not the case in the scenario cited.

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Viral hepatitis C

Q:

Following the ICD-10-AM index, the correct code to assign for viral hepatitis C, not otherwise specified is B17.1 *Acute hepatitis C.* However ACS 0104 *Viral hepatitis* gives advice which overrides the default in the Alphabetic Index. Is this correct, and if so, should the default in the index be amended as per the advice in the standard?

A:

The ICD-10-AM Alphabetic Index defaults viral hepatitis type C to B17.1 *Acute hepatitis C* as per ICD-10. However, this is not supported by Australian clinicians and ACS 0104 *Viral hepatitis* was created in Second Edition to provide guidance on the classification of viral hepatitis.

Coders should follow the standard practice of searching for terms in the Alphabetic Index, and then verify code assignment by referring to the Tabular List and any applicable *Australian Coding Standards*.

Therefore, symptomatic hepatitis C without specification of acuity (ie acute or chronic) is classified to B18.2 *Chronic viral hepatitis C*, by following the guidelines in ACS 0104.

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Electrochemotherapy

Q:

What is the correct code assignment for electrochemotherapy?

A:

Electrochemotherapy is a therapeutic approach which facilitates the delivery of non-permeant drugs directly into the interior of a cell. This is achieved by the local application of short and intense electric impulses that transiently allow permeation of the cell membrane; and transportation of molecules that otherwise would not be permitted by the cell membrane.

Electrochemotherapy is becoming widely used to improve anticancer drug delivery into cells. Applying electric impulses to the area to be treated when the concentration of the drug in the tumour is at its peak has been effective in delivering non-permeant cytotoxic drugs, such as bleomycin, or low-permeant cytotoxic drugs such as, cisplatin, directly into the targeted area. The treatment can be repeated over the course of weeks or months to achieve regression of large lesions.

There is no specific code in ACHI for electrochemotherapy. Assign an appropriate code from block **[1920]** *Administration of pharmacotherapy* with an extension of -00 for electrochemotherapy.

Where electrochemotherapy is performed on skin lesions, assign as an additional code either 30195-06 **[1612]** *Electrotherapy of lesion of skin, single lesion* or 30195-07 **[1612]** *Electrotherapy of lesion of skin, multiple lesions*, as appropriate.

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Transanal endoscopic microsurgery (TEMS)

Q:

What is the correct code to assign for TEMS?

A:

Transanal endoscopic microsurgery (TEMS) is a technique used for the resection of rectal tumours. It combines the use of specialised equipment, including an operating proctoscope, gas insufflation and magnified stereoscopic views with conventional surgical preparation and suturing. TEMS overcomes the limitations of local resection and allows the removal of lesions through the anus that are not normally accessible.

The correct code to assign for TEMS is 32103-00 **[933]** *Per anal excision of lesion or tissue of rectum via stereoscopic rectoscopy*, following the index pathway:

Excision

- lesion(s)

- - rectum

- - - via

- - - - stereoscopic rectoscopy 32103-00 **[933]**

or

Excision

- tumour

- - rectum (per anal) (submucosal)

- - - via stereoscopic rectoscopy 32103-00 **[933]**or

Rectoscopy

- stereoscopic, with excision of lesion, per anal 32103-00 **[933]**

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Radial endoscopic ultrasound (EUS)

Q:

What is the correct code to assign for radial endoscopic ultrasound (EUS)?

A:

In ACHI Sixth Edition, radial endoscopic ultrasound (EUS) should be assigned a code from block 1949 *Intraoperative ultrasound*, as appropriate.

In ACHI Seventh Edition, radial endoscopic ultrasound should be assigned to the new code - 30668-00 **[1949]** *Endoscopic ultrasound*.

However, EUS should only be coded if it meets the criteria for code assignment as per the guidelines in ACS 0042 *Procedures normally not coded*.

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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.

Q:

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?

A:

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.

Q:

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?

A:

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, andclarification 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.

Q:

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?

A:

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*.

Q:

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?

A:

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.

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Methicillin Resistant or Multi-Resistant *Staphylococcus aureus* (MRSA) or Vancomycin Resistant Enterococcus (VRE) carriers

Q:

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

A:

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,* and assign a code from Z06.5- – Z06.7- for the drug resistant microorganism.

For a carrier of MRSA follow the index pathway:

Carrier (suspected)

- staphylococci Z22.3

and

Resistance, resistant (to)

- methicillin (cloxacillin) (dicloxacillin) (flucloxacillin)(oxacillin) Z06.52

OR

Resistance, resistant (to)

- multiple
- - antibiotics Z06.67

For a carrier of VRE follow the Alphabetic Index:

Carrier (suspected)

- streptococci Z22.3

and

Resistance, resistant (to)

- vancomycin Z06.61

See also Coding Rule: *Carrier of drug resistant microorganisms.*

Q:

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

A:

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.

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

Q:

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*?

A:

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.

Q:

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

A:

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:

Surgery

- prophylactic Z40.9

- - removal for risk-factors related to malignant neoplasm

- - - specified organ 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.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

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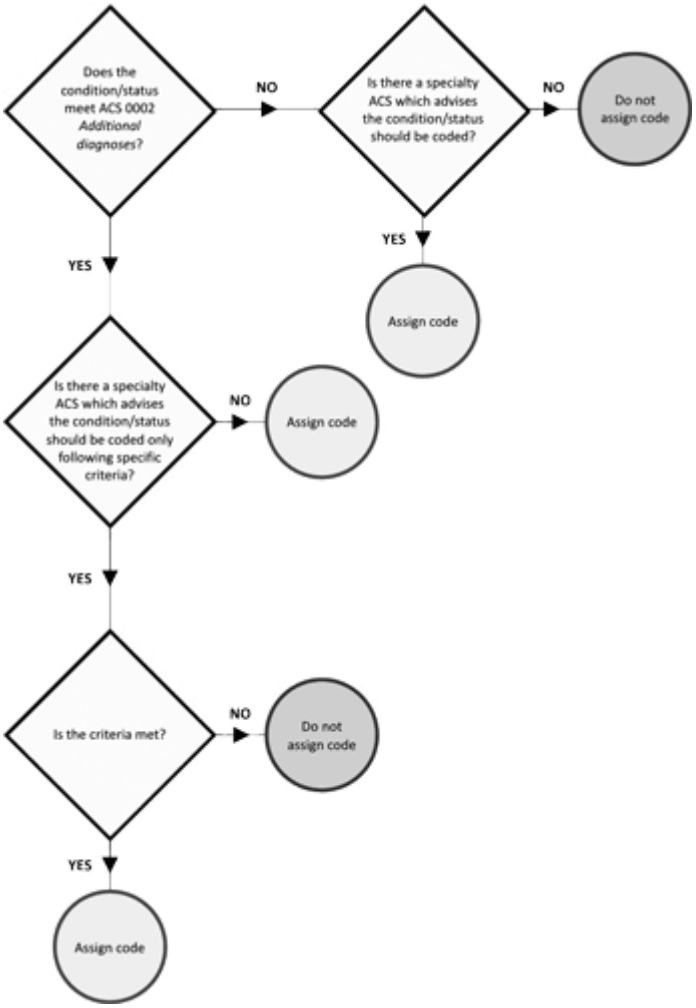
ACS 0002 *Additional diagnoses* and specialty standards (1 of 4)

Q:

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 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 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 *Stroke* 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 *Drug, alcohol and tobacco use disorders* and should be coded.

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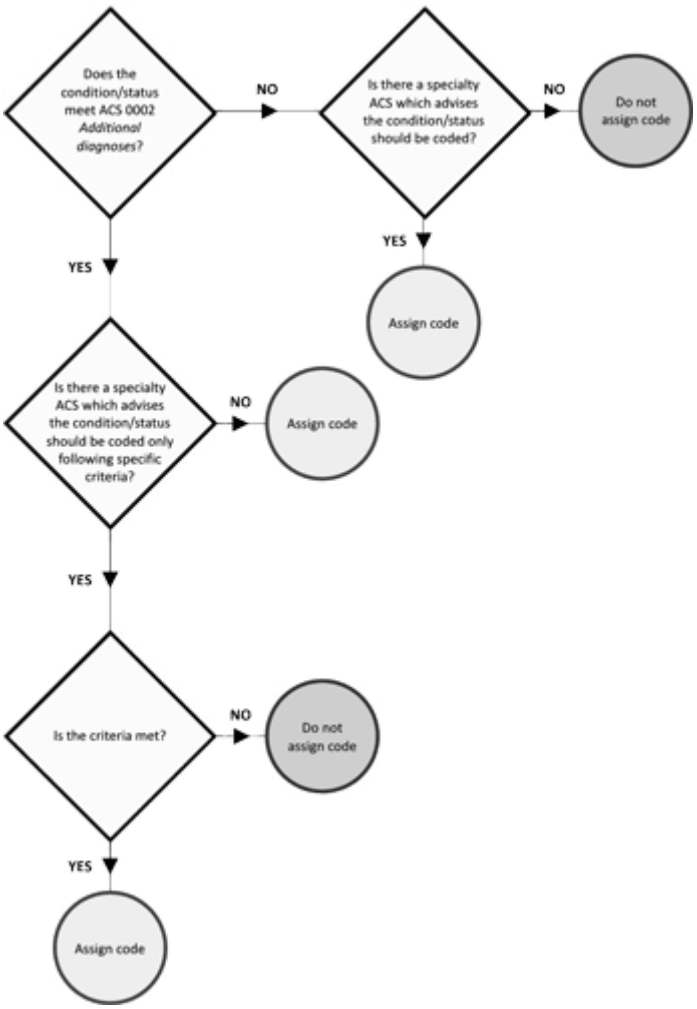
ACS 0002 *Additional diagnoses* and specialty standards (2 of 4)

Q:

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 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 *Stroke* and should not be coded.

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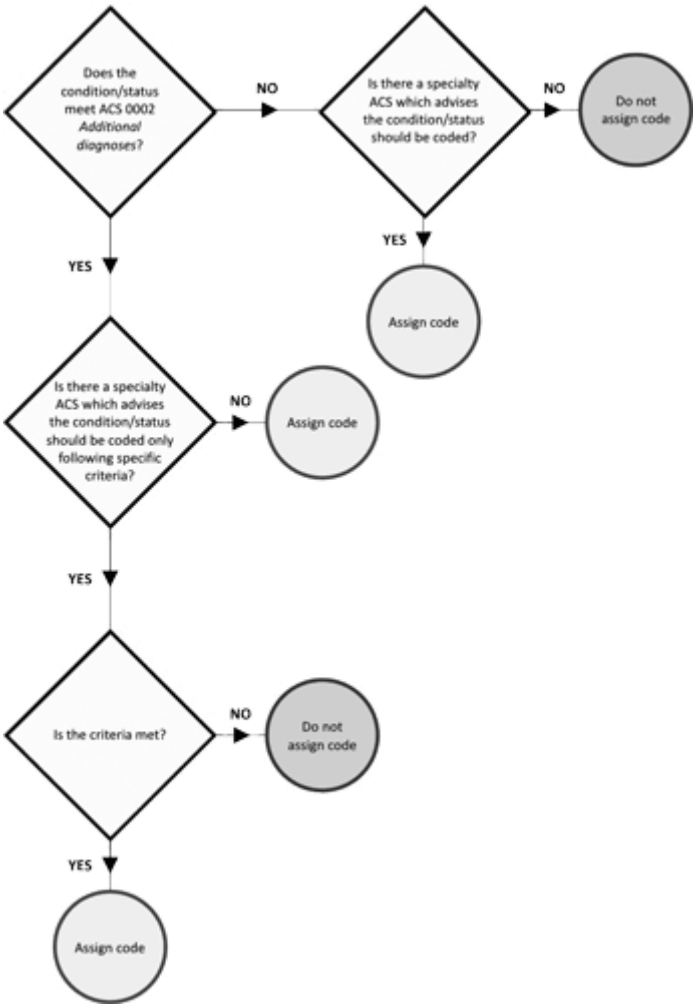
ACS 0002 *Additional diagnoses* and specialty standards (3 of 4)

Q:

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 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 *Drug, alcohol and tobacco use disorders* and should be coded.

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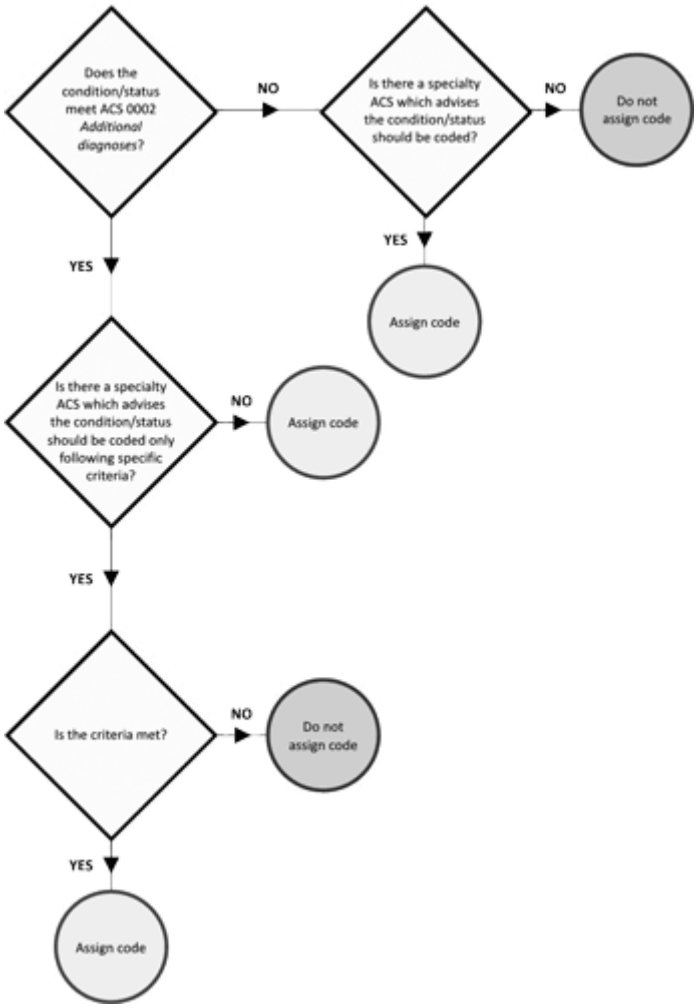
ACS 0002 *Additional diagnoses* and specialty standards (4 of 4)

Q:

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 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 *Viral hepatitis*.

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Carpal tunnel syndrome in pregnancy

Q:

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

A:

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

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Babycenter, Carpal tunnel syndrome. Accessed 16 September 2009. http://www.babycenter.com.au/pregnancy/antenatalhealth/naturalremedies/carpaltunnelsy...Better Health Channel, Carpal tunnel syndrome. Accessed 16 September 2009. http://www.betterhealth.viv.gov.au/bhcv2/bhcarticles.nsf/pages/Carpal_tunnel_syndrome

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De Morsier’s syndrome

Q:

What is the correct code assignment for DeMorsier’s syndrome?

A:

De Morsier’s syndrome, also known as septo-opticdysplasia (SOD), is a rare disorder characterised by abnormal development of the optic disc, pituitary deficiencies, and often agenesis (absence) of the septumpellucidum (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.

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Incorrect drug given in hospital

Q:

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'.

A:

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.

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Anaemia in myelodysplastic syndromes

Q:

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

A:

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 itis 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*

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Drug induced diarrhoea

Q:

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

A:

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-Sjukvarden, 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.

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AV nodal re-entrant tachycardia (AVNRT)

Q:

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

A:

AVNRT is the most common type of re-entrant supraventricular tachycardia (SVT). Because of the abrupt onset and termination of the re-entrant 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

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Sequestration of intervertebral disc

Q:

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

A:

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*.

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Sliding Scale Insulin

Q:

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

A:

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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Neonatal jaundice

Q:

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?

A:

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.

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Use of abbreviations, symbols and test result values to inform code assignment for abnormal pathology results

Q:

When can coders use abbreviations, symbols and test result values documented in the clinical record to assign conditions, eg ↓Hb or Hb 98 documented and transfusion given - can anaemia be assigned? ↓K or K2.9 documented and potassium supplements commenced - can hypokalaemia be assigned?

A:

Clinicians may document test result values as well as abbreviations and symbols in the clinical record as shorthand to indicate conditions such as anaemia, hypokalaemia, hypercalcaemia etc.

Where such shorthand is used to document/describe a condition, each instance must be assessed on its merits and where possible confirmed with a clinician to ensure that the documentation sufficiently describes a condition that is both supported by an appropriate index entry and meets the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*.

Test result values, symbols and abbreviations are not to be used in isolation to inform code assignment and coders should therefore:

clarify the significance of the documented shorthand (test result, values, abbreviations and symbols) with the clinician to inform code assignment

Where this is not possible assign a code for the condition represented in shorthand (as described above) **only** if:

test results (pathology report) verify that a result is abnormal AND

there is an appropriate ICD-10-AM index pathway AND

it meets the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*.

For example, where ↓Hb or a haemoglobin level (eg.Hb 98) is documented as the indication for a transfusion and the test results (pathology report) and/or the clinician verifies the patient's haemoglobin is below the normal range, follow the index pathway:

Low

- haemoglobin

to assign D64.9 *Anaemia, unspecified*.

Where ↓K or a potassium level (eg.K 2.9) is documented as the indication for commencement of medication and the test results and/or clinician verifies the patient's potassium is below the normal range, follow the index pathways:

Deficiency

- potassium (K)


IHACPA

Depletion

- potassium

Hypokalaemia

Hypopotassaemia

to assign E87.6 *Hypokalaemia*.

However, if ICD-10-AM does not provide an index look up or there is uncertainty or ambiguity in relation to such abbreviated forms of documentation, always confirm with the clinician prior to code assignment.

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Procedural complications

Q:

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

A:

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

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

Misadventure

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

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

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

Therefore, for this scenario, follow the index pathway:

Arrest, arrested

- cardiac

- - postprocedural I97.8

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

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

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Coding from times documented on partogram

Q:

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

A:

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

This advice has a minor modification to

correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

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Food challenges

Q:

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

A:

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

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

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

Observation

- suspected (undiagnosed) (unproven)

- - toxic effects from ingested substance (drug) (poison) Z03.6

and

History (of) (personal)

- family, of

- - allergy NEC Z84.8

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BK virus

Q:

What is the correct code to assign for BK virus?

A:

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

This virus is normally latent, however, it may be reactivated in immunocompromised or immunosuppressed patients. It is believed to be the cause of nephropathy, nephritis and haemorrhagic cystitis in organ transplant recipients. The correct code to assign for BK virus is B97.8 *Other viral agents as the cause of diseases classified to other chapters* by following the index pathway:

Infection, infected

- virus NEC

- - specified type NEC

- - - as cause of disease classified elsewhere B97.8

Codes from category B95-B97 *Bacterial, viral and other infectious agents* are not intended for use as principal diagnoses. As indicated in the code titles, they are provided for use as supplementary or additional codes to identify the infectious agent(s) in diseases classified elsewhere. See 10-AM Commandments March 2007 (Vol. 13, No. 4).

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Bairnsdale ulcer

Q:

What is the correct code for a Bairnsdale ulcer?

A:

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

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Admission for creation of an AV fistula

Q:

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

1. Cases of chronic kidney disease with ongoing kidney replacement therapy, whether by dialysis or by transplant, which comply with ACS 0002 *Additional diagnoses*, require a code from N18.- *Chronic kidney disease* to describe the current stage of disease, except in routine dialysis only admissions.
2. For routine dialysis only admissions it can be assumed from the assignment of Z49.1 *Extracorporeal dialysis* or Z49.2 *Other dialysis* that the patient has CKD - stage 5 (see also ACS 1404 *Admission for kidney dialysis*).

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

A:

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

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Transferred patient: acute on chronic kidney disease

Q:

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

A:

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

'In this scenario assign N18.9 *Chronic kidney disease*, unspecified for the chronic component of the disease as the eGFR will not be a true indicator of the underlying level of kidney function.

However if 'end-stage' is documented or the patient is on ongoing haemodialysis or peritoneal dialysis then N18.5 Chronic kidney disease, stage 5 would be assigned.'

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Patient controlled analgesia (PCAs)

Q:

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

A:

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

[1912] *Postprocedural analgesia*

i. Management of neuraxial block (92516-00)

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

iii. Subcutaneous postprocedural analgesic infusion (90030-00)

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

v. Intravenous postprocedural analgesic infusion (92518-01)

Subcutaneous and intravenous postprocedural analgesic infusions should not be coded and ACS0031 will be amended in Seventh Edition to reflect this advice with points iii-v being deleted in the above hierarchy of codes.

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Anaemia in neoplastic disease

Q:

Please clarify the following:

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

Anaemia and melaena ? cause

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

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

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

b. The following advice was issued in Coding Matters Vol 6, No 1: 'Code D63.0* *Anaemia in neoplastic disease* should be assigned when anaemia occurs in, due to or with a neoplastic condition. The specific code for the neoplasm should be assigned when known, as indicated by the inclusion term: D63.0* *Anaemia in neoplastic disease*

Conditions in Chapter 2 (C00-D48).'Does this advice still apply?

A:

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

b. The NCCH acknowledges there has been difficulty in applying this advice, particularly where the anaemia is unrelated to the neoplasm. It was not intended for this code to be assigned where the anaemia has been documented as due to an unknown cause or a nonneoplastic condition. The codes in category D63 *Anaemia in chronic diseases classified elsewhere* have been revised for ICD-10-AM Seventh Edition.

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Insertion of fiducial markers into the prostate

Q:

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

A:

Fiducial markers are implantable devices used as a tool in image-guided radiotherapy (IGRT). The markers may also be called fiducial seeds or gold seed markers. Gold seeds are the most frequently used markers. The seeds are inserted into the prostate via a needle using transrectal ultrasound. Several days after insertion of the seeds treatment planning by CT simulation is commenced. There is currently no specific code in ACHI for insertion of fiducial markers into prostate, therefore assign 90395-00 **[1170]** *Other procedures on prostate*. A specific code for this procedure has been included in ACHI Seventh Edition.

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Osteomyelitis of knee due to *Burkholderia pseudomallei* infection

Q:

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

A:

Osteomyelitis is an unusual but well recognised manifestation of melioidosis, a disease that is endemic in South-East Asia and northern Australia. Infection is caused by *Burkholderia pseudomallei* which can be acquired by ingestion, inhalation or wound contamination. Infection more commonly occurs in people with coexistent conditions such as diabetes, renal impairment, chronic pulmonary disease and immunosuppression. Subacute presentations often mimic other disease processes and patients may not always be clinically septic. Treatment for osteomyelitis often requires surgical drainage and multiple antibiotic therapy. The correct codes to assign for the scenario cited above are M86.86 *Other osteomyelitis, lower leg* and B96.88 *Other and unspecified bacterial agents as the cause of diseases classified to other chapters*, following the pathways:

Osteomyelitis (infective) (septic) (suppurative)

- specified NEC M86.8-

And

Burkholder NEC

- *pseudomallei (see also Melioidosis)*

- - as the cause of disease classified elsewhere B96.88

Or

Infection, infected

- *Burkholderia* NEC

- - *pseudomallei (see also Melioidosis)*

- - - as the cause of disease classified elsewhere B96.88

Bibliography

Nandurkar, D Lau, K, Melioidosis as a Cause of Multifocal Osteomyelitis, Clinical Nuclear Medicine, Volume 31(1), January 2006, pp 25-27. Accessed 15 July 2009. http://journals.lww.com/nuclearmed/Abstract/2006/01000/Melioidosis_as_a_Cause_of_Multifocal_Osteomyelitis.9.aspxPopoff, I, Nagamori, J Currie, B, Melioidotic Osteomyelitis in Northern Australia, ANZ Journal of Surgery, Volume 67, Issue 10 (p 692-695). Published Online 21 January 2008. Accessed 15 July 2009. http://www3.interscience.wiley.com/cgi-bin/fulltext/119163131/PDFSTART

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Coding of sedation with ventilation/intubation

Q:

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

A:

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

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Clinical record 2 - acute kidney failure due to dehydration and medications

Q:

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

A:

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

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Clinical record 5 - Bradycardia

Q:

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

A:

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

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

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

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

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

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

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

and assign:

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

R00.1 *Bradycardia, unspecified*

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

> '**Misadventure**
>
> A misadventure is defined as a complication occurring during medical or surgical care. It may be noted at the time of the procedure or after completion of the procedure.
>
> From the documentation we know the complication occurred intraoperatively and the external cause code then identifies the timing of the complication. Assign Y65.8 *Other specified misadventures during surgical and medical care* as per the following classification guidelines:


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Misadventure

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

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

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Clinical record 5 - Procedure: short colonoscopy

Q:

Why was a short colonoscopy coded in clinical record 5?

A:

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

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

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

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

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Clinical record 5 - principal diagnosis: diverticulosis

Q:

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

A:

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

Additional codes were assigned for the anaemia and melaena (refer to ACS 1103 *Gastrointestinal (GI) haemorrhage*) and as the contact bleeding (transverse colon) occurred at a different site to the diverticulosis (sigmoid colon) no link has been made between these two conditions.

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Clinical record 6 - Bacterial agents resistant to antibiotics (Z06.-)

Q:

Why was Z06.99 *Agent resistant to other single specified antibiotic* assigned in clinical record 6?

A:

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

> 'If the clinician has documented in the record that the organism causing the infection is resistant to an antibiotic, then the appropriate code from Z06.- *Bacterial agents resistant to antibiotics* must also be assigned. A code from category Z06.- *Bacterial agents resistant to antibiotics* is assigned as an additional code to identify the antibiotic to which a bacterial agent is resistant.'

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

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Clinical record 6 - Ischaemic heart disease

Q:

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

A:

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

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

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

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

- the 'old' myocardial infarction occurred more than four weeks (28 days) ago;
- the patient is currently not receiving care (observation, evaluation or treatment) for their 'old' myocardial infarction; and
- the 'old' myocardial infarction meets the criteria in ACS 2112 *Personal history*.

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Case scenario 3 - intraoperative haemorrhage

Q:

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

A:

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

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

Haemorrhage at any site resulting from a procedure

Excludes: haematoma of obstetric wound (O90.2)

haemorrhage due to or associated with prosthetic devices, implants and grafts (T82.8, T83.8T84.8, T85.8)

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

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Case scenario 3 - haematoma

Q:

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

A:

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

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

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

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

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

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

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Case scenario 3 - coding of I25.2 *Old myocardial infarction* and Z95.5 *Presence of coronary angioplasty implant and graft*

Q:

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

A:

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

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Case scenario 4 - Principal diagnosis: R07.4 *Chest pain, unspecified*

Q:

In case scenario 4: Principal diagnosis Bradycardia History:

ESRD secondary to CKD Hypertension Mitral regurgitation Gout Patient was transferred from another hospital dialysis centre on 11/8 for investigation and management of chest pain and bradycardia. He was noted to have chest pain while receiving dialysis and his heart rate was 40bpm. Following transfer he was still experiencing some dizziness and chest pain which was eventually relieved by GTN...

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

A:

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

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

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Case scenario 4 - Ventricular bigeminy noted on ECG

Q:

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

A:

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

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

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Case scenario 5 - coding of fluid overload

Q:

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

A:

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

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

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

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Case scenario 6 - Hickman's catheter

Q:

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

A:

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

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

Changes are being made to this area of the classification for Seventh Edition to provide specific guidance on the coding of IV lines and catheters. See also advice in 10-AM Commandments - *Multiple coding of procedures*, published in Coding Matters September 2009 (Vol 16, No 2).

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Case scenario 7 - revision of burns scar

Q:

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

A:

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

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

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

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Case scenario 8 - primigravida

Q:

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

A:

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

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Case scenario 9 - Central cord syndrome (CCS)

Q:

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

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

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

A:

Central cord syndrome (CCS) is an acute incomplete cervical spinal cord injury (SCI). This syndrome, usually the result of trauma, is associated with damage to the large nerve fibres that carry information directly from the cerebral cortex to the spinal cord. The segment of spinal cord affected by central cord syndrome is the cervical segment, the part of the spinal cord that is encased within the first seven vertebrae, running from the base of the brain and into the neck.

The cord syndromes describe the area (almost cross sectionally) of the spinal cord that has been affected by the lesion (ie contusion/haemorrhage etc). A common cause of this type of injury includes trauma.

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

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

http://www.answers.com/topic/central-cord-syndrome

http://www.ninds.nih.gov/disorders/central_cord/central_cord.htm

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

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

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Neonatal jaundice and preterm delivery (P59.0)

Q:

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

A:

No, the index indicates that the jaundice can be ‘due to or associated with’ preterm delivery.

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Art therapy

Q:

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

A:

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

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

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

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

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Correction of forefoot deformity

Q:

A patient is admitted for correction of a forefoot deformity. The body of the operation report describes the exact procedure as an arthrodesis of the 1st metatarsophalangeal (MTP) joint and four osteotomies of separate toes with internal fixation. What is the correct code assignment?

A:

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

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

Arthrodesis (with fixation device)

- metatarsophalangeal, 1st 49845-00 **[1543]**

And

Osteotomy

- toe

- - with internal fixation 48403-01 **[1528]**

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Biventricular pacemaker - contusion of thorax

Q:

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

A:

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

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Alcohol poisoning

Q:

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

A:

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

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

Intoxication

- alcoholic (acute) (with) F10.0

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

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

Table of Drugs and Chemicals

Alcohol

- beverage T51.0

and appropriate external cause of injury codes.

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

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Retained placenta - with and without haemorrhage

Q:

What is the difference between:

O72.0 *Third-stage haemorrhage*

O72.2 *Delayed and secondary postpartum haemorrhage*

and

O73.0 *Retained placenta without haemorrhage*

O73.1 *Retained portions of placenta and membranes, without haemorrhage*?

A:

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

Retention, retained

- placenta (total) (with haemorrhage) O72.0

- - without haemorrhage O73.0

- - portions or fragments (with haemorrhage) O72.2

- - - without haemorrhage O73.1

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

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ACS 0020 *Bilateral/multiple procedures*: point 5 - coding of excision of skin lesions

Q:

Could you please clarify the coding of excision of skin lesions in point 5 of ACS 0020 *Bilateral/multiple procedures*? For example, if a patient is admitted for excision of a BCC on the forearm and a compound naevus on the breast and both are excised during the same visit to theatre, what code(s) would be assigned?

A:

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

1. Procedures with a bilateral code
2. Inherently bilateral procedures
3. Procedures with no code option for bilateral

Multiple procedures

1. The SAME PROCEDURE repeated during the episode of care at different visits to theatre
2. The SAME PROCEDURE repeated during a visit to theatre involving ONE ENTRY POINT/APPROACH and similar/same lesions
3. The SAME PROCEDURE repeated during a visit to theatre involving ONE ENTRY POINT/APPROACH and different lesions
4. The SAME PROCEDURE repeated during a visit to theatre involving MORE THAN ONE ENTRY POINT/APPROACH and more than one non-bilateral site
5. Skin or subcutaneous lesion removal

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

Excision -- *see also Removal*

- lesion(s) -- *see also Excision, tumour and Excision, cyst and Excision, polyp*

- - skin and subcutaneous tissue

- - - specified site NEC 31205-00 **[1620]**

- - - - ankle 31235-04 **[1620]**

- - - - calf 31235-03 **[1620]**

- - - - cheek 31235-00 **[1620]**

- - - - ear 31230-02 **[1620]**

- - - - - wedge 45665-02 **[1663]**

- - - - eyelid 31230-00 **[1620]**
- - - - - wedge 45665-01 **[1662]**
- - - - finger 31230-04 **[1620]**
- - - - foot 31235-04 **[1620]**
- - - - forehead 31235-00 **[1620]**
- - - - genitals 31230-05 **[1620]**
- - - - hand 31235-02 **[1620]**
- - - - head NEC 31235-00 **[1620]**
- - - - hip 31235-03 **[1620]**
- - - - knee 31235-03 **[1620]**
- - - - leg 31235-03 **[1620]**
- - - - lip *(see also Excision, lesion(s), lip)* 31230-03 **[1620]**
- - - - - wedge 45665-00 **[1664]**
- - - - neck 31235-01 **[1620]**
- - - - nose 31230-01 **[1620]**
- - - - penis 31230-05 **[1620]**
- - - - pre and postauricular region 31235-00 **[1620]**
- - - - scrotum 31230-05 **[1620]**
- - - - thigh 31235-03 **[1620]**
- - - - thumb 31230-04 **[1620]**
- - - - toe 31235-04 **[1620]**
- - - - vulva 31230-05 **[1620]**
- - - - wrist 31235-02 **[1620]**

The following examples can assist in code assignment:

- single or multiple forehead skin sites eg assign 31235-00 **[1620]** once only
- lesion(s) removed from hip, thigh and knee assign 31235-03 **[1620]** once only as ACHI provides the same code for these sites
- lesion(s) removed from hand and foot assign 31235-02 **[1620]** and 31235-04 **[1620]** as ACHI provides a separate code for each site.

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Multiple coding of procedures

Q:

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

A:

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

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

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

See also, 10-AM Commandments June 2008 - Central venous and arterial lines (Vol 15, No 1) and advice issued regarding the coding of multiple CT scans in FAQs, part 2 published in Coding Matters December 2008 (Vol 15, No 3) and advice regarding the insertion of Hickman's line in FAQs published in this edition of Coding Matters September 2009 (Vol 16, No 2). These issues have been addressed for the Seventh Edition of ICD-10-AM/ACHI/ACS.

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Ref No: TN199 | Published On: 15-Sep-2009 | Status: Retired | Retired On: 30-Jun-2013

Molecular Adsorbent Recirculating System (MARS) treatment

Q:

What is the correct code to assign for MARS treatment?

A:

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

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

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Radiofrequency ablation of stellate ganglion

Q:

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

A:

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

Ablation

- nerve -- *see also Neurotomy*

Neurotomy

- peripheral

- - percutaneous, by

- - - radiofrequency 39323-00 **[72]**

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

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Descmets Stripping Endothelial Keratoplasty (DSEK)

Q:

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

A:

DSEK is a type of partial thickness keratoplasty.

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

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Ileocolic resection

Q:

When a portion of the ileum is removed along with the caecum the procedure is called an ileocolic resection. There is no index entry for this procedure, so what code(s) should be assigned? ACHI does not contain a specific code for ileocolic resection.

A:

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

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

And

Colectomy

- local -- *see Colectomy, limited* ...

- limited (local) (with anastomosis) 32003-00 **[913]**

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

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Z91.1 *Personal history of noncompliance with medical treatment and regimen*

Q:

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

A:

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

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

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

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Principal diagnosis: patient admitted with multiple microvascular complications of their diabetes

Q:

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

A:

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

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

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

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Idiopathic Infantile Arterial Calcification (IIAC)

Q:

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

A:

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

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

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

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Incontinence

Q:

Please clarify ACS 1808 *Incontinence* below in relation to the following:

1808 INCONTINENCE

“Incontinence is clinically significant when the incontinence:

- is not clinically considered to be physiologically normal,
- is not clinically considered to be developmentally normal, or
- is persistent in a patient with significant disability or mental retardation.

Urinary and faecal incontinence codes (R32 *Unspecified urinary incontinence*, R15 *Faecal incontinence*) should be assigned only when the incontinence is persistent prior to admission, is present at discharge or persists for at least seven days.”

Should coders use the information in the first paragraph of the ACS to determine if the incontinence is ‘clinically significant’ before following the classification advice in the second paragraph or is this paragraph for information only?

A:

R32 Unspecified urinary incontinence and R15 Faecal incontinence should be assigned if they meet the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*. Additionally, advice in ACS 1808 *Incontinence* should be followed. Therefore, the first paragraph is for information only.

Q:

When following the classification advice in the second paragraph, would a code for incontinence be assigned for any patient, with any length of stay (including same day) admitted for any condition who was incontinent once only, providing it was on their day of discharge. That is, would you assign an additional code for incontinence for a same day admission of an elderly patient where voluminous incontinence is noted but is not the principal reason for admission?

A:

Coders should apply the advice in the second paragraph where the intent is to code ‘persistent’ faecal and/or urinary incontinence. So, for a same day episode of care, the advice to assign a code for incontinence present at discharge should only be followed where the documentation confirms that incontinence is a persistent problem.

Q:

Does this ACS cover all types of urinary incontinence or only those classifiable to R32 *Unspecified urinary incontinence*?

A:

The advice in ACS 1808 is for urinary incontinence classifiable to R32 *Unspecified urinary incontinence*, only. It does not apply to other types of urinary incontinence eg overflow, stress incontinence etc.

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Soft tissue injuries (STIs)

Q:

Can you clarify ACS 1331 *Soft tissue injuries*, particularly in relation to contusions which are classified as superficial injuries rather than soft tissue injuries?

A:

Soft tissue injuries include damage to muscles, ligaments and tendons. They usually fall into one of the following:

- contusions (bruises)
- sprains
- strains

A **contusion** is an injury to soft tissue often produced by a blunt force such as a kick, fall or blow.

A **sprain** is an injury to a ligament and is often caused by a wrench or twist.

While a **strain** is an injury to a muscle or tendon and is often caused by overuse, force or stretching.

ACS 1331 *Soft tissue injuries* advises that where a more specific injury is documented (eg contusion, sprain or strain), these should be coded rather than following the index pathway '*Injury, site*'. Where soft tissue injury is the only description documented for an injury, assign a code by following the index pathway '*Injury, site*'. ICD-10-AM, as per ICD-10, classifies 'contusion' as a superficial injury, however, this does not alter the classification advice above.

The NCCH will review ACS 1331 *Soft tissue injuries* for a future edition of the ACS.

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Combination drug coding

Q:

How should poisoning/adverse effect due to combination drugs be coded? For example, Mersyndol, which is a combination of 3 drugs; *codeine, paracetamol* and *doxylamine succinate*.

A:

If a combination drug is documented as the cause of a poisoning/adverse effect - and no individual component is identified as being responsible for the poisoning/adverse effect, assign a code for each of the components.

> **Example 1**: Patient admitted with poisoning by Mersyndol (codeine, paracetamol and doxylamine succinate). No individual component of the Mersyndol was identified as the cause of the poisoning.
>
> Table of Drugs and Chemicals:
>
> Codeine...
>
> T40.2 Doxylamine...
>
> T45.0 Paracetamol...T39.1
>
> Assign:T40.2 *(Poisoning by) Other opioids* T45.0 *(Poisoning by) Antiallergic and antiemetic drugs*T39.1 *(Poisoning by) 4-Aminophenol derivatives*
>
> With a code for any significant manifestation that meets the criteria in ACS 0002 *Additional diagnoses*, plus appropriate external cause, place of occurrence and activity codes.

If a combination drug is documented as the cause of a poisoning/adverse effect - and one of the components is identified as causing the poisoning/adverse effect, assign a code for that drug only. Code(s) for the other components of the combination drug are not required.

> **Example 2**: Patient admitted with bronchospasm due to ingestion of Mersyndol (codeine, paracetamol and doxylamine succinate) - taken as directed on the packet, for menstrual cramps. The codeine was documented as the cause of the bronchospasm.
>
> Table of Drugs and Chemicals:Codeine...
>
> Y45.0Assign:J98.0 *Diseases of bronchus, not elsewhere classified*
>
> Y45.0 *(Drugs ... causing adverse effects in therapeutic use) Opioids and related analgesics*
>
> With appropriate place of occurrence code.

See also ACS 1901 *Poisoning*, ACS 1902 *Adverse effects* and ACS 1903 *Two or more drugs taken in combination*.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

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Complications of surgical and medical care

Headache due to anaesthesia

Q:

How do you code headache due to anaesthesia (other than spinal and epidural anaesthesia)?

A:

To code headache due to anaesthetic drugs or anaesthesia, follow the guidelines in ACS 1904 *Procedural complications* and ACS 1902 *Adverse effects, Drugs*.

For headache due to anaesthetic drugs, follow the index pathway:

Headache

- drug induced NEC G44.4

and assign G44.4 *Drug-induced headache, not elsewhere classified* with an external cause code to identify the drug.

If the headache is specified as due to anaesthesia, but not specifically the anaesthetic drugs, follow the index pathway:

Complications

- anaesthesia, anaesthetic NEC *(see also Anaesthesia, complication or reaction NEC)* T88.5

and assign T88.5 *Other complications of anaesthesia* with R51 *Headache* as an additional diagnosis to complete the clinical picture.

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Leaking gastrostomy tube

Q:

What is the correct code assignment for leaking gastrostomy tube?

A:

To assign a code for leaking gastrostomy tube follow the guidelines in ACS 1904 *Procedural complications*:

“Firstly, check the Alphabetic Index under the main term which best describes the complication, for the subterm of ‘procedural’ or ‘postprocedural’ ... In some cases, rather than the generic term ‘postprocedural’, the subterm may directly describe the procedure involved.”

Therefore, the correct code to assign is T85.5 *Mechanical complication of gastrointestinal prosthetic devices, implants and grafts* by following the index pathway:

Leak, leakage

- device, implant or graft

- - gastrointestinal (bile duct) (oesophagus) T85.5 with

Y83.3 *Surgical operation with formation of external stoma* and

Y92.22 *Health service area*.

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Postprocedural bile leak

Q:

What is the correct code assignment for postprocedural bile leak?

A:

When postprocedural/anastomotic bile leakage is documented but trauma or mechanical complication (conditions listed in T82.0) due to gastrointestinal implant is not specified, assign K91.8 *Other postprocedural disorders of the digestive system, not elsewhere classified*, following the index pathway:

Complication

- digestive

- - postprocedural

- - - specified NEC K91.8

K83.8 *Other specified diseases of biliary tract* may be assigned as an additional code to specify the site of the postprocedural/anastomotic bile leak. Where there is documentation that the postprocedural/anastomotic bile leak is due to trauma or mechanical complication (conditions listed in T82.0), assign the appropriate codes from Chapter 19 *Injury, Poisoning and Certain Other Consequences of External Causes* (S00-T98) as per the guidelines in ACS 1904 *Procedural complications*.

For example, for a postprocedural/anastomotic bile leak due to:

- **operative trauma** - assign T81.2 *Accidental puncture and laceration during a procedure, not elsewhere classified* with the appropriate injury code (S code) to identify the site of the trauma.
- **mechanical complication** (conditions listed in T82.0) due to a gastrointestinal implant - assign T85.5 *Mechanical complication of gastrointestinal prosthetic devices, implants and grafts.*

In addition, assign external cause of injury and place of occurrence codes as appropriate.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

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Pyelonephritis with renal calculus and hydronephrosis

Q:

What is the correct code assignment for pyelonephritis with renal calculus and hydronephrosis?

A:

The correct code assignment for pyelonephritis with calculus and hydronephrosis is N13.2 *Hydronephrosis with renal and ureteral calculus obstruction* following the pathway:

Pyelonephritis

- with calculus

- - - with hydronephrosis N13.2

If the condition is documented with an infection, N13.6 *Pyonephrosis* may also be assigned with an additional code (B95-B97) to identify any infectious agent, to complete the clinical picture. See also ACS 0002 *Additional diagnoses, Multiple coding* and ICD-10-AM Tabular List: *Conventions used in the Tabular List of Diseases*.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

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Periductal mastitis

Q:

What is the correct code to assign for periductal mastitis?

A:

The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), used in the United States, assigns periductal mastitis to mammary duct ectasia while ICD-10-AM makes no such link. A literature review reveals that periductal mastitis has been confused with and called duct ectasia. However, duct ectasia is almost certainly a separate condition affecting an older age group and characterised by subareolar duct dilatation and less pronounced and less active periductal inflammation. Current evidence suggests that smoking is an important factor in the aetiology of periductal mastitis but not in duct ectasia.

Therefore, the correct code to assign for periductal mastitis is N61 *Inflammatory disorders of breast* following the index pathway:

Mastitis (acute) (infective) (nonpuerperal) (subacute) N61

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Duodenoscope assisted cholangiopancreatoscopy (DACP)

Q:

What is the correct procedure code to assign for duodenoscope assisted cholangiopancreatoscopy?

A:

Duodenoscope assisted cholangiopancreatoscopy (DACP) allows direct visualisation of the biliary and pancreatic ducts. It is beneficial in circumstances where direct ductal visualisation is helpful in clarifying a diagnosis or providing targeted treatment that is not possible with conventional fluoroscopic imaging.

The procedure was first described in the mid-1970s when endoscopic retrograde cholangiopancreatoscopy (ERCP) was in its infancy. The procedure involves a small calibre cholangiopancreatoscope (daughter scope or baby scope) being passed through the accessory channel of the duodenoscope and is used to cannulate the ampulla of Vater and obtain images of the bile duct and then the pancreatic duct. The technique, however, was not widely accepted due to expensive and inadequate instruments which suffered frequent breakage, poor optics, etc.

However, in recent years technological improvements have overcome the inadequate equipment of the past and DACP may expand management options for pancreaticobiliary disorders in the future.The correct code assignment for DACP is:

30442-00 **[957]** *Choledochoscopy* and30473-00 **[1005]** *Panendoscopy to duodenum*

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This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

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Poisoning

Q:

ACS 1901 *Poisoning* states that ‘In addition to the code for poisoning, an additional code should be assigned to indicate any significant manifestation (eg coma, arrhythmia).

‘In a scenario where a patient is transferred to an Intensive Care Unit (sedated/ventilated) from another hospital following carbon monoxide poisoning/benzodiazepine overdose and it is noted that an arrhythmia was treated at the scene, can this ACS be applied (ie can a code for the arrhythmia be assigned) at the receiving hospital where the condition is no longer present?

A:

ACS 1901 Poisoning intends to provide guidance on the sequencing of code assignment for poisoning episodes of care. It highlights that in addition to a code from the poisoning chapter an additional code may be assigned for any ‘significant manifestations’. It was not intended to expand the interpretation of ‘significant manifestations’. Coders should follow the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses* to determine if a code for a manifestation of poisoning should be assigned.

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Elevated prostate specific antigen (PSA)

Q:

What is the correct principal diagnosis selection for a day stay urology admission where ‘elevated PSA’ alone is documented as the principal diagnosis on the discharge summary and as the indication on the operation report but where the histopathology report received after discharge indicates adenocarcinoma?

A:

Prostate specific antigen (PSA) is a protein that is secreted into ejaculate which helps to nourish the sperm. Normally, only tiny amounts enter the bloodstream. However, cancer cells and other conditions can interfere with proper functioning and cause large amounts to enter the blood. It is currently the most widely used method to screen for prostate cancer. It is acknowledged that elevated PSA is also an indicator of other conditions such as benign prostatic hyperplasia (BPH), urinary tract infections and prostatitis. For the scenario cited, where histopathology has confirmed a diagnosis of adenoacarcinoma, this should be assigned as the principal diagnosis. The adenoacarcinoma should be coded as a finding that adds specificity to the diagnosis of ‘elevated PSA’ as per the guidelines in ACS 0010 *General abstraction guidelines, Test Results*.Clinical advice has confirmed that R79.8 *Other specified abnormal findings of blood chemistry* is the correct code to assign for elevated PSA.

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Neonatal withdrawal due to maternal use of prescribed medication

Q:

What is the correct code to assign for a neonate suffering withdrawal due to maternal use of prescribed pain medication during pregnancy?

A:

The correct code to assign for the neonate in this scenario is P96.1 *Neonatal withdrawal symptoms from maternal use of drugs of addiction* following the index pathway:

Reaction

- drug NEC

- - withdrawal

- - - newborn P96.1

The assignment of this code is not affected by whether or not the mother is drug dependent.

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In vitro fertilisation (IVF)

Q:

Please clarify the advice under In vitro fertilisation (IVF) in ACS 1437 *Infertility* concerning the assignment of an additional code from N97 *Female infertility*.

A:

1437 INFERTILITY In vitro fertilisation (IVF)

When a female is admitted specifically for IVF procedures, and the principal diagnosis is 'IVF' or 'infertility', Z31.2 *In vitro fertilisation* should be assigned as the principal diagnosis code. An additional code from category N97 *Female infertility*, for the type of infertility may be assigned if known, including N97.4 *Female infertility associated with male factors*.

The intent of the advice in the above paragraph is that female patients admitted specifically for 'IVF' with documented 'infertility' should have Z31.2 *In vitro fertilisation* assigned as the principal diagnosis. A code classifiable to N97 *Female infertility* should be assigned as an additional code to specify the type of infertility, including N97.9 *Female infertility, unspecified* for female infertility NOS. It is not necessary to assign a code from category N97 if the reason for the IVF is not specified or it is performed for another reason.

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Parafoveal telangiectasia

Q:

What is the correct code assignment for parafoveal telangiectasia treated by Avastin® injection into retinal blood vessels?

A:

Parafoveal or perifoveal telangiectasia, also known as macular telangiectasis, is a peculiar retinal vascular disorder that affects the central portion of the macula. Dilated retinal capillaries occur around the temporal aspect of the foveal area, eventually encircling it completely causing progressive loss of vision. The correct code to assign for parafoveal telangiectasia is H35.0 *Background retinopathy and retinal vascular changes* following the pathway:

Disease, diseased

- retina, retinal

- - vascular lesion H35.0

Or

Lesion

- retina, retinal

- - vascular H35.0

Avastin® (Bevacizumab) works by blocking a substance known as vascular endothelial growth factor (VEGF). Blocking or inhibiting VEGF helps prevent further growth of blood vessels. Initially, the drug was approved for the treatment of metastatic colorectal cancer to block blood vessels that the cancer needs to continue growing.

More recently ophthalmologists have injected Avastin® into the posterior chamber of the eye to treat age related macular degeneration and other eye conditions that cause loss of vision due to abnormal growth of blood vessels in the back of the eye, such as parafoveal telangiectasia. The drug was used because research indicated that VEGF is one of the causes for the growth of the abnormal vessels that cause these conditions.

The correct code to assign for Avastin® injection into abnormal retinal blood vessels is 42740-03 **[209]** *Administration of therapeutic agent into posterior chamber* following the index pathway:

Injection

- posterior chamber (by paracentesis) (eye) (therapeutic agent) 42740-03 **[209]**

The NCCH will consider improvements to the index for this condition and procedure for a future edition of ICD-10-AM/ACHI.

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Intercostal neuralgia

Q:

What is the correct code assignment for intercostal neuralgia?

A:

The current index entries under *Neuralgia* and *Neuritis* do not include a subterm for intercostal. This may lead coders to assign G58.8 *Other specified mononeuropathies*. However, the index entry for Neuropathy has a subterm for intercostal, which assigns G58.0 *Intercostal neuropathy*, which is the correct code assignment for intercostal neuralgia.

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Deep inferior epigastric perforator (DIEP) flap for breast reconstruction

Q:

What is the correct code to assign for a DIEP flap for breast reconstruction?

A:

The correct code to assign for a DIEP flap for breast reconstruction is 45530-00 **[1756]** *Reconstruction of breast using myocutaneous flap*. Even though a DIEP flap does not use myocutaneous tissue, myocutaneous is a nonessential modifier in the Alphabetic Index, despite being specified in the code title.

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Human immunodeficiency virus (HIV) in pregnancy

Q:

Should a code from Chapter 15 *Pregnancy, Childbirth and the Puerperium* be assigned in addition to a code for human immunodeficiency virus [HIV] disease (B20-B24) for HIV complicating pregnancy, delivery or the puerperium?

A:

There is no index entry specifically for HIV complicating pregnancy and there is an exclusion note for 'human immunodeficiency virus [HIV] disease (B20-B24)' at O98 *Maternal infectious and parasitic diseases classifiable elsewhere* but complicating pregnancy, childbirth and the puerperium. Therefore, it is unnecessary to assign a code from Chapter 15 *Pregnancy, Childbirth and the Puerperium* in addition to a code from B20-B24 for HIV complicating pregnancy, childbirth or the puerperium.

Z33 *Pregnant state, incidental* may be assigned as an additional code for episodes of care where a patient is admitted for HIV and is pregnant as per the advice in ACS 1521 *Conditions complicating pregnancy, Incidental pregnant state*.

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Excisional debridement

Q:

Should an additional code for suture of wound be assigned with 30023-01 **[1566]** *Excisional debridement of soft tissue involving bone or cartilage* as it does not contain an 'includes' note for suture of wound as in 30023-00 **[1566]** *Excisional debridement of soft tissue*?

A:

30023-00 **[1566]** *Excisional debridement of soft tissue* has the following note:

'*Includes:* suture of wound'

This has led some coders to assume that as there is no similar note at 30023-01 **[1566]** *Excisional debridement of soft tissue involving bone or cartilage*, that any suture of the wound should be assigned as an additional code for this procedure as it does not contain the same includes note.

However, in these circumstances the guidelines in ACS 0016 *General Procedure Guidelines - Procedure Components* apply and it is unnecessary to assign an additional code for suture of wound performed with excisional debridement. It is a component of the procedure.

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Endoscopic lithotripsy of encrusted ureteric stent

Q:

What is the correct code to assign for endoscopic lithotripsy of an encrusted ureteric stent?

A:

Ureteral stents are an integral part of urological practice. Stents can migrate, fragment or be forgotten and a portion of these will become calcified. Treatment to render a patient stent-free in these circumstances includes ureteroscopy, percutaneous nephroscopy, cystoscopic electrohydraulic lithotripsy, extracorporeal shock wave lithotripsy, open cysto-litholapaxy and simple nephrectomy - or a combination of the above.

The correct code to assign for endoscopic lithotripsy of an encrusted ureteric stent is 36809-01 **[1074]** *Endoscopic destruction of ureteric lesion*. Calcified encrustation is considered calculous material, therefore, the correct pathway is *Destruction/calculus/ureter*. Assign also a code for removal of ureteric stent as appropriate.

Bibliography

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This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

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Macular degeneration with diabetes mellitus

Q:

Should E1-.34 **Diabetes mellitus with other retinopathy* be assigned in addition to H35.3 *Degeneration of macula and posterior pole* in a patient with macular degeneration and diabetes mellitus?

A:

There is no index entry for '*Diabetes, with macular degeneration*' in ICD-10-AM. Clinical advice indicates that there is no cause and effect relationship between macular degeneration and diabetes mellitus and it is therefore, inappropriate to assign E1-.34 **Diabetes mellitus with other retinopathy* in the above scenario. These conditions should be coded separately unless the clinician clearly documents a link such as diabetic maculopathy.

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Unspecified gastroenteritis complicating pregnancy

Q:

What is the correct code to assign for unspecified gastroenteritis complicating pregnancy?

A:

The correct code assignment for unspecified gastroenteritis complicating pregnancy is O98.8 *Other maternal infectious and parasitic diseases complicating pregnancy, childbirth and the puerperium* and A09.9 *Gastroenteritis and colitis of unspecified origin*. Updates to the '*Pregnancy, complicated by*' section of the WHO ICD-10 Alphabetical Index were made, however, some of these indexing changes have yet to be incorporated into ICD-10-AM. A review of this area of the ICD-10-AM Alphabetic Index is being undertaken for a future edition.

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External cause codes for renal dialysis

Q:

What is the correct external cause code assignment for complications related to renal dialysis?

A:

The correct external cause code to assign for a complication related to any mode of dialysis is Y84.1 *Kidney dialysis* irrespective of whether it is a complication of the fistula, catheter or the infusion. The ‘T code’ assigned describes the type of complication and the ‘external cause’ code identifies that it is due to kidney dialysis.

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Sympathetic storm following traumatic brain injury

Q:

What is the correct code to assign for sympathetic storm following traumatic brain injury?

A:

Sympathetic storming occurs in 15% to 33% of patients with severe traumatic brain injury who are comatose. It is an exaggerated stress response marked by agitation or restlessness and can be associated with fever, posturing, tachycardia, hypertension and diaphoresis. It is thought to be caused by an increase in activity of the sympathetic nervous system created by a disassociation or loss of balance between the sympathetic and parasympathetic nervous systems. In addition to coding out the traumatic brain injury the NCCH advises that sympathetic storm should be classified to G90.8 *Other disorders of autonomic nervous system* by following the pathway(s):

Disorder

- autonomic nervous system

- - specified NEC G90.8

or

Imbalance

- autonomic G90.8

or

Imbalance

- sympathetic G90.8

Assign also codes for manifestations of the sympathetic storm, as appropriate, if they meet the criteria in ACS 0002 *Additional diagnoses*.

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Creation of arteriovenous fistulas for dialysis treatment

Q:

When should Z49.0 *Preparatory care for dialysis* be assigned for an admission for creation of an arteriovenous fistula and when should a complication code from category T82 *Complications of cardiac and vascular prosthetic devices, implants and grafts* be assigned?

A:

Z49.0 *Preparatory care for dialysis* should be assigned for those admissions where the intention is for creation of a new fistula in preparation to commence dialysis treatment. Where the reason for creation of a new fistula is due to a complication relating to an existing fistula (even when the new fistula is being created at a different site), then assign the appropriate complication code from category T82 *Complications of cardiac and vascular prosthetic devices, implants and grafts* with external cause codes Y84.1 *Kidney dialysis* and Y92.22 *Health service area*.

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Apophysiodesis of femur

Q:

What is the correct intervention code to assign for apophysiodesis of the femur?

A:

The correct code to assign for apophysiodesis of the femur is 48500-00 **[1491]** *Epiphysiodesis of femur*. Clinical advice confirms that an *apophysiodesis* is the same as an *epiphysiodesis* of the femur, except that it is performed at the proximal end of the femur rather than the distal end, which is more common. Clinical advice also indicated that:

> "Technically a growth point that leads to a muscle attachment is an apophysis whereas a growth plate to a joint is an epiphysis." Courtenay, Brett (personal communication, Orthopaedic Clinician)

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

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Excoriation skin of breast

Q:

What is the correct code to assign for non traumatic excoriation of skin of breast?

A:

Non traumatic excoriation of skin of breast is also known as intertrigo.

Intertrigo is inflammation of skinfolds caused by skin-on-skin friction or chafing of warm, moist skin in areas such as the inner thighs and genitalia, the armpits, under the breasts, under abdominal folds, behind the ears and the web spaces between the fingers and toes. The condition is particularly common in obese patients who are exposed to high heat and humidity, but it can occur in anyone. The correct code to assign for non traumatic excoriation of skin of breast is L30.4 *Erythema intertrigo*.

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

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Failure to progress in labour

Q:

What is the correct code to assign for failure to progress in labour?

A:

Failure to progress in labour is a description rather thana diagnostic term, therefore a code for the underlying condition resulting in failure to progress should be assigned. Underlying causes may include cephalopelvic disproportion, malpresentation, inefficient uterine action, (primary uterine inertia or secondary uterine inertia), cervical dystocia, maternal exhaustion etc.

In the absence of documentation of an underlying cause for failure to progress, clinical advice indicates that the correct code to assign is O62.9 *Abnormalities of forces of labour, unspecified*.

The NCCH will consider improvements to the Alphabetic Index for failure to progress in labour for a future edition ofICD-10-AM.

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Anticoagulation therapy pre and post surgery

Q:

What is the correct code assignment for patients admitted prior and post surgery for anticoagulation therapy when the surgery is performed at another hospital?

A:

The correct code assignment for a patient admitted for anticoagulant stabilisation prior to surgery to be performed at another hospital is:

Z51.4 *Preparatory care for subsequent treatment, not elsewhere classified*

Z92.1 *Personal history of long term (current) use of anticoagulants*

The correct code assignment for a patient admitted for anticoagulant stabilisation post surgery performed at another hospital is:

Z48.8 *Other specified surgical follow-up care*

Z92.1 *Personal history of long term (current) use of anticoagulants*

See also ACS 2103 *Admission for post acute care*.

NB: If there is a contractual arrangement existing between the two hospitals in the scenario cited then the guidelines within ACS 0029 *Coding of contracted procedures* should also be followed.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS

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Procedural complications

Q:

In ACS 1904 *Procedural complications, infected intravenous (IV) sites*, the classification section provides advice on:

- Localised infection - due to device
- Systemic infection - due to procedure or infusion

What codes would be assigned if a systemic infection that has resulted from the device, ie starts as a local infection due to the device, and then progresses to a systemic infection eg seen in cancer pts who have a Hickman's who are more prone to developing an infection due to their low immune system?

A:

If there is clear documentation in the clinical record that the infection was due to a device and it then becomes systemic assign T82.7 *Infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts* and the appropriate sepsis code to capture that it is now a more systemic infection.

Q:

The following issues were raised regarding the coding of procedural complications:

- Coding of CVAs, MI, haemorrhages, hypertension which occur during a procedure (ie intra-operatively) - are these classified to T81.8 *Other complications of procedures, not elsewhere classified* then the external cause being a misadventure or is the condition really a result of an existing condition and therefore just use the specific chapter code without an external cause code?
- If the condition doesn't meet the definition for a procedural complication then should the condition be coded in its own right and therefore a T code is not assigned?
- What codes should be assigned for an intra-operative haemorrhage? - a T code plus a Misadventure external cause code as per ACS 1904 *Procedural complications, Definition of a misadventure*.

A:

If the intraoperative event eg haemorrhage, MI, CVA etc meets:

- the definition of an additional diagnosis as per ACS 0002 *Additional diagnoses*

  and

- the definition for a procedural complication as per ACS 1904, (ie is directly related to the surgical/procedural intervention)

then for the diagnosis code, apply ACS 1904 and follow the index lookups. This means that the first diagnosis code could come from either the end of chapter codes or the T code section.

The next code in the string will indicate the condition/problem ie MI, CVA etc and an external cause code will be assigned from Y60-Y69 *Misadventures to patients during surgical and medical care*, refer to examples 17 and 18 in ACS 1904.

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ACS 1521 *Conditions Complicating Pregnancy* (1 of 2)

ACS 1521 and adequate documentation to determine that a condition has complicated a pregnancy

Q:

In the following scenario a pregnant female is admitted with a diagnosis of cholestasis but there is no documentation to suggest that cholestasis has complicated the pregnancy except for a note on discharge which states 'for antenatal clinic review next week with repeat LFTs and increased CTG monitoring', is this adequate documentation to determine the condition has complicated the pregnancy?

A:

A condition in pregnancy such as in the scenario cited above which requires increased CTG monitoring is sufficient documentation to indicate the condition has complicated the pregnancy.

Therefore the appropriate code from category O98 *Maternal infectious and parasitic diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium* or O99 *Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium* should be assigned for conditions such as those in the scenario above, together with an additional code from the other chapters of ICD-10-AM to identify the specific condition, as per ACS 1521.

The issue of how you determine whether a nonobstetric condition complicates or is aggravated by the pregnancy in the delivery episode of care (including the postpartum period) is problematic as past clinical advice indicates that even clinicians are unable to clearly define this. It is unlikely, therefore, that documentation will indicate whether a nonobstetric condition is complicating or aggravating the pregnancy in the delivery/postpartum episode of care. The rule of thumb for many coders appears to have been to assign a code from O98 or O99 as appropriate for nonobstetric conditions in this period and then to assign a code for the condition based on ACS 0027 *Multiple coding*.

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ACS 1521 *Conditions Complicating Pregnancy* (2 of 2)

ACS 1521 and the postpartum period

Q:

Does the logic in ACS 1521 Conditions complicating pregnancy apply to the postpartum period?

A:

ACS 1521 states:

'Chapter 15 *Pregnancy, childbirth and the puerperium* contains two blocks of codes for complications related to pregnancy, O20-O29 *Other maternal disorders predominantly related to pregnancy* and O94-O99 *Other obstetric conditions, not elsewhere classified*. Conditions that are known to occur commonly in pregnancy have specific codes in O20-O29. To code other conditions complicating pregnancy (or being aggravated by the pregnancy or that are the main reason for obstetric care), a code from O98 *Maternal infectious and parasitic diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium* or O99 *Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium* is assigned, together with an additional code from the other chapters of ICD-10-AM to identify the specific condition.'

Historically, ICD-10 was developed for single condition coding, that is, only one code was assigned for each condition and therefore it was important to capture as much information as possible by one code assignment. The codes in category O99 *Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium* reflect this concept as they capture the fact that the patient is pregnant and that they have another condition (classifiable elsewhere) that is reflected in the code title. In Australia however, for morbidity coding, we follow the logic of multiple coding, as outlined in ACS 0002 *Additional diagnoses, Multiple coding* and ACS 1521 *Conditions complicating pregnancy* and assign an additional code for the specific condition.

The issue of how you determine whether a nonobstetric condition complicates or is aggravated by the pregnancy in the delivery episode of care (including the postpartum period) is problematic as past clinical advice indicates that even clinicians are unable to clearly define this. It is unlikely, therefore, that documentation will indicate whether a nonobstetric condition is complicating or aggravating the pregnancy in the delivery/postpartum episode of care. The rule of thumb for many coders appears to have been to assign a code from O98 or O99 as appropriate for nonobstetric conditions in this period and then to assign a code for the condition based on ACS 0002 *Additional diagnoses, Multiple coding*. We advise that this practice should continue as per the following scenarios where there is a nonobstetric condition in the postpartum period of the delivery episode of care.

Scenario 1:

Multigravida, spontaneous normal vaginal delivery (NVD), single liveborn infant, nil complications but on day three develops dysuria. Seen by RMO who advises Ural and to see GP after discharge from hospital.

Principal Diagnosis:

O80 *Single spontaneous delivery*

Additional diagnoses:

O99.8 *Other specified diseases and conditions complicating pregnancy, childbirth and the puerperium* Conditions in C00-D48, H00-H95, M00-M99, N00-N99, Q00-Q99 and R00-R99

R30.0 *Dysuria*

Z37.0 *Single live birth*

Scenario 2:

Primigravida, spontaneous NVD, single liveborn infant, small tear not requiring suturing, who develops acute appendicitis on day two post delivery (documentation states has had abdominal pain for five days, but attributed to irritable uterus by GP). Went on to have laparoscopic appendicectomy, discharged on day six.

Principal diagnosis:

O80 *Single spontaneous delivery*

Additional diagnoses:

O99.6 *Diseases of the digestive system complicating pregnancy, childbirth and the puerperium* Conditions in K00-K93

K35.9 *Acute appendicitis, unspecified*

Z37.0 *Single live birth*

and appropriate procedure codes.

Scenario 3:

Primigravida, spontaneous NVD, single liveborn infant, has haemorrhoids noted on day two and was given medication and advised to follow up with GP on discharge.

Principal diagnosis:

O80 *Single spontaneous delivery*

Additional diagnosis:

O87.2 *Haemorrhoids in the puerperium*

Z37.0 *Single live birth*

Scenario 4:

Primigravida, spontaneous NVD, single liveborn infant, no complications, but develops pulmonary embolus on day three (family history of pulmonary embolus).

Principal Diagnosis:

O80 *Single spontaneous delivery*

Additional Diagnosis:

O88.2 *Obstetric blood clot embolism*

Z37.0 *Single live birth*

NB: We have assumed these diagnoses have all met either ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*.

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Failed/difficult intubation

Q:

When should a code for difficult intubation be assigned?

A:

Difficult intubation is poorly defined in literature. It is sometimes described as repeated attempts at intubation, the use of bougie or other intubation aid. The American Society of Anesthesiologists in their article entitled Practice Guidelines for Management of the Difficult Airway, Anesthesiology, Vol. 98, No. 5, May 2003 state:

'A standard definition of the difficult airway cannot be identified in available literature. For these Guidelines, a difficult airway is defined as the clinical situation in which a conventionally trained anesthesiologist experiences difficulty with face mask ventilation of the upper airway, difficulty with tracheal intubation, or both.'

The following codes:

T88.4 *Failed or difficult intubation*

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

Y92.22 *Health service area*

should only be assigned when the 'failed' or 'difficult' intubation meets the criteria in ACS 0002 *Additional diagnoses*.

However, these codes should not be routinely assigned when 'difficult intubation' is documented.

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Anaesthetic Coding

Q:

Where intubation for an anaesthetic is indicated by terms such as LM3, PM3, LMA4 or laryngeal, but ventilation was spontaneous (ie not controlled) should it be coded as a general anaesthetic or sedation?

A:

Where documentation is unclear as to the type of anaesthetic being administered follow the guidelines in ACS 0031 *Anaesthesia*. For classification purposes in ACHI and the ACS 'general anesthesia' is indicated by the use of an artificial airway, such as an endotracheal tube, laryngeal mask or Guedel airway (see ACS 0031 *Anaesthesia, point 2, Sedation*). ACS 0031 *Anaesthesia* will be reviewed for a future edition of the ACS.

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Ventilation (1 of 2)

Q:

If a patient is intubated and ventilated for <1 hour and then transferred to another hospital what codes are assigned?

A:

As per ACS 1006 *Ventilatory support* hours of mechanical ventilation should be interpreted as completed cumulative hours (point 1c.) and any method of intubation for ventilatory support is not coded (point 2b.). For classification purposes if a patient is intubated and ventilated for less than one hour the intubation and ventilation are not coded. Amendments will be made to ACS 1006 to reflect this advice.

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Ventilation (2 of 2)

Q:

If a patient, during one episode of care, has three theatre episodes with periods of post ventilation all of which are <24 hours and the three periods of ventilation (excluding the theatre time) add up to >24 hours, should the ventilation be coded as per the first dot point at point C in ACS 1006 *Ventilatory support Classification section*?

A:

No, point F in the classification section of ACS 1006 *Ventilatory support* should be followed. Each visit to theatre, where the patient is intubated and extubated, needs to be looked at individually and if the period of ventilation post surgery is <=24 hours a code for ventilation is not assigned and not used cumulatively with other periods of ventilation in the episode of care.

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Obstetrics/Gynaecology

Q:

Hysterectomy has a code also instruction for debulking of uterus at blocks **[1268]** and **[1269]** - is this the same as morcellation?

A:

Debulking is the removal of a major portion of the material that composes a lesion, such as the surgical removal of most of a tumour so that there is less tumour load for subsequent treatment by chemotherapy or radiation. Often with uterine tumours they need to be ‘debulked’ prior to a hysterectomy being performed.

differs from morcellation where there is the division of solid tissue (such as an organ) into pieces, which can then be removed often laparoscopically.

If ‘debulking’ is documented in the operation report assign 35658-00 **[1270]** *Debulking of uterus preceding hysterectomy*.

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Drug and alcohol (1 of 4)

Q:

Why can't Y91.9 *Alcohol involvement, not otherwise specified* be assigned to indicate alcohol involvement in an injury/accident admission? In the past this code has been routinely assigned to identify that there has been alcohol involvement, although the patient may not have been intoxicated at the time they presented to hospital.

A:

At some of the workshops coders indicated that the victim who is admitted to hospital is not the one who has actually used alcohol. It is often the perpetrator of the assault who was influenced by alcohol and therefore coders wanted to assign Y91.9 to reflect this. The classification was not designed to capture this level of detail and as indicated in ACS 0002 *Additional diagnoses*:

> 'the national morbidity data collection is not intended to describe the current disease status of the inpatient population but rather, the conditions that are significant in terms of treatment required, investigations needed and resources used in each episode of care'.

Also, as the title of category Y91 is '*Evidence of alcohol involvement determined by level of intoxication*' the codes from this category cannot be assigned if the patient is not intoxicated at the time of admission to hospital. ACS 0503 *Drug, alcohol and tobacco use disorders* also indicates that these codes are not to be used for inpatient morbidity coding.

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Drug and alcohol (2 of 4)

Q:

When can Z72.1 *Alcohol use* be assigned?

A:

The note in category Z72 *Problems related to lifestyle* indicates that:

> 'hazardous use is a pattern of substance use that increases the risk of harmful consequences for the user. In contrast to harmful use, hazardous use refers to patterns of use that are of public health significance despite the absence of any current disorder in the individual user'.

Therefore this code can only be assigned if the clinician indicates there has been hazardous use of alcohol. It should be remembered that a code for alcohol cannot be routinely assigned, as we do with smoking, because of the subjective nature of its usage ie when looking at age, sex, weight issues etc. and that code assignment is still dependent on the condition meeting the criteria in ACS 0002 *Additional diagnoses*.

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Drug and alcohol (3 of 4)

Q:

If alcohol involvement has necessitated an admission to hospital for treatment of an injury but no blood alcohol level is documented, what code should be used?

A:

Category Y91 *Evidence of alcohol involvement determined by level of intoxication* is not to be used for inpatient morbidity coding as per ACS 0503 *Drug, alcohol and tobacco use disorders*. In the scenario cited to indicate that alcohol was involved, Z72.1 *Alcohol use* may be assigned if the patient was affected by alcohol at the time of the injury and no blood alcohol level has been documented.

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Drug and alcohol (4 of 4)

Q:

As the blood alcohol levels specified at Y90 *Evidence of alcohol involvement determined by blood alcohol level* do not always match what is documented in the clinical record or reported by hospital pathology laboratories, can the NCCH publish the mappings for this in Coding Matters?

A:

The table below provides the equivalent laboratory ranges for blood alcohol level as reported in ICD-10-AM and may be used as a guide for code assignment:

Conversion of Blood Alcohol Readings for ICD-10-AM Sixth Edition

	mmol/L	mg/100mL	g/100mL
Patient's Alcohol	10	46	0.05

ICD-10-AM Sixth Edition code	mmol/L		mg/100mL		g/100mL	
	Lo	Hi	Lo	Hi	Lo	Hi
Y90.0		4.3	<	20		0.02
Y90.1	4.3	8.5	20	39	0.02	0.039
Y90.2	8.7	12.8	40	59	0.04	0.059
Y90.3	13.0	17.2	60	79	0.06	0.079
Y90.4	17.4	21.5	80	99	0.08	0.099
Y90.5	21.7	25.9	100	119	0.1	0.119
Y90.6	26.1	43.3	120	199	0.12	0.199
Y90.7	43.5	52.0	200	239	0.2	0.239
Y90.8	52.2		240	>	0.24	

The table above is applicable for use in ICD-10-AM/ACHI/ACS Seventh Edition and onwards.

(Coding Matters December 2008 Volume 15, Number 3)

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

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IHACPA

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Chronic kidney disease

Q:

The default for ‘diabetes with chronic kidney disease’ is E1-.22 *_Diabetes mellitus with established diabetic nephropathy_*, why isn’t E1-.21 *_Diabetes mellitus with incipient diabetic nephropathy_* assigned as this is the ‘lesser’ degree, or not have a default at all?

A:

Patients who have CKD stages 1-2 are usually asymptomatic and an eGFR may not always be performed. Therefore if the patient has diabetes with CKD and the diabetes meets ACS 0001 or ACS 0002 for code assignment a logical default in this instance is to E1-.22 *_Diabetes mellitus with established diabetic nephropathy_*.

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Laser ablation of the lower ureter

Q:

What is the correct code to assign for laser ablation of the lower ureter?

A:

Laser treatment is increasingly being used for a variety of urological procedures, including ablation of ureteric anastomotic and congenital strictures.The correct code to assign for laser ablation of the lower ureter is 90358-00 **[1088]** *Other procedures on ureter*. Assign also the appropriate codes for endoscopy or stent insertion if performed.

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Principal/Additional diagnoses (1 of 3)

Q:

Patient admitted for breast lumpectomy histopathology pending and patient was discharged. Findings showed cancer. What is coded as the principal diagnosis, the breast lump or the cancer?

A:

As per ACS 0010 *General abstraction guidelines - Test results*, the histopathology result is providing further specificity to an already documented condition. In this scenario the patient was admitted for the removal of a breast lump and the histopathology confirmed that the lump was cancerous; therefore, the cancer would be coded as the principal diagnosis.

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Principal/Additional diagnoses (2 of 3)

Q:

If a patient is admitted with chest pain and there is documentation of risk factors such as hypertension, family history of IHD etc and tests such as scans are performed for the risk factors, should the risk factors be coded?

A:

As per ACS 0002 *Additional diagnoses - Risk factors*, these factors should only be coded if they meet the additional diagnosis criteria or another standard indicates they should be coded, ie if the tests are performed for the hypertension, family history of IHD etc, these conditions would then meet the additional diagnosis criteria for code assignment.

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Ref No: TN203 | Published On: 15-Sep-2008 | Status: Superseded | Superseded On: 15-Jun-2012 | Superseded By: TN428

Principal/Additional diagnoses (3 of 3)

Q:

In day only dialysis admissions, should codes be assigned for any additional diagnoses, eg CKD, diabetes etc?

A:

As most day only dialysis admissions are autogenerated, it is difficult to assign additional diagnosis codes when the full record is not available at the time of the coding process. Therefore, for day only admissions for dialysis, only assign Z49.1 *Extracorporeal dialysis for extracorporeal dialysis* or Z49.2 *Other dialysis for peritoneal dialysis* together with the appropriate procedure code. Additional diagnosis codes should only be assigned if the conditions meet ACS 0002 *Additional diagnoses*.

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Pharmacotherapy (1 of 7)

Q:

Is a Hickman’s catheter considered to be a vascular access device (VAD)?

A:

For classification purposes, a Hickman’s catheter does not meet the definition of a vascular access device in ACHI as it does not have a reservoir attached. A Hickman’s catheter is classified in ACHI as a venous catheter.

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Pharmacotherapy (2 of 7)

Q:

When a VAD is flushed and a heparin lock is given, should the maintenance code be assigned as well as a code for the infusion of the drug?

A:

No, flushing and a heparin lock is part of the infusion procedure and therefore a maintenance code will only be assigned if no infusion is given as per the following excludes note:

13939-02 **[1922]** *Maintenance (alone) of vascular access device* ...

Excludes: that:

- for vascular catheter without reservoir attached (92058-00 **[1890]**)
- with administration of pharmacotherapy (96199 **[1920]**)

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Pharmacotherapy (3 of 7)

Q:

Is a permacath a VAD?

A:

A permacath is classified in ACHI as a venous catheter.

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Pharmacotherapy (4 of 7)

Q:

If a patient is admitted for insertion of a Port-A-Cath, should Z45.2 *Adjustment and management of vascular access device* be assigned as the principal diagnosis or the reason for the insertion ie cancer codes?

A:

As per ACS 0002 *Additional diagnoses*:

> "The national morbidity data collection is not intended to describe the current disease status of the inpatient population but rather, the conditions that are significant in terms of treatment required, investigations needed and resources used in each episode of care".

If the admission is only for the insertion of a Port-A-Cath then Z45.2 is assigned as the principal diagnosis. Additional diagnosis codes for the neoplasm are only assigned if the condition meets ACS 0002 *Additional diagnoses*, ie if treatment of the neoplasm commences during the episode of care.

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Pharmacotherapy (5 of 7)

Q:

If admission is for removal of Port-A-Cath, should the neoplasm codes be assigned as additional diagnosis?

A:

To assign a code for the neoplasm, this condition needs to meet the criteria in ACS 0002 *Additional diagnoses* (refer also to question 4 above).

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Pharmacotherapy (6 of 7)

Q:

Which ICD-10-AM/ACHI codes are assigned for a CADD disconnection only?

A:

Assign Z45.1 *Adjustment and management of drug delivery or implanted device* and 13942-02 **[1922]** *Maintenance (alone) of drug delivery device*.

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Pharmacotherapy (7 of 7)

Q:

What ICD-10-AM/ACHI codes are assigned for an admission for port flush only?

A:

Assign Z45.2 *Adjustment and management of vascular access device* and 13939-02 **[1922]** *Maintenance (alone) of vascular access device*.

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Stones spilling from the gallbladder during cholecystectomy

Q:

When stones spill from the gallbladder during cholecystectomy, should this be coded as a complication or misadventure?

A:

During either open incision or laparoscopic cholecystectomy procedures, stones can spill into the patient's peritoneal cavity. This occurs during surgical decompression or as a result of unintentional tears. Surgical decompression occurs when the gallbladder is intentionally perforated to extract fluid so that the gallbladder can be removed through an exit port when the procedure is performed laparoscopically.

A common decompression method involves using an aspirating needle attached to a 35 mL syringe or low pressure suction tip. If the fluid or bile is thick, the gallbladder is incised a few millimetres to accommodate a small open-ended suction tip. Small stones and fluid are removed by suction before the gallbladder is extracted through an exit port. Surgical decompression can result in minor spillage of stones which doesn't necessarily cause a problem and is not considered a misadventure. If an adverse effect of stone spillage due to surgical decompression of the gallbladder is documented and it meets the criteria in ACS 0002 *Additional diagnoses*, refer to the guidelines in ACS 1904 *Procedural complications* under the heading *Classification of procedural complications (diagnosis codes)* and *Classification of external causes of procedural complications (external cause codes)* for code assignment.

Unintentional tear of the gallbladder is the most common reason a stone is lost. Perforations or tears occur during sharp or blunt dissection, electrosurgery, instrument malfunction or tissue resistance. When this happens, gallbladder contents spill into the peritoneal cavity. If the gallbladder is inflamed, purulent discharge can also spill into the cavity, increasing the potential for postoperative infection.Where there is documentation of unintentional tear/rupture of the gallbladder, which may or may not result in spillage of stones, and it meets the criteria in ACS 0002 *Additional diagnoses*, assign:

T81.2 *Accidental puncture and laceration during a procedure, not elsewhere classified*

S36.17 *Injury of gallbladder*

Y60.0 *Unintentional cut, puncture, perforation or haemorrhage during surgical and medical care, during surgical operation*

Y92.22 *Health service area*

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Ventilation

Q:

If a patient is ventilated for surgery for 6 hrs - ICU 10 hrs - back to theatre 6 hrs - ICU 15 hrs and is then finally extubated, how is this type of scenario coded?

A:

As per ACS 1006 *Ventilatory support* point 1 *f,* even though the ventilation was originally initiated for surgery, if it continues for >24 hours post surgery (including subsequent surgical episodes) then it should be coded with the duration beginning from the time of the first intraoperative intubation. Minor errata changes will be made to this section of the standard.

In the scenario cited, CVS continued for 31 hours (10+6+15=31) post the original surgery; therefore, count the number of hours of CVS from the time of initial intubation = 37 hours ventilation, assign 13882-01 **[569]** *Management of continuous ventilatory support, > 24 and < 96 hours*.

Q:

If NETS (Newborn & paediatric Emergency Transport Service) team (a medical retrieval service for critically ill newborns, infants and children) is called in to intubate and ventilate patients before transfer to another hospital, should this be coded?

A:

No, the NETS team stabilise the patient using their own equipment prior to transferring the patient; therefore, this should not be coded as part of the hospital care episode. The NETS team maintain their own records on the care provided.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

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Chronic kidney disease

Q:

Should renal bone disease be included in ACS 1438 *Chronic kidney disease* and indexed in ICD-10-AM?

A:

Renal bone disease, or renal osteodystrophy, is a feature of chronic kidney disease with the same risk factors. Both conditions are due to an underlying cause. Renal bone disease is classified to N25.0 *Renal osteodystrophy* following the index pathway *Osteodystrophy, renal*. On consultation with the clinicians it was felt this condition did not warrant inclusion in the current standard.

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Patient remaining in hospital receiving care whilst awaiting transport back to a remote community

Q:

What is the correct code to assign to classify the above scenario?

A:

The correct code to assign for this scenario is Z59.8 *Other problems related to housing and economic circumstances* following the index pathway:

Isolation, isolated

- dwelling Z59.8

Or

Problem

- housing

- - isolated Z59.8

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Perinatal

Q:

Premature baby is re-admitted 3 weeks after initial episode of care for continuing UTIs. Should this be coded using the P or N codes?

A:

As per ACS 1605 *Conditions originating in the perinatal period*:

'Codes from ICD-10-AM Chapter 16 Certain conditions originating in the perinatal period:

- will still apply for infants > 28 days who are still in the birth episode and
- will still apply for infants > 28 days who are discharged and subsequently readmitted with a condition documented as originating in the perinatal period.'

Therefore, in this scenario, as the UTI originated in the perinatal period, assign P39.3 *Neonatal urinary tract infection*.

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Bilateral/multiple procedures

Q:

If skin lesions are removed from both the left and right ear, how many ACHI codes are assigned?

A:

In the scenario, cited assign 31230-02 **[1620]** *Excision of lesion(s) of skin and subcutaneous tissue of ear* ONCE only. The term 'lesion' has been made plural in ACHI Sixth Edition to reflect that multiple lesions have been excised. The 'bilateral' nature of the procedure in the example should be disregarded and the point 5 in the ACS followed.

ACHI also provides some site specific codes for the removal of skin lesions, and where these exist, they may be assigned.

Q:

Patient admitted for diathermy of endometriosis of multiple sites, eg fallopian tube, omentum, ovary etc. Is a procedure code assigned to reflect each site that is diathermied?

A:

No, only one procedure code is assigned as per ACS 0020 *Bilateral/multiple procedures - Multiple procedures* classification point 2:

> '**The SAME PROCEDURE repeated during a visit to theatre involving ONE ENTRY POINT/APPROACH and similar/same lesions** Assign one code for these procedure types'.

There are ACHI index entries to specify the different sites. However, as the same code is allocated for each of these sites the code should only be assigned once.

Refer to Q3 below which covers the scenario where the codes are different.

Q:

If a repair is done via the same approach on multiple, (eg two flexor and extensor) tendons of the right hand, what codes are assigned?

A:

As ACHI provides separate procedure codes for each site (lesion), in this scenario one code would be assigned for each site, ie the flexor and extensor tendon as per ACS 0020 *Bilateral/multiple procedures - Multiple procedures* classification point 3:

46420-00 **[1466]** *Primary repair of extensor tendon of hand*

46432-00 **[1466]** *Primary repair of flexor tendon of hand, distal to A1 Pulley*

Q:

If an angioplasty is performed on both the right and left renal arteries at one operative episode, should this be coded once or twice since there are two kidneys?

A:

An angioplasty can be performed on one or both renal arteries. If the angioplasty is performed on both renal arteries with separate entry points, within the one operative episode, the following guidelines should be followed in ACS 0020 *Bilateral/multiple procedures - Multiple procedures* classification point 4:

> '**The SAME PROCEDURE repeated during a visit to theatre involving MORE THAN ONE ENTRY POINT/APPROACH and more than one non-bilateral site** Assign a code for each procedure as there is a separate entry point/approach for each one'.

Q:

Egg retrieval from each ovary via laparoscope for IVF. Should this be coded once or twice?

A:

As per ACS 0020 Bilateral/multiple procedures - Multiple procedures classification point 2:

> '**The SAME PROCEDURE repeated during a visit to theatre involving ONE ENTRY POINT/APPROACH and similar/same lesions** Assign one code for these procedure types'.

Q:

If a patient has three skin grafts to the nose, how many codes are assigned?

A:

If there are separate incisions/entry points for each of the three grafts, then three codes would be assigned.

Q:

A patient is admitted for facet joint injections at L2/L3 and L3/L4, how many codes would be assigned?

A:

In a facet nerve block injections are performed using x-ray guidance. A local anaesthetic is used to numb the area before starting. A small diameter spinal needle is guided into the joint and then a small volume of local anaesthetic mixed with steroid is injected. Single joints or groups of joints are usually injected in the same episode of care.

For the case cited, two ACHI codes would be assigned to reflect the different entry points per level, ie L2/L3 = 1 code L3/L4 = 1 code

Q:

How many ACHI codes would be assigned for the following scenarios:

- If liposuction on multiple sites, eg thigh and stomach, would a code be assigned for each separate entry point?
- Botox injections to right and left thigh muscles - two entry points therefore two codes?

A:

In both scenarios two ACHI codes would be assigned as there are separate entry points for each procedure as per ACS 0020 *Bilateral/multiple - Multiple procedures* classification point 4.

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Condition onset flag

Q:

Patient is admitted with impaired glucose regulation and is diagnosed with diabetes mellitus during the episode of care, which condition onset flag is assigned?

A:

Assign a code for the diabetes as per the excludes note at E09 *Impaired glucose regulation* and the condition onset value of 2 - *Condition not noted as arising during the episode of admitted patient care* as the condition was present on admission.

Q:

Some coders felt that condition onset for jaundice in a preterm infant should be 2 because the jaundice is related to the prematurity and you would be assigning P59.0 *Neonatal jaundice associated with preterm delivery*. Is this correct?

A:

No, the prematurity is present on admission, ie the baby was born prematurely, and not all premature babies develop jaundice. Jaundice may be associated with a preterm baby; however, the jaundice doesn't arise until a few days after birth and is therefore assigned a condition onset flag of 1 - *Condition with onset during the episode of admitted patient care*.

Q:

Is there a guideline for assigning condition onset for dagger and asterisk conditions?

A:

Yes, follow ACS 0048 *Condition onset flag - Guide for use* point 8: When a condition requires more than one disease code to describe it, it is possible and allowable, that each disease code can have a different condition onset flag value.

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Diabetes

Q:

If you have hypercholesterolaemia documented in the clinical record and the test results indicate increased triglycerides and decreased HDL, can this be used to assign a code for dyslipidaemia?

A:

Yes, test results can be used to confirm an already documented condition as per ACS 0010 *General abstraction guidelines - Test results - Findings* that provide more specificity about a diagnosis and ACS 0401 *Diabetes mellitus and impaired glucose regulation - Dyslipidaemia* which indicates that:

> 'The characteristic pretreatment dyslipidaemia attributed to insulin resistance features elevated fasting triglycerides and depressed HDL-cholesterol fraction.'

Hypercholesterolaemia is a type of dyslipidaemia and therefore more information can be obtained from the test results to be able to code the characteristic dyslipidaemia which meets the criteria for insulin resistance.

Q:

Does I10 *Essential (primary) hypertension* need to be assigned if a patient has hypertensive kidney disease (I12) or hypertensive heart and kidney disease (I13) and Type 2 diabetes mellitus, when the diabetes meets ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*?

A:

In this scenario, as there is a causal relationship documented between the chronic kidney disease and hypertension etc, a code from I12.- *Hypertensive kidney disease* or I13.- *Hypertensive heart and kidney disease* should be assigned as per ACS 0913 *Hypertensive kidney disease* (I12), ACS 0927 *Hypertensive heart and kidney disease* (I13) and ACS 1438 *Chronic kidney disease*. This patient also meets the criteria for insulin resistance, therefore, E11.72 *Type 2 Diabetes mellitus with features of insulin resistance* is assigned and it is not necessary to assign I10 *Essential (primary) hypertension* as the 'hypertension' has already been captured in I12.-.

Correct code assignment for the scenario when diabetes meets ACS 0001 *Principal diagnosis* would be: E11.72 *Type 2 Diabetes mellitus with features of insulin resistance* I12.- *Hypertensive kidney disease* or I13.- *Hypertensive heart and kidney disease*, and E11.22 *Type 2 Diabetes mellitus with established diabetic nephropathy*

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Malnutrition

The NCCH and CSAC have agreed that malnutrition may be coded when it is documented by a dietitian in the clinical record. This decision is supported in the Introduction to the *Australian Coding Standard*s (ACS) as follows:

> "The term 'clinician' is used throughout the document and refers to the treating medical officer but may refer to other clinicians such as midwives, nurses and allied health professionals. In order to assign a code associated with a particular clinician's documentation, the documented information must be appropriate to the clinician's discipline."

Dietitians meet the definition of a clinician in the ACS and diagnosis and treatment of malnutrition is appropriate to their profession.

Malnutrition must meet the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses* to be coded.

This advice highlights a change to current coding practice and is effective from the implementation of ICD-10-AM Sixth Edition, July 2008. This advice overrules previous advice published by the NCCH regarding the documentation of malnutrition by dietitians in the clinical record, which advised that a diagnosis of malnutrition documented by a dietitian must be verified by the primary treating clinician for the purposes of morbidity reporting.

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Diarrhoea due to *Clostridium difficile*

Q:

What is the correct code to assign for diarrhoea due to *Clostridium difficile*?

A:

Clostridium difficile is the most common cause of infectious hospital-acquired diarrhoea in developed countries. Although in most cases it causes a relatively mild illness, occasionally, and particularly in elderly patients, it may result in serious illness and even death. The bacterium produces two toxins which are responsible for the diarrhoea and which damage the cells lining the bowel. However, not all strains of *C. difficile* produce toxin; these strains are unlikely to cause disease and patients colonised by them remain healthy.

Almost all patients who develop *C. difficile* diarrhoea are taking, or have recently been given, antibiotic therapy. Diarrhoea is the most common symptom but abdominal pain and fever may also occur. In the majority of patients, the illness is mild and full recovery is usual, although elderly patients may become seriously ill with dehydration as a consequence of the diarrhoea. Occasionally patients may develop a severe form of the disease called pseudomembranous colitis, which is characterised by significant damage to the large bowel.

The current index pathway directs coders to assign A04.8 *Other specified bacterial intestinal infections*. However, clinical advice received by the NCCH indicates that the correct code to assign is A04.7 *Enterocolitis due to Clostridium difficile*. The indexing of this condition will be reviewed for a future edition of ICD-10-AM.

This advice highlights a change to current coding practice and is effective from the implementation of ICD-10-AM Sixth Edition, July 2008.

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Diabetes mellitus and blood sugar levels (BSLs)

The ICD-10-AM Third Edition Education Program *Frequently Asked Questions (FAQs) - part 2* - contained the following advice:

> "Diabetes should be coded when it meets the criteria in ACS 0002 Additional diagnoses. The taking of BSLs is one indication that diabetes mellitus meets the criteria of ACS 0002."

This advice was also published on the NCCH Queries Database. ACS 0002 *Additional diagnoses* has been revised for the ACS Sixth Edition. During the revision process, the issue of diabetes and BSLs was discussed by the NCCH and the Coding Standards Advisory Committee (CSAC). Both the NCCH and CSAC subsequently supported the advice that diabetes should only be coded when it meets the criteria in ACS 0002. Revision to ACS 0002 advises:

> "The national morbidity data collection is not intended to describe the current disease status of the inpatient population but rather, the conditions that are significant in terms of treatment required, investigations needed and resources used in each episode of care.
>
> For coding purposes, additional diagnoses should be interpreted as conditions that affect patient management in terms of requiring any of the following:
>
> - commencement, alteration or adjustment of therapeutic treatment
> - diagnostic procedures
> - increased clinical care and/or monitoring."

The above criteria should be applied to each individual case in order to determine the appropriateness of assigning codes for diabetes mellitus. Coders should not automatically assign diabetes codes when BSLs are documented in the clinical record. BSLs are routinely recorded for many diabetic patients and should therefore **not** be assumed to indicate increased clinical care or monitoring.

As this advice may lead to a change in coding practice for some coders it is effective from the implementation of ICD-10-AM Sixth Edition, July 2008.

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Lateral canthal sling

Q:

What is the correct procedure code to assign for a lateral canthal sling?

A:

A lateral canthal sling is a relatively new procedure performed for repair of ectropion/entropion.Block **[239]** *Procedures for ectropion or entropion* contains several procedures which are specifically used to repair ectropions and/or entropions. However, ACS 0741 *Ectropion/Entropion* also advises that "Other procedures classified elsewhere in the ACHI Tabular List may be performed to repair an ectropion or entropion, such as grafts, canthoplasty and tarsal strip procedure".

The correct code to assign for lateral canthal sling is 45614-01 **[1684]** *Tarsal strip procedure* with additional codes 42590-00 **[235]** *Lateral canthoplasty* and/or 45626-00 **[239]** *Correction of ectropion or entropion by suture technique*, as appropriate.

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Ovarian stimulation/hyperstimulation syndrome

Q:

What codes should be assigned for ovarian stimulation/hyperstimulation syndrome?

A:

Ovarian hyperstimulation syndrome (OHSS) is a side effect that can occur in some women who have had follicle stimulating hormone (FSH) injected for egg growth.

Some patients respond excessively to the drug and the dose given. If large numbers of eggs grow and are subsequently released, the high hormone levels emanating from these hyperstimulated ovaries, combined with the increased size of the ovaries, may cause a series of side effects. This combination of symptoms and signs is called ovarian hyperstimulation syndrome.

Assign N98.1 *Hyperstimulation of ovaries*, by following the index pathway: *Hyperstimulation, ovaries (associated with induced ovulation)*.

Assign an external cause code by referring to the Table of Drugs and Chemicals and selecting a code for ‘adverse effect in therapeutic use’ for the specific drug.

Where the type of drug is not specified, assign Y42.8 *Other and unspecified hormones and their synthetic substitutes* by following the pathway in the Table of Drugs and Chemicals: *Hormone NEC, adverse effect in therapeutic use*.

Assign also Y92.22 *Health service area* for place of occurrence.

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Exclusion notes

ICD-10-AM is an adaptation of the World Health Organization (WHO) ICD-10 which is used in many countries for morbidity reporting. ACS 0033 *Conventions used in the tabular list of diseases* includes discussion of exclusion notes.

The exclusion note meanings were developed by WHO, and, as a basic ICD convention, have remained unaltered in ICD-10-AM. However, for morbidity coding in Australia, we practice multiple condition coding, which means that the type 1 exclusion note should not be followed in the way that it was intended (ie only a single code is required). The difference between type 1 and type 2 exclusions is not readily apparent and often causes confusion for the coder.

Type 1 exclusion notes

A type 1 exclusion note is intended for use in countries where only the single most important condition for an episode of care is reported. The loose interpretation is *'it' goes somewhere else*. Obvious examples of type 1 exclusion notes are those that follow the hierarchy of the classification. For example, if there is a code for a condition in one of the specialty chapters (eg musculoskeletal) but that condition can occur in pregnancy or the perinatal period, then it is likely that the code will have an exclusion note sending the coder to the appropriate 'in pregnancy' or 'in the perinatal period' code for that condition (note that the exclusion note may appear at the beginning of the chapter or block, not only at the code).

Sometimes the code in the pregnancy or perinatal chapter may not have enough detail to translate the diagnostic statement into code. For example, the code may say 'other conditions complicating pregnancy'. In such cases, coders should assign the pregnancy code AND the code where the exclusion note applies. The two codes translate the medical statement.

Ultimately, the coder's main aim is to translate medical statements into code - see ACS 0033 *Conventions used in the tabular list of diseases* which states:

> "If the application of an exclusion note results in the medical statement not being fully represented by code(s), then you may need to re-examine the code assignments. A good way to test the appropriateness of your code assignments is to translate the codes back to the medical statement."

It is not critical that clinical coders identify the type of exclusion note, but, rather, that they apply the multiple coding principle. Coders also need to follow advice in standards ACS 0001 *Principal diagnosis*, ACS 0002 *Additional diagnoses* and ACS 0027 *Multiple coding*, as well as specialty standards such as ACS 0401 *Diabetes mellitus and impaired glucose regulation*, and point (f) in ACS 1802 *Signs and symptoms*.

Some examples follow which demonstrate how to interpret exclusion notes to ensure that the medical statement is appropriately captured.

Example 1

Diagnosis: Exhaustion during pregnancy R53 *Malaise and fatigue* ...

Excludes: ....

exhaustion and fatigue (due to)(in): ...

- pregnancy (O26.88)

There is an exclusion note at R53 *Malaise and fatigue* which excludes pregnancy (O26.88). However, to fully translate this medical statement into code you need to assign both O26.88 *Other specified pregnancy-related conditions* and R53 *Malaise and fatigue*.

Example 2

Diagnosis: Raynaud's syndrome with gangrene R02*Gangrene, not elsewhere classified*

Excludes: gangrene in:

- atherosclerosis (I70.24)
- diabetes mellitus (E1-.52, E1-.69, E1-.73)
- other peripheral vascular diseases (I73.-)

There is an exclusion note at R02 *Gangrene, not elsewhere classified* which excludes gangrene in other peripheral vascular diseases (I73.-). However, to fully translate this medical statement into code, you need to assign both I73.0 *Raynaud's syndrome* and R02, as I73.0 does not include detail about the gangrene. This is reinforced by advice in ACS 0027 *Multiple coding* and point (f) in ACS 1802 *Signs and symptoms*.

Example 3

Diagnosis: Type 2 diabetes mellitus with a fatty change in

liver (non-alcohol related). K76.0

Fatty (change of) liver, not elsewhere classified

Excludes: with diabetes mellitus (E1-.72)

There is an exclusion note at K76.0 which excludes fatty liver with diabetes mellitus with features of insulin resistance. However, to fully translate this medical statement into code, you need to assign both E11.72 *Type 2 diabetes mellitus with features of insulin resistance* and K76.0 *Fatty (change of) liver, not elsewhere classified*. This is reinforced by advice in ACS 0401 *Diabetes mellitus and impaired glucose regulation*.

Type 2 exclusion notes

The loose interpretation of a type 2 exclusion note is *You might think 'it' goes here but it does not*. These notes are 'hints' to ensure correct code selection. We might think that a particular diagnosis should be coded within a particular category, but the exclusion note instructs you to go elsewhere. A good example of this is when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition. Another example of a type 2 exclusion note is example 2 in ACS 0033 *Conventions used in the tabular list of diseases*. In this example, bronchiectasis is an excluded concept at J44 *Other chronic obstructive pulmonary disease* because

bronchiectasis could be mistakenly classified to J44. This does not mean that coders cannot use both J44 and J47 if documentation supports their assignment. Again, review the codes to ensure that the medical statement is fully translated by the assigned codes.

Example 1

Diagnosis: Intussusception of appendix K56.1 *Intussusception*

Excludes: intussusception of appendix (K38.8)

This exclusion note directs coders to assign K38.8 where the intussusception is of the appendix. K38.8 is the only code required as intussusception of appendix is an inclusion term at this code.

Note also that proper use of the alphabetic index avoids this situation as the index entry of 'Intussusception of appendix' indicates K38.8.

Interesting background information: Exclusion notes were developed for ICD-10 as a means of moving around the tabular list without an index. WHO developed the index after the ICD-10 tabular list was developed which accounts for why some exclusion notes are like this one above. Essentially, this exclusion note is only useful if one is browsing the tabular list.

Example 2

Diagnosis: Cholelithiasis with obstruction K82.0 *Obstruction of gallbladder*

Excludes: with cholelithiasis (K80.-)

This code has an exclusion note which directs coders to assign the appropriate code from category K80 *Cholelithiasis*. ICD-10-AM classifies the obstruction with a fifth character subdivision for use with conditions listed under category K80, for with or without mention of obstruction. K80.21 *Calculus of gallbladder without cholecystitis, with obstruction* fully describes the medical statement and there is no need to assign K82.0.

Remember, it isn't essential that you can identify the type of exclusion note but that you ensure the codes you select fully translate the medical statement.

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for implementation 01 April 2008.

Ref No: TN206 | Published On: 15-Dec-2007 | Status: Retired | Retired On: 30-Jun-2019

Velamentous Insertion of Cord

Q:

What is the correct code to assign for velamentous insertion of cord?

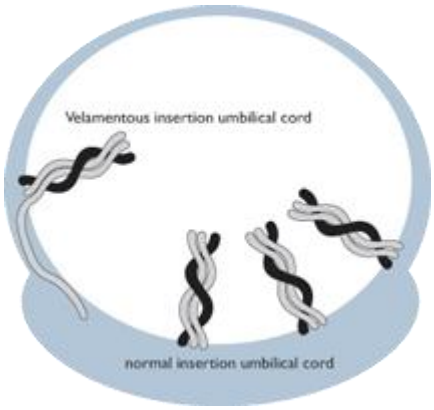
A:

Normally, veins run from the middle of the placenta via the umbilical cord to the fetus. The umbilical cord inserts on the placental mass in about 99% of cases, with the insertion site varying from the centre of the fetal surface to the border of the placenta. Velamentous insertion is used to describe the condition in which the umbilical cord inserts on the chorioamniotic membranes rather than on the placental mass.

The incidence of this condition is about 1.1% in singleton gestations and 8.7% in twin gestations. The incidence of velamentous insertion is even higher in early pregnancy: in spontaneous abortions it has been estimated to be 33% between the ninth and twelfth weeks and 26% between the thirteenth and sixteenth weeks.

The most significant problem arising from a velamentous insertion of the umbilical cord is vasa praevia, a dangerous condition in which the velamentous umbilical vessels traverse the fetal membranes in the lower uterine segment below the presenting part. In 6% of singleton gestations with a velamentous insertion, vasa praevia is a coexisting condition. These unprotected vessels may rupture at any time during pregnancy, causing fetal haemorrhage and death.

The picture below shows a velamentous cord insertion. For velamentous insertion of cord, where care or intervention is required before the onset of labour, assign O43.1 *Malformation of placenta* following the pathway:



Insertion

- cord (umbilical) lateral or velamentous O43.1

or

Pregnancy

- complicated by

- - abnormal, abnormality

- - - placenta, placental (vessel) O43.1

Where the abnormality is first diagnosed during labour, or requires care and/or intervention during labour, assign O69.8 *Labour and delivery complicated by other cord complications* following the pathway:

Complication(s)

- umbilical cord

- - velamentous insertion O69.8

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This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

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Ref No: TN206 | Published On: 15-Dec-2007 | Status: Retired | Retired On: 30-Jun-2015

Reactive Airway Disease

Q:

What code should be assigned for reactive airways disease?

A:

The terms *reactive airways* and *reactive airways disease* have in recent years been used by doctors as synonyms for asthma. *Reactive airways disease* is a general term and does not indicate a specific diagnosis. It may be used to describe a history of coughing, wheezing and shortness of breath due to an undetermined cause. These signs and symptoms may or may not be caused by asthma.

Use of the term in part, reflects the difficulty with establishing a diagnosis of asthma in some situations and most particularly in children. In very young children, the diagnosis of asthma is problematic because histories and good quality pulmonary function tests are difficult to obtain. Asthma is also a diagnosis that carries a negative connotation for patients. Hence, this nonspecific term may be used in clinical contexts ranging from asthma, to wheezy bronchitis, to viral bronchiolitis or even to pneumonia.

In adults, the term is sometimes popular in instances where a physician obtains a history of wheeze, sputum production or inhaler use but a formal diagnosis of asthma is not in the patient record. A formal diagnosis of asthma requires documentation of reversible airway obstruction or airway hyperactivity in the setting of a typical history of asthma. If this information is missing, or elements of a typical asthma history are missing, the physician may document reactive airways disease to convey that the patient has some sort of airway problem.

The most appropriate code to assign for reactive airways disease in the absence of a diagnosis of asthma or another acute respiratory condition is J98.8 *Other specified respiratory disorders*.

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for implementation 01 January 2008.

Ref No: TN206 | Published On: 15-Dec-2007 | Status: Retired | Retired On: 30-Jun-2013

Conjunctival Intraepithelial Neoplasia

Q:

What is the correct code assignment for conjunctival intraepithelial neoplasia?

A:

Corneal and conjunctival intraepithelial neoplasia (CIN) is a precancerous lesion of the ocular surface. It is typically found in Caucasian men aged in their mid 60s.

CIN is composed of dysplastic and thickened epithelial cells, with increased cell proliferation and irregularity of the individual epithelial cells. Histopathological changes are graded as mild, moderate or severe. A lesion is termed ‘carcinoma in situ’ when it shows full thickness epithelial involvement. Finally, when tumour cells invade the epithelial basement membrane, the lesion becomes an invasive squamous cell carcinoma (SCC) and the patient is at risk of metastatic disease.

Excessive ultraviolet light exposure has been identified as a major risk factor in the development of CIN. Other causative factors may include petroleum products, heavy cigarette smoking, light-coloured hair and ocular pigmentation, living in an equatorial region and viral infection - including herpes simplex type 1, human papillomavirus (HPV) and HIV. HPV types 16 and 18 have been associated with intraepithelial neoplasia of the uterine cervix. DNA from HPV types 16 and 18 has been demonstrated in both benign and malignant cervical and conjunctival lesions, giving strong evidence for an aetiologic role of HPV in the development of CIN.

The correct code to assign for conjunctival intraepithelial neoplasia is H11.8 *Other specified disorders of conjunctiva*.

Assign also B97.7 *Papillomavirus as the cause of diseases classified to other chapters* if HPV is documented.

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Ref No: TN206 | Published On: 15-Dec-2007 | Status: Retired | Retired On: 30-Jun-2013

Polycythaemia

Q:

What is the correct code to assign for polycythaemia, unspecified?

A:

Polycythaemia is a condition in which there is a net increase in the total number of red blood cells in the body. The overproduction of red blood cells may be due to a primary process in the bone marrow (a so-called myeloproliferative syndrome), or it may be a reaction to chronically low oxygen levels or, rarely, a malignancy.

Primary polycythaemia is a rare condition, often called polycythaemia vera (PCV), polycythaemia rubra vera (PRV) or erythraemia. It occurs when excess red blood cells are produced as a result of an abnormality of the bone marrow. Often, excess white blood cells and platelets are also produced. Polycythaemia vera is classified as a myeloproliferative disease.

Secondary polycythaemia refers to elevated numbers of red blood cells not caused by bone marrow abnormalities. Usually, anything that reduces the amount of oxygen available to the body prompts the increased production of red blood cells. Some of the factors that may cause secondary polycythaemia include:

- cigarette smoking
- lung disease
- heart disease
- high altitudes
- certain tumours

The current index default in ICD-10-AM for polycythaemia (not otherwise specified) assigns D45 *Polycythaemia vera* (and M9950/3 *Polycythaemia vera*) with primary, rubra and vera listed as non-essential modifiers. However, D45 *Polycythaemia vera* should be assigned only in those cases where polycythaemia (rubra) vera or primary polycythaemia is documented. In the absence of this documentation and where no further information is provided, assign D75.1 *Secondary polycythaemia*.

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Dementia due to secondary parkinsonism

Q:

If a patient has dementia due to secondary parkinsonism, is it correct to assign F02.3 as an additional code to capture the dementia in the context of Parkinson's disease?

A:

F02.3* *Dementia in Parkinson's disease* is an asterisk code and should only be assigned in combination with G20 *Parkinson's disease* as it appears in the Alphabetic Index. For example:

Parkinsonism

- with

- - dementia G20+ F02.3*

G20 *Parkinson's disease* classifies idiopathic or primary parkinsonism/Parkinson's disease or parkinsonism/Parkinson's disease not otherwise stated.

Secondary parkinsonism is similar to Parkinson's disease, but is caused by certain medications, other nervous system disorders or other illnesses. It is classified in ICD-10-AM to G21 *Secondary parkinsonism* where the dagger asterisk convention does not apply.

Therefore, when a patient has dementia linked to secondary parkinsonism, assign a code from G21 with F03 *Unspecified dementia* and sequence following the criteria in ACS 0001 *Principal diagnosis, Aetiology and manifestation convention*.

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This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

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Refeeding syndrome

Q:

What is the correct code to assign for refeeding syndrome?

A:

Refeeding syndrome is a syndrome consisting of metabolic disturbances that occur as a result of reinstitution of nutrition to patients who are starved or severely malnourished. Patients may develop fluid and electrolyte disorders, especially hypophosphataemia, along with neurologic, pulmonary, cardiac, neuromuscular and haematologic complications.

Code the component features of refeeding syndrome separately as per the guidelines in ACS 0005 *Syndromes*.

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Gliadel® wafer insertion

Q:

What is the correct procedure code to assign for Gliadel(R) wafer insertion?

A:

Gliadel® wafer insertion is performed on newly diagnosed patients with high-grade malignant glioma, as an adjunct to surgery and radiation. It is also indicated in recurrent glioblastoma multiforme patients as an adjunct to surgery.

The Gliadel® wafer is a thin, coin-sized 'wafer' that contains the chemotherapy agent carmustine (BiCNU). It is implanted directly into the cavity of the brain from which a cancer is removed and delivers chemotherapy directly into the surrounding cells, killing additional cancer cells that may be undetectable near the site of the cancer.

The correct code to assign for Gliadel® wafer insertion is 96201-00 **[1920]** *Intracavitary administration of pharmacological agent, antineoplastic agent*, following the pathway:

Administration

- agent (to)
- - pharmacological
- - intracavitary 96201 **[1920]**

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for implementation 01 October 2007.

Ref No: TN208 | Published On: 15-Jun-2007 | Status: Retired | Retired On: 30-Jun-2013

Entropion/Ectropion Repair

Q:

Is there a default code for entropion/ectropion repair, unspecified?

A:

There is no default code in the ACHI Alphabetic Index for repair of entropion or ectropion and clinical advice confirms that it is not appropriate to have one.

Procedure codes for repair of ectropion or entropion are listed in block **[239]** and include:

- cauterisation
- tightening or shortening of inferior retractors
- suture technique
- wedge resection.

Coders should be guided by the documentation in the operation report as to the type of repair and clarify with the clinician if in doubt.

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Ref No: TN209 | Published On: 15-Mar-2007 | Status: Retired | Retired On: 30-Jun-2013

B95–B97 *Bacterial, Viral and Other Infectious Agents*

The codes from the above category are not intended for use as principal diagnoses. As indicated in the code titles, they are provided for use as supplementary or additional codes to identify the infectious agent(s) in diseases classified elsewhere.

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Postoperative anaemia

The NCCH received a query asking whether postoperative anaemia could be assumed as posthaemorrhagic anaemia in the absence of any documented cause.

Postoperative anaemia in surgical patients is not always caused by acute haemorrhage. It may occur in cases with poor nutrition, pre-existing anaemia, blood disorders with low haemoglobin, chronic kidney disease, malignancy, other chronic diseases such as rheumatoid arthritis or irritable bowel disease or diminished erythropoiesis during postoperative recovery.

Classification

D62 *Acute posthaemorrhagic anaemia* should only be assigned for post-operative cases where the cause of anaemia is documented as due to haemorrhage.

There must be confirmation from the clinician that postoperative anaemia is due to acute haemorrhage to be able to assign the abovementioned code.

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Ref No: TN210 | Published On: 15-Dec-2006 | Status: Superseded | Superseded On: 15-Jun-2012 | Superseded By: Q2715

Diabetes with carpal tunnel syndrome

The NCCH was asked to clarify whether carpal tunnel syndrome in a patient with diabetes should be assigned E1-.41 **Diabetes mellitus with diabetic mononeuropathy* as carpal tunnel syndrome can be regarded as a mononeuropathy.

Clinical advice received by the NCCH on this issue indicates that it is still under deliberation and no consensus has been achieved.

Classification

Therefore, until further clinical advice is received, carpal tunnel syndrome in a patient with diabetes should not be coded to diabetic mononeuropathy.

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Assignment of Chapter 17 *Congenital malformations,deformations and chromosomal abnormalities* codes (Q00-Q99) as additional diagnoses

The NCCH was asked to clarify if Q codes should be assigned as additional diagnoses to indicate the genetic nature of a disease in conditions such as otosclerosis, familial adenomatous polyposis (FAP) and hereditary non-polyposis colon cancer (HNPCC). The issue of genetic links to specific conditions is complex and controversial. Debate on this issue is ongoing at the World Health Organization within the revision work on ICD-11.

A congenital condition is one that is present at or before birth. Congenital conditions may be inherited. For example, osteogenesis imperfecta is a genetic disorder that is present at birth. Some congenital conditions are acquired due to the impact of environmental factors on the developing fetus. These conditions are not inherited. For example, congenital syphilis is caused by Treponema pallidum, passing through the placenta. It should be noted that some congenital conditions, although present at birth, may not be detected for some years.

A genetic condition occurs due to defective genes and tends to run in families. Genetic disorders may be present at birth (and hence are also congenital) or they may occur at any time throughout life. An individual may carry a defective gene and never exhibit the characteristics of that disease.

Classification

Codes from Chapter 17 *Congenital malformations, deformations and chromosomal abnormalities* (Q00-Q99) should only be assigned for a condition by following the correct pathways in ICD-10-AM Alphabetic Index. An exception is the assignment of a code from Q87.- *Other specified congenital malformation syndromes affecting multiple systems* as detailed in ACS 0005 *Syndromes*. For otosclerosis, assign a code from H80 *Otosclerosis*. Research indicates that genetic susceptibility is only one of a number of risk factors that may cause the condition.

Other risk factors include gender, pregnancy, race, non-fluoridated water or viral infections. The exact cause is often unknown. Although otosclerosis may be caused by genetic susceptibility, it is not generally present at birth (and is therefore not a congenital condition). Similarly, although FAP and HNPCC are caused by defective genes, affected individuals are not born with colon disease and some may never develop colon disease.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

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Ref No: TN211 | Published On: 15-Sep-2006 | Status: Retired | Retired On: 01-Jul-2017

Admissions for colonoscopy with no underlying symptoms or family history

The NCCH received a query on principal diagnosis assignment when no abnormalities are detected in a patient admitted for colonoscopy with no underlying symptoms or family history. The query specifically related to cases where colonoscopy is performed due to age or anxiety, such as anxiety about death of a friend from colon cancer.

Classification

ACS 2111 *Screening for specific disorders* should be followed in these cases. Assign an appropriate screening code (Z11, Z12, Z13) as the principal diagnosis. Assign Z71.1 *Person with feared complaint in whom no diagnosis is made* as an additional diagnosis.

Example 1:

Patient admitted for colonoscopy due to anxiety from death of a close friend with colon cancer. No abnormalities were detected on colonoscopy.

Codes:

Z12.1*Special screening examination for neoplasm of intestinal tract*

Z71.1*Person with feared complaint in whom no diagnosis is made*

32090-00 **[905]** *Fibreoptic colonoscopy to caecum*

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Ref No: TN211 | Published On: 15-Sep-2006 | Status: Retired | Retired On: 30-Jun-2013

Botox injections into salivary gland

The NCCH received a query asking about the code assignment for botox injection into salivary gland to reduce drooling in a child with cerebral palsy.

Classification

Assign 18360-00 **[1552]** *Administration of botulinum toxin into soft tissue, not elsewhere classified* for botox injection into salivary gland. The index pathway is:

Injection (around) (into) (of) -- *see also Administration*

- botulinum toxin (Botox) (Botoxin) NEC *(see also Injection, by site)* 18360-00 **[1552]**

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Ref No: TN211 | Published On: 15-Sep-2006 | Status: Retired | Retired On: 30-Jun-2013

Follow-up examinations with detection of new conditions

The NCCH received a query asking what code should be assigned as the principal diagnosis when a new condition is detected that is unrelated to the specific disorder being 'followed-up'.

Classification

ACS 2113 *Follow-up examinations for specific disorders* should be followed in these cases. Assign an appropriate follow-up code (Z08, Z09) as the principal diagnosis. Assign the newly detected condition as an additional diagnosis only if it meets the criteria of ACS 0002 *Additional diagnoses*. Coders should also be aware that ACS 0046 *Diagnosis selection for same-day endoscopy* does not apply to follow-up examinations.

Example 1:

Patient admitted for follow-up of familial adenomatous polyposis excised one year ago. A hyperplastic polyp, confirmed on histopathology, was removed during colonoscopy.

Codes:

Z09.0 *Follow-up examination after surgery for other conditions*

Z86.0 *Personal history of other neoplasms*

K63.58 *Other polyp of colon*

32093-00 **[911]** *Fibreoptic colonoscopy to caecum, with polypectomy*

A polyp or tumour of a different histopathology should not be regarded as a residual condition or recurrence unless there is clinical advice to the contrary.

Example 2:

Colonoscopy performed for follow-up of familial adenomatous polyposis, excised one year ago. Diverticulosis found; no treatment was given.Codes:

Z09.0*Follow-up examination after surgery for other conditions*

Z86.0*Personal history of other neoplasms*

32090-00 **[905]** *Fibreoptic colonoscopy to caecum*

Example 3:

Patient admitted for follow-up of TCC bladder excised six months ago. A benign bladder tumour confirmed on histopathology was excised during cystoscopy.Codes:

Z08.0*Follow-up examination after surgery for malignant neoplasm*

Z85.5*Personal history of malignant neoplasm of urinary tract*

D30.3 *Benign neoplasm of bladder*

Appropriate morphology code

36840-02 **[1100]** *Endoscopic resection of a single lesion of bladder <= 2cm or tissue of bladder*

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Spinal stabilisation methods in spinal surgery

The NCCH has received queries regarding which procedure codes to assign for the various stabilisation devices and systems used in spinal surgery such as DIAM spacer, Wallis stabilisation system, etc.

Classification

As these devices and systems are used for stabilisation of the spine, assign 48678-00 **[1390]** *Simple internal fixation of spine*. Where it is documented as stabilisation of second cervical vertebra, assign 40316-00 **[1390]** *Odontoid screw fixation*.

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Ref No: TN213 | Published On: 15-Mar-2006 | Status: Retired | Retired On: 30-Jun-2013

Cholelithiasis with acute on chronic cholecystitis

There has been confusion regarding the correct code assignment for this condition as there are no further index entries for the term ‘chronic’ under the lead term ‘Cholecystitis’.

Classification

Only one code K80.0- *Calculus of gallbladder with acute cholecystitis* is required for this condition. The index pathways are as follows:

Calculus, calculi, calculous

- gallbladder K80.2—

- - with cholecystitis (chronic) K80.1—

- - - acute K80.0-

Cholelithiasis (cystic duct) (gallbladder) (impacted) (multiple) K80.2—

- with cholecystitis (chronic) K80.1—

- - acute K80.0-

As the term ‘chronic’ is a nonessential modifier in the index pathways, the chronic condition need not be coded separately (ACS 0001 *Principal Diagnosis, Acute and chronic conditions*).

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Ref No: TN213 | Published On: 15-Mar-2006 | Status: Retired | Retired On: 30-Jun-2013

Digital Subtraction Angiography (DSA) of abdomen and aorta

A query was received by the NCCH asking how to code DSA of abdomen and aorta when it is performed at the same time. ACHI does not contain combination codes for DSA of abdomen or thorax with aortography. The index also directs DSA of aorta to 'Angiography, by digital subtraction technique, head and neck'.

Classification

The aorta is considered a component of the thoracic and abdominal vessels. It is not necessary to assign a separate code for the aortography when it is performed together with DSA of abdomen or thorax. Assign a code from block **[1994]** *Digital subtraction angiography of abdomen* or block **[1993]** *Digital subtraction angiography of thorax* by following the index pathways:

Angiography

- by

- - digital subtraction technique (DSA) (regional)

- - - abdomen (<= 3 data acquisition runs) 60024-00 **[1994]**

- - - - 4-6 data acquisition runs 60027-00 **[1994]**

- - - - 7-9 data acquisition runs 60030-00 **[1994]**

- - - - >= 10 data acquisition runs 60033-00 **[1994]**

- - - thorax (<= 3 data acquisition runs) 60012-00 **[1993]**

- - - - 4-6 data acquisition runs 60015-00 **[1993]**

- - - - 7-9 data acquisition runs 60018-00 **[1993]**

- - - - >=10 data acquisition runs 60021-00 **[1993]**

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Morphology codes for the abbreviated term ‘Ca’

The NCCH was asked to clarify whether the abbreviation ‘Ca’ should be interpreted as ‘cancer’ or ‘carcinoma’. The NCCH was also asked which morphology code to assign when the abbreviation ‘Ca’ is used in the absence of any other defining documentation in a medical record.

Clinicians, cancer registries and various medical dictionaries have all indicated that ‘Ca’ can be used interchangeably to mean ‘cancer’ or ‘carcinoma’. On further review of the use of this abbreviation, WHO ICD-10 indicates that the term ‘cancer’ when modified by an adjective or adjectival phrase indicating a morphological type, should be coded in the same manner as ‘carcinoma’ with that adjective or phrase. Thus, ‘squamous cell cancer’ should be coded in the same manner as ‘squamous cell carcinoma’, which appears in the list under ‘Carcinoma’ (ICD-10-AM Alphabetic Index of Diseases).

If the term ‘cancer’ is preceded by a term other than a morphological descriptor, assign the morphology code M8000/3 *Neoplasm, malignant*. Therefore, if prostate Ca is documented without any available histology report or clinical clarification, assign M8000/3 *Neoplasm, malignant*.

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Enteryx procedure

The NCCH received a query asking which procedure code to assign for the injection of Enteryx in the treatment of gastro-oesophageal reflux disease. This procedure is performed endoscopically by injecting a special liquid solution into the wall of the lower oesophagus. The liquid solidifies into a spongy implant which acts as a barrier to prevent the reflux of the stomach's contents including acid.

The Department of Health and Ageing has listed Enteryx as a prosthesis in Schedule 5 benefits, payable in respect of surgically implanted prostheses, human tissue items and other medical devices.

Classification

When coding endoscopic injection of Enteryx, assign 30490-00 **[853]** *Endoscopic insertion of oesophageal prosthesis*.

The pathway in the Alphabetic Index is as follows:

Insertion

- prosthesis, prosthetic device

- - oesophageal (endoscopic) 30490-00 **[853]**

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Incisional hernia

The NCCH received a query regarding the assigning of a code from category Y83 Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure as an additional code to K43 Ventral hernia for incisional hernias.

Incisional hernia is defined as a protrusion of a portion of an organ or tissue through the abdominal wall where scar tissue formed after surgery has become thin or weakened. 'Risk factors for incisional ventral hernia include: wound infection, abdominal distension, pulmonary complications, male gender, age, obesity, emergency procedures, early re-operation, jaundice, underlying disease process, type of closure, suture material used in closure and choice of original incision. They can also be a result of too much tension with the initial closure of the abdominal incision, which creates poor healing, swelling and wound separation' (ASERNIP-S 2004).

Classification

As there are other factors that may contribute to incisional hernia apart from the procedure itself, the decision to assign a code from Y83 as an additional diagnosis code should be made on a case by case basis. If a causal link is documented between a previous surgical procedure and an incisional hernia, assign Y83.- as an additional code to complete the clinical picture.

See also ACS 2001 *External cause code use and sequencing*.

Reference:

Australian Safety and Efficacy Register of New Interventional Procedures - Surgical (2004), Laparoscopic ventral hernia repair, accessed: 21 May 2013, available: http://www.surgeons.org/media/292081/LVHRaccelreview.pdf.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

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Ref No: TN215 | Published On: 15-Sep-2005 | Status: Superseded | Superseded On: 15-Jun-2012 | Superseded By: Q2712

Ultrasound guided compression of a false femoral artery aneurysm

Ultrasound guided compression of a false femoral artery aneurysm, also known as duplex-guided compression therapy, is a relatively new method of treating pseudoaneurysms (Burnett, nd). 'During the procedure, the neck or tract of the pseudoaneurysm is compressed by an ultrasound transducer until there is no blood flow detected in the pathway. Compressions, lasting up to one hour, are usually applied in ten minute time intervals. Colour flow imaging confirms compression of the neck and patency of the artery and vein' (James, 2002).

Classification

In cases where ultrasound guided compression of a false femoral artery aneurysm is documented, assign 55238-00 **[1946]** *Duplex ultrasound of arteries or bypass grafts in lower limb, unilateral*.

According to ACS 0042 *Procedures normally not coded*, ultrasound is not normally coded. However, in this case, it is integral to the procedure.

References

Burnett A (no date) Australasian Society for Ultrasound in Medicine. How to successfully compress femoral false aneurysms. Accessed 13 June 2005: http://www.asum.com.au/open/papers/burnett.htmlJames B (2002) Coosa Valley Technical College. Pseudoaneurysm. Accessed 7 June 2005: http://test.cvtcollege.org/Ac_Programs/dms_vascular/studentbrandie.html

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for implementation 01 October 2005.

Ref No: TN216 | Published On: 15-Jun-2005 | Status: Retired | Retired On: 30-Jun-2019

Albumex transfusion

Albumex is a natural plasma component prepared from pooled human plasma and is used as a plasma volume expander in the treatment of shock due to blood loss. The classification of drugs in ICD-10-AM is according to their class and not their therapeutic indication. Plasma volume (blood) expander is classified as a type of blood product in ICD-10-AM. Therefore, transfusion of Albumex should be classified according to the guidelines in ACS 0302 *Blood transfusions*.

Classification

For documentation of transfusion of Albumex, assign 92062-00 **[1893]** *Administration of other serum*.

Bibliography

Australian Red Cross Blood Service (2013), *Fractionated plasma products: Albumin*, accessed: 22 April 2013, available: http://www.transfusion.com.au/node/25.

This advice has a minor modification to correspond with an update in a subsequent edition ofICD-10-AM/ACHI/ACS.

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Use of external cause codes with obstetric codes

The majority of codes in Chapter 15 Pregnancy, childbirth and the puerperium relating to complications do not require an additional external cause code as the concept is bundled within the disease code. However, there is no convention in ICD-10-AM prohibiting the use of an external cause code with some codes in Chapter 15 Pregnancy, childbirth and the puerperium. Therefore, the use of an external cause code with obstetric code/s is acceptable if it provides further specificity.

Example: During caesarean section, the initial incision extended into upper cervix resulting in cervical laceration.

Codes:

O71.3 *Obstetric laceration of cervix*

Y60.0 *(Unintentional cut) during surgical operation*

Y92.22 *Health Service Area*

See also ACS 2001 *External cause code use and sequencing.*

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

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Venous lakes

Venous lakes are a type of vascular ectasia or vascular dilation which includes spider angiomas and telangiectases. They occur when superficial blood vessels dilate resulting in a single bluish or red/blue, soft, painless nodule which is compressible under the skin. The exact cause of venous lakes is unknown, but they are believed to be related to chronic sun exposure and damage. Venous lakes are more prevalent in people aged over 50 years. Venous lakes differ from varicose veins in a number of ways. Notably, venous lakes have a different appearance to varicose veins and present mostly on the face, lips, ears and neck. Varicose veins commonly present on the lower limbs and may involve multiple vessels.

Classification

Documentation of ‘venous lake’ should be classified as: I78.1 *Naevus, non-neoplastic.*

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Venous eczema

Venous eczema (also known as gravitational or stasis eczema) is a type of skin disease associated with poor venous circulation/chronic venous hypertension. It predominately affects older people, mostly women and typically presents as a red, itchy, scaly rash with or without the presence of a venous ulcer or varicose veins. Venous eczema usually appears on the lower legs around the ankles (Kumar & Clark 2012). Clinical advice is that venous eczema is a rare occurrence in sites other than the lower limb.

Classification

Documentation of venous eczema should be classified as: I83.1 *Varicose veins of lower extremities with inflammation*.

The lookup pathway in the Alphabetic Index of Diseases is:

Eczema

- stasis I83.1

or

Eczema

- varicose I83.1

Reference

Kumar, P and Clark, ML (2012), Clinical Medicine, 8th edn, Elsevier.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

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Ref No: TN217 | Published On: 15-Mar-2005 | Status: Retired | Retired On: 30-Jun-2015

Surgical microfracture of knee

Microfracture involves penetration of bone at the base of a cartilage defect. This causes formation of a ‘superclot’ in the base of the lesion. The theory behind this treatment is that the superclot contains factors and cells which allow cartilage regeneration. The area of cartilage damage is debrided and an ‘awl’ (or arthroscopic pick) is used to produce hole(s) in the bone at the base of the defect. It is a one stage arthroscopic surgery that is appropriate for smaller and localised chondral defects in the knee (www.linvatec.com/products-knee-accessories.htm).

Classification

Surgical microfracture of the knee (with awl) should be classified as:49559-00 **[1520]** *Arthroscopic chondroplasty of knee with multiple drilling or implant.*

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Squamous metaplasia of cervix

Squamous metaplasia is a normal physiological change in cervical tissue which has no sinister significance (Oats; Pepperell, 2004). Squamous metaplasia of the cervix may lead to cervical dysplasia, an abnormal growth of the epithelial tissue on the surface of the cervix (Glickman 2004).

Classification

Documentation of squamous metaplasia of the cervix as an incidental finding does not require coding. Cervical dysplasia should be coded as N87 *Dysplasia of cervix uteri*.

References

Glickman J (2004) Health Science Report. Squamous metaplasia of the cervix. Accessed 28 June 2004: http://www.health-science-report.com/cervical-dysplasia/treatment-for-cervical-dysplasia/squamous-metaplasia-of-the-cervix.html

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for implementation 01 January 2005.

Ref No: TN218 | Published On: 15-Dec-2004 | Status: Retired | Retired On: 30-Jun-2013

Minimally invasive injectable graft (MIIG)

MIIG is a bone void filler paste. It is injected into osseous defects (either surgically created or traumatic). The paste cures in situ then resorbs and is replaced with bone during the healing process. The cured paste provides a temporary support media for bone fragments during the surgical procedure but does not provide structural support during the healing process (Wright Medical Technology nd).

Classification

'Injection of MIIG' is usually performed in conjunction with another procedure, such as reduction of a fracture. Therefore, it is not necessary to assign a separate code for insertion of the MIIG.

References

Wright Medical Technology (no date) MIIG Minimally invasive injectable graft (product information) Accessed 28 June 2004: http://www.wmt.com/Literature/docs/128801-2_Eng.pdf

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Ref No: TN218 | Published On: 15-Dec-2004 | Status: Retired | Retired On: 30-Jun-2013

Autotransfusion of blood

Perioperative (intraoperative or postoperative) autotransfusion of blood involves the use of various blood conservation/salvage techniques and devices, such as the bellovac drain. An example of a blood conservation technique is ‘cell saver’, where blood is collected intraoperatively, mixed with an anticoagulant, concentrated/washed, and reinfused back into the patient (www.perfusion.com.au/CCP/Details%20in%20perfusion%20technique/Autotransfusion.htm).

The purpose of autotransfusion is to recycle blood that is usually lost and discarded during or after surgery and can minimise or eliminate the need to use donor blood (BloodBook.com 2001, Ley 1996).

Classification

Documentation of these types of autologous blood transfusion should be coded as 92060-00 **[1893]** *Administration of autologous blood*. ‘Intraoperative blood salvage’ is an inclusion term at this code.

References

Bloodbook.com (2001) Guide to blood transfusion: what to do if you need blood. Accessed 28 June 2004: http://www.bloodbook.com/trans-guide.html

Glickman J (2004) Health Science Report. Intraoperative and postoperative blood salvage. AACN Clinical Issues. 1996 May, 7(2):238-48. Accessed 28 June 2004: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrievedb=PubMedlist_uids=8718386dopt=Abstract

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Ref No: TN218 | Published On: 15-Dec-2004 | Status: Retired | Retired On: 30-Jun-2013

Torted appendix epiploicae sigmoid colon

The NCCH received a query regarding a diagnosis of torted appendix epiploicae of the sigmoid colon. The histology report detailed ‘fatty tissue, necrotic and inflamed’. The torted appendix epiploicae was removed laparoscopically. An appendix epiploicae is a pouch of visceral peritoneum filled with fat, attached in rows along the entire length of the colon (excluding the rectum). Torsion of the appendix epiploicae results in infarction, calcification of the fat contents and pedicle atrophy (Takada et al, 1998, pp441-442).

Documentation of torsion of the appendix epiploicae should be coded to K55.0 *Acute vascular disorders of intestine*.

Laparoscopic removal of the torted appendix epiploicae should be coded as ‘epiploectomy’: 96189-01 **[989]** *Laparoscopic omentectomy.*

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Spinal cord compression secondary to neoplasm

The NCCH was asked to comment on the classification of spinal cord compression secondary to a neoplasm. The inquirer suggested G99.2* *Myelopathy in diseases classified elsewhere* should be used as an additional diagnosis to indicate that spinal cord compression has occurred as the result of a coexisting neoplastic condition, for example, rectal carcinoma. The NCCH agrees with this logic.

Spinal cord compression is a type of myelopathy, that is, functional disturbance or pathological change in the spinal cord. However, since G99.2* is a general, unspecified code, an additional code should also be assigned to specify the type of myelopathy.

Classification

Where spinal cord compression is documented as occurring as the direct consequence of a neoplastic condition, the following codes should be assigned to complete the clinical picture:

G99.2* *Myelopathy in diseases classified elsewhere*

G95.2 *Cord compression, unspecified*

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Ref No: TN219 | Published On: 15-Sep-2004 | Status: Retired | Retired On: 30-Jun-2013

Nuclear medicine red cell scan

Labelled red cell scan/study, may be performed for the following admissions:

- 'PR bleeding +++' in a patient with pancreatic carcinoma, plus liver and spleen metastases
- 'PR bleeding since yesterday' in a patient who had a small bowel resection 10 days previously and was being treated with Warfarin for atrial fibrillation

Red cell scans are nuclear medicine procedures. Nuclear medicine procedures in ICD-10-AM are classified as either 'imaging' or 'non-imaging'. With imaging procedures, radioactive elements are introduced into the patient, and then an image is traced and recorded. Non-imaging procedures also include the insertion of radioactive elements, but it is the body specimens (blood, urine, faeces and so forth) that are examined at a later date.

Classification

Documentation of red (blood) cell scan to determine the cause of gastrointestinal bleeding, should be coded as 61364-00 **[2007]** *Bowel haemorrhage study*, indexed as:

Nuclear medicine

- imaging (study)

- - bowel haemorrhage 61364-00 **[2007]**

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Ref No: TN220 | Published On: 15-Jun-2004 | Status: Retired | Retired On: 30-Jun-2006

Chemotherapy/radiotherapy during stem cell transplantation

During the transplant phase of stem cell transplantation, a patient receives high dose chemotherapy, with or without radiation treatment according to an established protocol. Upon completion of the chemotherapy and/or radiation treatment, the previously collected stem cells are transplanted into the patient by infusion.

Chemotherapy and radiotherapy are not inherent in the stem cell transplantation codes in block **[802]** *Bone marrow/stem cell transplantation*. Therefore, when chemotherapy and/or radiotherapy is performed with stem cell transplantation, appropriate codes should be assigned for each of these procedures.

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Helicobacter pylori

The NCCH would like to clarify the use of B96.81 *Helicobacter pylori [H. pylori] as the cause of diseases classified to other chapters*.

Clinical advice suggests that *Helicobacter pylori (H. pylori)* is usually associated with some inflammatory conditions or ulcers of the gastrointestinal tract, but not all. For example, *H. pylori* is not usually associated with oesophagitis.

ACS 1122 *Helicobacter/Campylobacter* lists the conditions most commonly associated with *H. pylori.*

B96.81 *Helicobacter pylori [H. pylori] as the cause of diseases classified to other chapters* should only be coded when it is found in the presence of the conditions listed in the standard or it is documented in association with another condition. That is, a causal relationship between the organism (*H. pylori*) and any morbid condition not specifically listed in the standard, should not be assumed by the coder, but must be supported by documentation.

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Ref No: TN221 | Published On: 15-Mar-2004 | Status: Retired | Retired On: 30-Jun-2013

ACS 1541 *Elective and emergency caesarean*

The NCCH has been alerted to the fact that some classification users find difficulty with interpreting and applying the definitions in ACS 1541 *Elective and emergency caesarean*. The most important point separating the two definitions of elective and emergency caesarean section in ICD-10-AM is the timing of the decision to perform the procedure. The urgency to perform the caesarean is not significant when deciding between these two definitions.

With an **elective caesarean** section, the decision to perform the procedure is made during the antenatal period. That is, there is never any intention that the patient will deliver vaginally. With an **emergency caesarean** section, the intention was for the patient to deliver vaginally (that is, a caesarean was not considered necessary prior to the onset of labour), but an emergency situation has meant that a caesarean has become essential. This definition does not include any patient in whom delivery by caesarean section had previously been planned.

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Uterosacral plication ([1283])

Uterosacral plication is inherent in an anterior and posterior repair for a cystocele and rectocele and a uterine prolapse repair.

Classification

Where ‘uterosacral plication’ is documented in conjunction with the above procedures, it is not necessary to code the procedure separately.

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Post transfusion jaundice

The current indexing of 'Jaundice, post-transfusion -- *see Hepatitis, viral, type B*' is a WHO update of ICD-10 that follows the indexing of this condition as per ICD-9-CM. Clinical advice given to the NCCH suggests that the current indexing for post-transfusion jaundice is misleading and outdated as there may be causes of the jaundice other than hepatitis B. For example, the jaundice may be due to haemolysis from a delayed transfusion reaction.

Classification

Where a definitive causal link has been made between a diagnosis of jaundice and a previous blood transfusion (for example, documentation of jaundice due to blood transfusion) and there is no documentation of another possible cause of the jaundice (such as, excessive haemolysis or viral hepatitis), the NCCH suggests the use of the following codes:

T80.8 *Other complications following infusion, transfusion and therapeutic injection*

R17 *Unspecified jaundice* (with appropriate external cause and place of occurrence codes).

Where the cause of the jaundice is specifically indicated as being the result of a 'delayed haemolytic transfusion reaction' or transfusion reaction causing haemolysis, the NCCH suggests:

D59.9 *Acquired haemolytic anaemia, unspecified* (with appropriate external cause and place of occurrence codes).

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Ref No: TN222 | Published On: 15-Dec-2003 | Status: Retired | Retired On: 30-Jun-2013

Chest and breast injuries in male patients

Any injury documented as occurring in the breast (or nipple) should be classified to a breast site code, regardless of the patient's gender. This action may result in the generation of a warning flag for these records.

Edit checks of morbidity data identify invalid or inconsistent information. 'Warning' flags are generated for potentially incorrect data. For example, 'Code S20.13 is usually associated with the female gender'. Warning flags do not prohibit the use of a code - they only alert the user to the possibility that an error may have been made.

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Ref No: TN222 | Published On: 15-Dec-2003 | Status: Retired | Retired On: 30-Jun-2013

ACS 2103 *Admission for convalescence/aftercare*

The NCCH has received a number of queries concerning the application of ACS 2103 *Admission for convalescence/aftercare*. The intent of this standard is to provide guidance for clinical coders when specific documentation is written in the clinical record regarding ‘convalescence’ and ‘postoperative convalescence’ when the patient may still be receiving treatment. It was not intended for this ACS to be applied to all cases where patients are transferred between hospitals. The term ‘transfer’ does not imply that all subsequent episodes of care are ‘aftercare’.

Classification

Clinical coders should make the most appropriate decision regarding code assignment by:

- applying the clinical coders creed by assessing each case individually
- referring to clinical documentation
- using appropriate coding standards

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Ref No: TN223 | Published On: 15-Sep-2003 | Status: Retired | Retired On: 30-Jun-2013

Possible errors in the interpretation of pathology results found during routine data analysis at the Australian Institute of Health and Welfare (AIHW) (ACS 0010)

The AIHW undertakes a data editing process during the compilation of the National Hospital Morbidity Database each year and records are checked for a number of rare and/or notifiable diseases. Any records with these diseases are queried with the relevant state or territory health authority and either confirmed or corrected. In 2000-2001 there were 143 records with diagnoses of a rare and/or notifiable disease queried with the states and territories. Some were confirmed as correct, others were corrected or deleted and others could not be confirmed or corrected.It is suspected that cases may be incorrectly coded to rare and/or notifiable conditions because of misinterpretation of pathology results by clinical coders for example:

- *Corynebacterium diphtheriae (C. diphtheriae)* is the cause of diphtheria, but can be carried asymptomatically. Identification of *C. diphtheriae* in a pathology result alone does not justify the assignment of a diagnosis from A36 *Diphtheria*. See also ACS 0010 *General abstraction guidelines*
- The name of an organism is documented in two parts - genus and species - for example: *Corynebacterium diphtheriae (C. diphtheriae)*
- A diagnosis code should be assigned based on the organism's full name. Significantly different organisms can have similar names so care should be taken in these circumstances
- The ICD-10-AM Alphabetic Index in some cases provides entries for diseases that include the name of an organism, for example: *Corynebacterium diphtheriae* myocarditis, ICD-10-AM contains the entry:

Myocarditis (chronic) (fibroid) (interstitial) (old) (progressive) (senile) (with arteriosclerosis) I51.4

- in (due to)

- - diphtheria A36.8+ I41.0*

The codes A36.8+ *Other diphtheria* and I41.0* *Myocarditis in bacterial diseases classified elsewhere* should only be assigned when there is clinical and toxogenic documentation of *Corynebacterium diphtheria*.

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Infected burn (ACS 1911)

A number of queries have been received regarding the classification of infected burns, particularly when no specific organism has been identified or documented.

Classification

For documentation of infected burn the following codes should be assigned:

- a code for the site of the burn (T20-T30)
- a code from T31 *Burns classified according to extent of body surface area involved*, to indicate the extent of the burn
- T79.3 *Post traumatic wound infection, NEC*, to indicate the infection
- a code from B95-B97 *Bacterial, viral and other infectious agents*, to indicate the organism, if known.

Please note that it is standard clinical practice in managing burns patients to treat infection prophylactically. Therefore, the clinician should always be consulted before an infection code is assigned (see ACS 1911 *Burns*).

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Regional block anaesthesia

ACS 0031 *Anaesthesia* states “The codes for regional blocks are divided on the general anatomical area of the administration of the block, ie the actual nerve involved is not required for assignment of the correct code”. That is, when selecting a code for regional anaesthesia, the code must describe the field of anaesthesia (the effect of the anaesthesia), not the point of administration.

Classification

The following codes should be used for documentation of regional block:

92509-XX **[1909]** *Regional block, nerve of head or neck*

92510-XX **[1909]** *Regional block, nerve of trunk*

92511-XX **[1909]** *Regional block, nerve of upper limb*

92512-XX **[1909]** *Regional block, nerve of lower limb*

where the anatomical area adjacent to ‘nerve of...’ describes the area being anaesthetised.

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Advanced Breast Biopsy Instrumentation (ABBI) ([1743])

Since 1995 the Advanced Breast Biopsy Instrumentation (ABBI) system has been available for the management of radiologically detected breast lesions. ABBI is a stereotactically guided procedure able to precisely locate and excise in a single step non-palpable breast lesions found on mammogram.

The procedure is performed under local anaesthesia and combines the placement of a wire marker and retrieval of a specimen into one minimally invasive procedure. It requires both radiological and surgical skills.

Using stereotactic imaging technology, the lesion is located and the area numbed with a local anaesthetic. A marking needle (guide wire) is inserted to mark the precise location of the lesion. Using the ABBI system, the surgeon inserts a cannula into the breast to obtain a specimen. The small opening is closed with a few stitches.

The main difference between the ABBI procedure and the traditional core biopsy is that the ABBI procedure removes one specimen in one pass. A vacuum assisted core biopsy device such as a mammotome can take multiple biopsies with one pass but cannot remove an entire lesion intact.

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Intestinal metaplasia

Metaplasia is the replacement of one adult tissue by another occurring in postnatal life. Typically, intestinal metaplasia is seen in the stomach in chronic gastritis and represents the conversion of gastric type mucosa to a mucosa that may closely resemble intestine, usually the small intestine. It is generally considered to be an acquired condition in response to a non-specific injury and inflammation such as in reflux.

Classification

Where intestinal metaplasia is documented in conjunction with other findings/diagnoses/symptoms, assign a code(s) for those conditions, as appropriate. Do not code the intestinal metaplasia. In cases where intestinal metaplasia is the only condition documented, please refer to ACS 0013 *'Other' and 'unspecified' codes*, for correct code assignment. For example, if the metaplasia is in the oesophagus, search the index for *Disease, oesophagus, specified NEC*, which indicates code K22.8 *Other specified diseases of oesophagus*.

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HIV/AIDS coding ...some helpful reminders (ACS 0102; B20-B24)

- Documentation of HIV status should always be coded even if the criteria for an additional diagnosis are not met. This instruction has been added to ACS 0102 *HIV/AIDS* in ICD-10-AM Third Edition.
- Ensure the appropriate stage of HIV disease is being coded. Once a B20-B24 *Human immunodeficiency virus (HIV) disease* code is used, you cannot go back to using Z21 *Asymptomatic HIV infection status*.

  Hint: Consult the whole record. Information in previous episodes of care should be taken into account.
- Use two (or more) codes to fully reflect the condition. Ensure the codes are sequenced according to the guidelines in ACS 0102 *HIV/AIDS*.

  Take particular care in sequencing dagger and asterisk codes.

  Hint: Index entry:

  Pneumonia

  - *pneumocystis (carinii)* B59+ J17.3*

  - - resulting from HIV disease B20

  Three codes are assigned. The B20-B24 code should be assigned, as well as the codes for the pneumocystis.
- Use Z29.2 *Other prophylactic therapy* as principal diagnosis (and sequence the HIV status code second) where a potential manifestation is being treated prophylactically and is not a current condition - for example, nebuliser treatment for a potential respiratory problem.

  Hint: To ward off opportunistic infection, prophylactic treatment may be initiated when T-cell counts fall. As the infection has not yet occurred, or is not current, the manifestation should not be coded.
- Clarify with the clinician if it is unclear whether the presenting condition is associated with the HIV disease. Test results such as antibodies, viral loads, or T-cell counts may provide an indication of disease progression. These should be interpreted by the clinician.

  Hint: Even if the condition is clearly not a manifestation of HIV, remember to still code the HIV status as an additional code. If a B20-B24 code has been previously assigned then B24 *Unspecified HIV disease* must be used (and not Z21 *Asymptomatic HIV infection status*).

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Breast reconstruction

Reconstruction of the breast may be performed at the same time the breast is removed or at a later date. An admission specifically for post-mastectomy breast reconstruction will have a principal diagnosis code of Z42.1 *Follow up care involving plastic surgery to breast*. The malignancy (or history of) will be coded as an additional diagnosis; whether to use the current malignancy code(s) or Z85.3 *Personal history of malignant neoplasm of breast* is dependent on the circumstances of the episode of care.

Further detailed guidance on when to code malignancies as current is contained in ACS 0236 *Neoplasm coding and sequencing*.

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Conduction anaesthesia ([1909])

Conduction anaesthesia is achieved when drugs are used to block nerve impulses before they reach the central nervous system (CNS). This is in contrast to general anaesthesia, which relies on the action of drugs within the central nervous system to produce unconsciousness and depress responses to painful stimulation.

The term ‘conduction anaesthesia’ in ACHI includes neuraxial block, regional blocks and infiltration of local anaesthetic. The codes for these procedures are included in block **[1909]** *Conduction anaesthesia*.

Intravenous regional anaesthesia (92519-XX [1909])

This technique consists of the intravenous injection of a local anaesthetic drug into the blood vessels of a limb, usually the arm, that is isolated from the circulation by an arterial tourniquet. This is also known as retrograde perfusion of limb or Bier’s block. An intravenous cannula is inserted into the vein at the back of the hand and the arm is drained of blood by elevation or by the use of a special bandage. A double-cuff tourniquet is applied to the upper arm and inflated to 100mm Hg above the systolic blood pressure to prevent the blood vessels refilling. A solution of local anaesthetic is slowly injected through the cannula into the blood vessels and is absorbed by the surrounding tissue. The cuff must not be deflated under 30 minutes as this may allow release of the local anaesthetic in the general circulation. This technique is commonly used in emergency departments to reduce fractures of the wrist.

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Awareness during anaesthesia

Awareness during anaesthesia occurs when a muscle relaxant has been administered (parenteral or intravenous) in combination with cerebral anaesthesia and the patient is aware but unable to move to indicate the lack of anaesthetic effect. It does not occur with inhalational anaesthesia alone, as in this case the patient is able to move to express their displeasure at the lack of anaesthesia. Awareness during anaesthesia is always regarded in the anaesthetic literature as a complication of the anaesthesia.

Classification

Awareness during anaesthesia is not classified as a misadventure as in most cases correct procedures are followed and the lack of anaesthetic effect may be due to unknown factors. Where there is clinical documentation of ‘awareness during anaesthesia’, please assign the following codes:

T88.5 *Other specified complication of anaesthesia*

Y48.1 *Parenteral anaesthetics causing adverse effects in therapeutic use*

Y92.22 *Place of occurrence at or in health service area*

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for implementation 01 January 2002.

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Tonsillotomy

Tonsillotomy is a relatively new procedure that involves intracapsular removal of tonsil tissue. In this procedure, a 'channeling' technique is employed to debulk the tonsil, rather than excise the entire tonsil. In the weeks following the procedure, tissue adjacent to the channels continues to shrink, further reducing the size of the tonsils.

Classification

Clinical advice received by the NCCH indicates that the procedure of tonsillotomy should be assigned 41789-00 **[412]** *Tonsillectomy without adenoidectomy* or 41789-01 **[412]** *Tonsillectomy with adenoidectomy* as appropriate. Whilst this procedure employs a different method for removal of tonsillar tissue, it is yet to be proven as a viable and long-term alternative to routine tonsillectomy.

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Injection of thrombin and autologous growth factor (AGF) into bone

In this procedure, concentrated autologous growth factors (AGF) are harvested from the patient via haemapheresis. The buffy coat containing the concentrated platelets and growth factors is filtered, mixed with thrombin and then sprayed over an amount of granules to form a gel. This AGF gel is then moulded into any shape and is used to graft bony defects. The remaining red blood cells and platelet deficient plasma are transfused back into the patient.

Classification

For the above procedure, please assign a code for bone graft of the appropriate site together with 13750-06 **[1892]** *Other therapeutic haemapheresis*.

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Low birth weight (P05 and P07)

A code for low birth weight at normal gestational age should only be assigned on the infant's record when this is documented by the obstetrician/clinician/midwife and meets the criteria of an additional diagnosis. It should not be assigned routinely for all babies less than 2500g at full term.

The correct code for this condition is P05.0 *Light for gestational age*. The codes from P07 *Disorders related to short gestation and low birth weight, not elsewhere classified* are intended for use where low birth weight occurs in a premature infant.

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Vertebroplasty ([1393])

Vertebroplasty is a technique that is being used to treat vertebral compression fractures. The procedure involves the injection of a cement-like material (polymethylmethacrylate - PMMA) into the vertebral body to stabilise and strengthen collapsed or crushed bone. Vertebroplasty is a nonsurgical procedure performed using fluoroscopic guidance.

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Osteosclerosis (M85.8-)

The term osteosclerosis describes hardening, thickening, and increased density of bone. It may involve part of a bone, a whole bone, or the whole skeleton. The most common form, called osteopetrosis, is a rare inherited disease where bones become brittle and fracture more easily than do normal bones. Osteosclerosis may also develop in part of a bone as a result of an infection or tumour.

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Abdominal apron/overhang (E65)

Patients may present for surgery, (eg liposuction, radical abdominoplasty) with a principal diagnosis of either ‘abdominal apron’ or ‘abdominal overhang’. In these cases ‘abdominal apron’ or ‘abdominal overhang’ refers to localised adiposity (E65 *Localised adiposity*), not lipodystrophy (E88.1 *Lipodystrophy, not elsewhere classified*). Lipodystrophy is a metabolic disorder of unknown cause. It may be a side effect of treatment with protease inhibitors in HIV-positive patients and is also associated with insulin resistance.

When the reason for surgery, such as localised adiposity, is documented, code this condition as the principal diagnosis even if the procedure performed is of a cosmetic nature. If the surgery is being undertaken for cosmetic reasons, Z41.1 *Other plastic surgery for unacceptable cosmetic appearance* should be assigned as an additional diagnosis. When the condition is not specified or is a term not indexed in ICD-10-AM, assign Z41.1 *Other plastic surgery for unacceptable cosmetic appearance* as the principal diagnosis.

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Obstetrics and gynaecology

Fetal distress O68

Fetal distress is a very subjective diagnosis. Experts are unable to reach consensus about its meaning. Clinicians often rely on their own criteria and experience to decide when a fetus is in jeopardy.

Despite repeated efforts to define it and to create guidelines for its management, fetal distress remains a difficult concept to classify. In many cases intervention is undertaken to prevent development of fetal distress. For example, the occurrence of an instrumental delivery for a suboptimal/ non-reassuring CTG is common.

Keeping this in mind, it is important to note that the code title for O68 *Labour and delivery complicated by fetal stress [distress]* relates to both fetal stress and fetal distress. Therefore, if a patient develops fetal distress that requires instrumental or surgical intervention, an appropriate code from O68 *Labour and delivery complicated by fetal stress [distress]* should be assigned.

Fetal scalp electrodes

A fetal scalp circular (spiral) electrode and applicator is a device used to obtain a fetal electrocardiogram during labour and delivery. It establishes electrical contact between fetal skin and an external monitoring device by a shallow subcutaneous puncture of fetal scalp tissue with a curved needle or needles.

When a fetal scalp electrode is applied, assign 16514-00 **[1341]** *Internal fetal monitoring* (on the mother's record).

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Shoulder pain (M25.51; M75.8)

The classification of shoulder pain in ICD-10-AM depends on whether the pain is true articular shoulder pain (ie pain in joint) or soft tissue pain in the shoulder region.

Articular shoulder joint pain is classified to M25.51 *Pain in joint, shoulder region*. Soft tissue pain in the shoulder region is classified to M75.8 *Other shoulder lesions*. A thorough check of the clinical record should reveal whether the pain is in the joint or the shoulder region. If in doubt, check with the treating clinician.

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Transverse colectomy ([913])

If transverse colectomy is documented in an operation report, determine the extent of resection and site of anastomosis and assign an appropriate code from block **[913]** *Colectomy*. Caution is needed in interpreting the report. In some cases of documented 'transverse colectomy' a right hemicolectomy or extended right hemicolectomy is in fact performed.

Some examples of documentation from operation reports follows:

Operation report no. 1

Operation: Transverse colectomy, liver biopsy

Midline incision. Liver nodule over dome of right lobe a wedge excision. Right colon mobilised. Transverse colon sectioned after ligation. Middle colic artery resected. Ascending colon anastomosed to descending colon.

Assign: 32003-00 **[913]** *Limited excision of large intestine with anastomosis*

Reason: The ascending colon was anastomosed to the descending colon and so an extended right hemicolectomy was not performed (only the hepatic flexure, transverse colon and splenic flexure was removed.

Operation report no. 2

Operation: Right hemicolectomy and proximal 1/2 transverse colectomy. Stapled primary anastomosis.

Assign: 32003-01 **[913]** *Right hemicolectomy with anastomosis*

Reason: The resection did not extend past the mid transverse colon and so an extended right hemicolectomy was not performed.

Operation report no. 3

Operation: Transverse colectomy

Midline abdo incision. Large Ca mid transverse colon. Liver OK. Transverse colon mobilised and resected. Anastomosis in 2 layers. Mesenteric window closed. Omentum sewn over anastomosis.

Assign: 32003-00 **[913]** *Limited excision of large intestine with anastomosis*

Reason: The description of the procedure is limited and it appears that only the transverse colon was removed. Without the detail of the site of the anastomosis, 32003-00 **[913]** *Limited excision of large intestine with anastomosis* is the best code. Clarify this choice of code with the surgeon before assigning.

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Continent appendicostomy (30375-30 [927])

A continent appendicostomy is the creation of a stoma by securing the extremity of the vermiform appendix to the anterior abdominal wall. This allows bowel flushing in children with constipation or faecal incontinence. It is also referred to as the Malone Antegrade Continence Enema (MACE) procedure or Malone's appendicostomy.

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Hornets, bees and wasps: External causes of injury due to venomous bites and stings (X23)

Kenneth D Winkel and James Harrison

Stings by bees and wasps are quite common. While most stings are no more than briefly painful, the consequences are sometimes severe, occasionally fatal. Bees differ from wasps in behaviour, composition of venom and in their distribution in Australia. Recent research shows marked differences in patterns of mortality from bee and wasp stings, but very little is known about patterns of morbidity. Better information on this, via hospitalisation data, would inform prevention and treatment.

Australia has a diverse range of venomous creatures capable of causing severe morbidity and mortality. Whilst most attention has focused upon snake and spider bite-related fatalities, arthropods such as honey bees (*Apis mellifera*) and European wasps (*Vespula germanica*) can also inflict dangerous stings. Indeed, due to their widespread distribution, bee and wasp stings are a leading cause of bite and sting related mortality globally.

Despite their importance, little has been published on the circumstances and incidence of severe bee and wasp sting related injuries. For example, an analysis of Australian bee sting fatalities that occurred during 1960-81 was unable to obtain adequate clinical information regarding most of the fatalities during that period[1]. Coronial records were examined for only 1 of the 27 fatalities identified in that study. Unfortunately, despite the increasing abundance[2] of the introduced and aggressive European wasp (*V. germanica*), even less information is available regarding wasp sting related fatalities in Australia than for bee stings[3,4,5].

The European honey bee was introduced to Australia in 1822 and is now widespread. By contrast the European wasp only arrived in Tasmania in 1957 and on the mainland (in Victoria), in 1977. Ecological restrictions are more limiting of the distribution of *V. germanica* in Australia than for *A. mellifera*. Consequently, the epidemiology of bee and wasp sting mortality in Australia appears distinctive. For example, most wasp mortality is concentrated amongst farmers in Queensland and north-eastern NSW[5]. Fatal bee stings, by contrast, occur in all states and territories and are grossly over-represented amongst bee-keepers and their families[6]. Other findings of these mortality studies are that many deaths occur less than an hour after a sting (typically only one sting), and affect people with a history of allergic response to previous stings. Adrenaline and immunotherapy amongst bee and wasp venom allergy patients are likely to be effective treatments, but they seem to be under-used. To date there have been no published studies of national trends in bee and wasp sting related morbidity.

Unfortunately our efforts to better define the burden and determinants of bee and wasp sting related morbidity have been limited by the categories provided in the International Classification of Diseases. Hornet, bee and wasp related injuries were all lumped under the same category (E905.3 in ICD-9-CM and X23 in ICD-10-AM). This effectively referred to bee and wasp stings only since there are no true hornets (genus *Vespa*) in Australia. No separate analysis of bee versus wasp sting related inpatient data is possible for separations prior to July 2000. Nevertheless the significance of bee and wasp stings can be gauged by the fact that they have, historically, constituted the second most common cause of hospitalisation due to venomous bites and stings in Australia[7,8]. They account for more admitted cases than snakes, and not quite as many as spiders.ICD-10-AM contains specific codes to distinguish bee and wasp sting injuires.

Table 1. **X23**X23 *Contact with hornets, wasps and bees*

.1 Contact with hornets

.2 Contact with wasps (includes yellow jacket)

.3 Contact with bees

.9 Contact with hornets, wasps and bees, unspecified

The usefulness of the categories depends on whether the information necessary to distinguish bee stings from wasp stings can be found in available records. We found that this distinction could be made with reasonable certainty for most deaths[5,6]. However this required a careful examination of the clinical record. The most important clues were the initial visual identification of the creature by a witness as opposed to the (sometimes inaccurate) medical attribution, and the presence or absence of a sting retained at the sting site. Honey bees always leave a retained sting (though this is not always seen) but wasps never do. While the availability of information in hospital records may differ from what we found for deaths, the following guidelines, based on our experience, are likely to help when applying the new codes to hospitalised cases.

1. If the stinging creature has been caught and identified as a bee or a wasp by a competent person, then code according to this assessment.
2. Bees leave their stinging organ embedded at the site of injury, while wasps do not. If there is mention of an embedded sting, then the case should normally be coded to X23.3 (bee).
3. Witnesses, including the patient, are likely to be at least as reliable at identifying the type of creature as most hospital personnel who did not see the event.

Fortunately, the number of bee and wasp stings resulting in admission to a hospital is not very large. For example, about 1,300 separations in 1997/98 included the Ecode value E905.3 Consequently, the additional distinction required by the extended version of X23 will not add greatly to the overall burden of coding. We and others will use the more specific information about bee and wasp sting morbidity that will result from this change to help improve preventative strategies and treatment. Kenneth D Winkel, MBBS, PhD, Director, Australian Venom Research Unit, Department of Pharmacology, University of Melbourne 3010 VIC. Tel. 03 8344 7753 Fax. 03 9348 2048. E-mail: k.winkel@pharmacology.unimelb.edu.auJames Harrison MBBS, MPH, Director, Research Centre for Injury Studies and AIHW National Injury Surveillance Unit, Flinders University, South Australia.

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Heart failure (I50)

Congestive heart failure (CHF/CCF) is a syndrome in which the heart is unable to pump at an adequate rate for the body's metabolic requirements. This causes signs and symptoms of volume overload or manifestations of impaired tissue perfusion such as oedema, fatigue and decreased exercise tolerance. It is not necessary to code volume (fluid) overload in a patient with CHF.Heart failure usually begins with the left ventricle not working efficiently (left ventricular failure - LVF), which results in congestion of the lungs. Assign I50.1 *Left ventricular failure*.

Failure of the pumping action of the right ventricle (right ventricular failure) is most commonly caused by prior left ventricular failure and results in congestion in veins and capillaries around the body. Therefore, if both LVF and CHF are documented, only I50.0 *Congestive heart failure* is assigned. Acute pulmonary oedema (APO) is a life-threatening manifestation of acute left ventricular failure secondary to sudden onset of pulmonary venous hypertension forcing fluid out of the pulmonary veins and into the pleural cavity (pleural effusion). If it is documented that the patient has APO and CHF, assign only I50.0 *Congestive heart failure*. It is not necessary to code pleural effusion unless specific treatment (eg drainage) is required.

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Newborns affected by maternal causes (P00-P04)

ICD-10-AM contains a range of codes to indicate that a newborn has been affected by a maternal condition:

P00 *Fetus and newborn affected by maternal conditions* that may be unrelated to present pregnancy

P01 *Fetus and newborn affected by maternal complications of pregnancy*

P02 *Fetus and newborn affected by complications of placenta, cord and membranes*

P03 *Fetus and newborn affected by other complications of labour and delivery*

P04 *Fetus and newborn affected by noxious influences transmitted via placenta or breast milk*

ACS 1609 *Newborns affected by maternal causes and birth trauma* provides guidance on the use of these codes.

To be able to assign one of these codes, the record must contain documentation of the newborn's problem (the effect) and a note that it was caused by one of the maternal conditions or a complication of pregnancy, labour or delivery. Therefore there will always be two codes: the problem and the cause. Always sequence the code for the problem first, followed by the code for the cause. A code from P00-P04 will never be the newborn's principal diagnosis code.

Codes from P10-P15 Birth trauma indicate that there has been some trauma during delivery and, as such, are likely to have an additional code from P03 *Fetus and newborn affected by other complications of labour and delivery* assigned. However, the cause and effect must be documented before a P03.- code can be assigned.

If the mother has a condition or complication of labour or delivery that does not cause any adverse effect to the baby:

- do not assign a code from P00-P04 on the baby's record
- if the maternal cause has necessitated provision of more health services than is usual for a newborn, it may be appropriate to assign Z76.2 Health supervision and care of other healthy infant and child (for example, in the case of post-caesarean observation) or Z03.7 Observation and evaluation of newborn for suspected condition not found.

There is no time limit for the use of codes from P00-P04. For example, a 25 year old patient presenting with vaginal clear cell adenocarcinoma due to intrauterine exposure to DES (diethylstilboestrol) would be assigned the cancer codes followed by P04.1 *Fetus and newborn affected by other maternal medication*. See also ACS 1605 *Definition of conditions originating in the perinatal period*.

Example 1

Single newborn with injury to the face (requiring suturing) as a result of caesarean section.

Code:

P15.4 *Birth trauma to face*

P03.4 *Fetus and newborn affected by caesarean delivery*

Z38.0 *Singleton, born in hospital.*

Example 2

Single newborn stated to be ‘small for dates’. Mother noted to be hypertensive. (No relationship between SFD and hypertension documented in the record.)

Code:

P05.1 *Small for gestational age*

Z38.0 *Singleton, born in hospital.*

Example 3

Single newborn delivered by caesarean section, admitted to special care nursery for post-caesarean observation. (No problem documented.)

Code:

Z76.2 *Health supervision and care of other healthy infant and child*

Z38.0 *Singleton, born in hospital.*

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Mental health issues (F70-F79)

The Mental Health Classification Update Forum (CUF) was held 8 September 2000. A number of decisions from the CUF are presented here as guidelines.

a) Mental retardation and intellectual disability/intellectual impairment ACS 0531 *Intellectual Impairment/Intellectual Disability*

The terms 'intellectual disability' and 'intellectual impairment' are not indexed in ICD-10-AM.

Intellectual disability

Clinicians advised that the term **intellectual disability** is used interchangeably with '**mental retardation**' and therefore when this term is documented, an appropriate code from categories F70-F79 *Mental retardation*, should be assigned. Bear in mind that F79.9 *Unspecified mental retardation, without mention of impairment of behaviour* should be used as the last resort. More information should be sought from the treating clinician to determine the extent of the impairment.

Intellectual impairment

In regard to the term intellectual impairment:

- If the condition is congenital, then a code from category F70-F79 *Mental retardation* can be assigned (endeavour to obtain the extent of the impairment from the treating clinician).
- If the condition is acquired, seek a more definitive diagnosis (ie dementia) from the clinician.

b) Cognitive impairment (F06.7; ACS 0532)

If cognitive impairment is recorded, further clarification as to the extent of the impairment (ie mild memory disturbance or loss following organic brain damage, dementia) should be sought from the clinician. If this is not possible, then R41.8 *Other and unspecified symptoms and signs involving cognitive functions and awareness* should be assigned.

F06.7 *Mild cognitive disorder* should be assigned only when terms supporting the diagnosis are documented.

c) Drug overdose - selection of principal diagnosis

It is often difficult to establish the principal diagnosis in these admissions when two different treatment patterns occur:

1. Acute intervention for the drug effect - this is often only a day or two in ICU
2. Psychiatric treatment for any associated psychiatric disorder - this may be days or weeks.

In many hospitals, the episode of care is treated as one acute episode which creates difficulties when assigning the principal diagnosis in these cases. Participants at the Mental Health CUF were asked to consider this issue. The possibility of a change of episode type, at the time the care focuses on the psychiatric condition, was discounted because the care type remains acute[1]. The possibility of basing the principal diagnosis selection on the type of treatment delivered to the overdose and the psychiatric condition was also discounted because treatments are too variable to be reliable as the criteria for assignment of the principal diagnosis. It was agreed that in such

cases, the overdose should be sequenced as the principal diagnosis because it is 'chiefly responsible for occasioning the patient's episode of care in hospital'. In cases where a patient is admitted for treatment of a drug overdose, and the patient subsequently receives treatment for an associated psychiatric condition in the same episode of care, the overdose code should be sequenced as the principal diagnosis.[1] Note that in Victoria the care type can be changed to 'psychiatric care'. Victoria's care type data domain differs from the NHDD care type data domain.

d) Cluster B personality disorder (ACS 0512)

The term cluster B personality disorder is a classification axis in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and this may explain its appearance in medical record documentation. In contrast, in ICD this term relates to a group of personality disorders: antisocial, borderline, histrionic, or narcissistic (more commonly, borderline or antisocial personality disorder). The predominant personality disorder should be coded first, together with any other documented personality disorders.

Whenever a diagnosis of cluster B personality disorder is documented, without identification of the predominant personality disorder, seek clarification from the clinician.

e) Coding of suspected conditions in mental health (ACS 0012)

The NCCH has a standard for coding suspected conditions (ACS 0012). However, this standard is difficult to apply in mental health because the clinical coder cannot reliably select symptoms to code due to the complexity of the conditions. The clinicians described the difficulties in diagnosing certain disorders. There may be a number of admissions before a definitive diagnosis can be determined, and this was especially true for adolescents.

Coding symptoms was not considered helpful or practical. One suggestion was to look at the treatment provided, however, this would vary greatly depending on the suspected disorder and a coding guideline would be difficult to develop.

There was general discussion on the possible inflation of estimates of hospitalisations for these conditions. Such an inflation may occur and, because confirmed and suspected cases cannot be distinguished from each other, the data may not be very useful for epidemiologists and others with an interest in hospitalisations for confirmed conditions. Alternatives for identifying suspected conditions remains an issue - a long term solution is required for coding suspected conditions in all specialties.

The clinicians agreed that in mental health, the suspected condition should be coded as a definitive diagnosis. If more than one suspected condition is documented, and it is not clear which suspected condition is the principal diagnosis, apply ACS 0001 *Principal Diagnosis, two or more diagnoses* that equally meet the definition for principal diagnosis.

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Consolidation of lung

Lungs are described as consolidated when the normal air-filled spaces distal to the bronchi are occupied by:

- blood
- pus
- water

Consolidation is confirmed by radiographic imaging, usually x-ray.

Causes of lung consolidation include:

- pulmonary oedema
- cardiogenic/fluid overload
- adult respiratory distress syndrome
- inhalation of noxious gases
- drug abuse
- neurogenic disorders (including head injuries)
- trauma, such as fat embolus
- renal disease
- eosinophilic lung disease
- collagen vascular disease
- pneumonia
- radiation pneumonitis
- neoplasm
- haematological disorders
- contusion
- infarction
- idiopathic pulmonary haemorrhage (Goodpasture's syndrome)
- sarcoidosis
- alveolar proteinosis

Consolidation of the lung is a symptom of an underlying condition or the result of injury or trauma. Often it is caused by pneumonia.

When the underlying condition is known, code only the underlying condition.

When the underlying condition is unknown, seek clinical advice.

In the case of injury, code only the injury which caused the consolidation.

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Shoulder Decompression Procedures

Decompression of the subacromial space may be achieved by performing an open acromioplasty, removal of coraco-acromial ligament and excision of distal clavicle.

The following breakdown of codes is to provide coders with an outline of what each code encompasses. 48903-00 **[1400]** *Decompression of subacromial space* may be achieved by acromioplasty, excision of the coraco-acromial ligament, excision of the distal clavicle, or a combination of these three procedures.

48906-00 **[1404]** *Repair of rotator cuff* applies to repair of the rotator including excision of the coraco-acromial ligament or removal of calcium deposits from the rotator cuff, or both of these procedures.

48909-00 **[1404]** *Repair of rotator cuff with decompression of subacromial space* applies to repair of the rotator cuff in combination with decompression of the subacromial space by acromioplasty, excision of the coraco-acromial ligament or excision of the distal clavicle, or any combination of these.

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Use of Z codes as principal diagnosis (Chapter 21 *Factors influencing health status and contact with health services*)

The use of a Z code (*Factors influencing health status and contact with health services*) as principal diagnosis is sometimes questioned by health funds as these codes often don't describe a 'disease' state. However, ICD-10-AM Z codes are legitimate principal diagnoses according to the current *Australian Coding Standards*. There are a few exceptions but these are only unacceptable in relation to DRG grouping and can be referenced in AR-DRG definitions manual. The following information may assist those involved in handling coded data for health funds.

The *Australian Coding Standards* are effective in all states and territories and are integral to both accreditation of coders and in the development of coder competency standards. Variation in application of such standards creates inaccuracies in national and state morbidity data, affects DRG grouping and consequently funding in some sectors and can have detrimental effects when hospital coding is audited.

The most commonly assigned principal diagnosis Z codes are those for short stay admissions, such as admissions for chemotherapy, endoscopy or dialysis.

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Endoscopic Stapling of Pharyngeal Pouch (41773-00 [421])

A pharyngeal pouch is a mucosal outpouching that arises at the junction of the pharynx and oesophagus. This may be referred to as a pharyngo-oesophageal or Zenker's diverticula.

Endoscopic diverticulotomy (Dohlman's procedure) using electrocautery or laser has been performed for pharyngeal pouch in the past. However, this 'sutureless' method was associated with postoperative complications, particularly mediastinitis. Endoscopic stapling diverticulotomy for pharyngeal pouch is a recent modification of Dohlman's procedure that uses a linear cutting stapling device. The stapling device divides the common septum between the oesophagus and pouch to create a single lumen while achieving simultaneous sealing of the divided edges of the mucosa and muscle.

Code assignment for endoscopic resection of pharyngeal pouch is based on the procedure performed, not the technology used. Therefore, assign 41773-00 **[421]** *Endoscopic resection of pharyngeal pouch* for all cases of endoscopic resection of pharyngeal pouch, whether via stapling, electrocautery or laser.

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IHACPA

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PICC (Peripherally Inserted Central Catheter) lines

(13815-00 [738]; 13815-01 [738]; ACS 0042)

A central venous catheter can be inserted into either the subclavian, jugular or peripheral veins (arm or upper leg). The catheter may be placed percutaneously (inserted through the skin) or by cut-down (inserted directly into a vein through an incision in the skin). The cephalic and brachial veins (at the elbow) are the peripheral veins usually used. The catheter is guided through the veins of insertion into the right atrium of the heart, the inferior vena cava or the superior vena cava.

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Minimally invasive coronary artery bypass (MICAB) grafts

MICAB describes a group of cardiac revascularisation procedures that do not require median sternotomy or the use of a cardiopulmonary bypass (CPB) machine. MICAB is a modification of conventional coronary artery bypass grafts performed via a small, limited access incision. In Australia, many MICAB procedures use a heart tissue stabilisation device called an ‘Octopus’. The ‘Octopus’ uses suction to immobilise local heart muscle. It is placed on either side of the recipient coronary artery and fixed to the operating table through an arm construction. This restricts motion at the anastomotic site allowing precise surgery to be performed.

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Postmenopausal bleeding while on hormone replacement therapy (N95.0; Y42.0)

Postmenopausal bleeding may occur as a result of:

- Gynaecological malignancy
- Benign neoplasms (fibroids, polyps)
- Atrophic vaginitis
- Endometrial hyperplasia

Postmenopausal bleeding may also occur while a person is on hormone replacement therapy (HRT).

HRT with a progestogen component is **expected** to cause bleeding just after ceasing the progestogen. Bleeding should only occur during the days when the progestogen is ceased. This bleeding is not considered irregular or a complication of HRT. **Irregular** bleeding while on HRT may occur during the first year of continuous HRT (the adjustment phase), but the bleeding should eventually cease. The continuation of irregular bleeding after twelve months generally warrants investigation.

Classification

When postmenopausal bleeding occurs in a patient on hormone replacement therapy, the HRT cannot be assumed to be the cause of the bleeding. Even in instances where no pathology is found, an external cause code (eg Y42.0 *Glucocorticoids and synthetic analogues causing adverse effects in therapeutic use*) cannot be assigned unless the clinician has **documented** the HRT **as the cause** of the post menopausal bleeding.

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Pregnancy-induced hypertension, pre-eclampsia and eclampsia (O13; O14; O15)

Generally, if sustained elevated blood pressure exists without proteinuria and/or oedema, the term 'PIH' is used. If hypertension exists with proteinuria and/or oedema, the term 'pre-eclampsia' is generally applied. However, the term 'pregnancy-induced hypertension' (PIH) may be used interchangeably with 'pre-eclampsia'.

PIH commonly arises in the second half of pregnancy or in the first 24 hours post-partum. Blood pressure usually returns to normal by 10 days post-partum.

Pre-eclampsia is characterised by the onset of acute hypertension with albuminuria and/or oedema. Complications of pre-eclampsia may include abruptio placentae, ophthalmic damage and pulmonary oedema. If untreated, pre-eclampsia will progress to eclampsia.

Eclampsia is the most life-threatening form of pregnancy-induced hypertension. It is characterised by grand mal seizures, hypertension, proteinuria, oedema and may progress to coma. Before a seizure, a patient may experience a body temperature of over 40 degree Celsius, anxiety, epigastric pain, severe headache and blurred vision. Complications of eclampsia may include cerebral haemorrhage, pulmonary oedema, renal failure, abruptio placentae and temporary blindness.

Classification

Pregnancy-induced hypertension without proteinuria is assigned O13 *Gestational [pregnancy-induced] hypertension without significant proteinuria*. Pregnancy-induced hypertension with proteinuria is assigned a code from category O14 *Gestational [pregnancy-induced] hypertension with significant proteinuria*, based on the documented level of severity. Category O14 should not be assigned on the basis of laboratory diagnostic results indicating proteinuria. **Rather, the clinical significance of the proteinuria must be documented by the treating clinician**.

Pre-eclampsia is divided into three codes based on its degree of severity: mild (O13 *Gestational [pregnancy-induced] hypertension without significant proteinuria*), moderate (O14.0 *Moderate pre-eclampsia*) and severe (O14.1 *Severe pre-eclampsia*). If the documentation in the clinical record does not indicate the degree of pre-eclampsia, and if a clinician cannot be consulted, assign the default in the index (O14.9 *Pre-eclampsia, unspecified*).

Classify eclampsia according to when the eclampsia began. That is, either during the pregnancy (O15.0 *Eclampsia in pregnancy*), during labour (O15.1 *Eclampsia in labour*) or during the puerperium (O15.2 *Eclampsia in the puerperium*). For example, if a patient is admitted at 30 weeks gestation after having an eclamptic fit and proceeds to an emergency lower segment caesarean section, O15.0 *Eclampsia in pregnancy* is assigned to reflect that the patient was not in labour when the eclampsia commenced.

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Unavailability and inaccessibility of health care facilities (Z75.3)

Z75.3 should be used as a 'flag' only to identify patients transferred because of a **suspected condition**. It is not necessary to assign Z75.3 for **ALL** transferred patients (the discharge status provides this information).

See also ACS 0012 *Suspected conditions*.

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Induction of labour/augmentation of labour ([1334]; [1335])

The NCCH has received a number of queries relating to induction/augmentation of labour and how to use the 'combined' codes in blocks **[1334]** *Medical or surgical induction of labour* and **[1335]** *Medical or surgical augmentation of labour* (NCCH query ID 506, 606, 741).Points to remember when deciding on the assignment of these codes:

1. Augmentation procedure codes are used only for patients who **have a spontaneous labour.** Any interventions assisting with the continuation of the spontaneous labour are classified as augmentation.
2. Induction procedure codes are used only for patients who **do not have a spontaneous labour**. Interventions used to start labour and/or assist with the continuation of the induced labour are classified as induction, regardless of when the procedure during the course of the labour is performed (ie induction by IV syntocin, then 3 hours later surgical induction by ARM).
3. Augmentation and induction procedure codes cannot be assigned together, ie labour is either spontaneous or induced, it cannot be both.

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Choledochoscopy

There are three ACHI codes relating to interventions performed with a choledochoscope:

30452-01 **[958]** *Choledochoscopy with stenting*

30452-02 **[959]** *Choledochoscopy with removal of calculus*

30452-00 **[971]** *Choledochoscopy with dilation*

A choledochoscope is a very small calibre endoscope introduced through the channel of the larger duodenoscope. Choledochoscopy can be performed in conjunction with open procedures, laparoscopic procedures or endoscopic procedures.

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Balloon thermo-ablation of endometrium (35622-00 [1263])

Endometrial ablation has been the treatment of choice since the late eighties for some women with heavy periods or post-menopausal women on hormone replacement therapy. The latest advance in endometrial ablation is called balloon thermo-ablation or thermal uterine balloon ablation. The basal layer of the endometrium is destroyed by heating, thus preventing the endometrium from regenerating during the next cycle, eventually bringing menses to a halt.

The hysteroscope, with a camera attached, is passed into the uterine cavity, giving the surgeon full view. A latex balloon attached to a catheter is inserted vaginally through the cervix and placed into the uterus and inflated with fluid. The fluid is then heated to 87 degree Celsius for 8 minutes, causing destruction of the endometrium.

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Transcatheter embolisation of blood vessels

Transcatheter embolisation of blood vessels is performed to therapeutically block or occlude blood vessels. This may be performed to arrest a haemorrhage, treat vascular anomalies such as arteriovenous malformations (AVM) or fistulas or to block blood supply to a tumour.

Embolisation can also be performed as a pre-cursor to surgery, such as excision of tumour or clipping of AVM, as embolisation reduces the risk of haemorrhage or infarct.

The technique involves the delivery of an agent or device through a small catheter and is generally performed in x-ray departments or catheter laboratories.

Many agents or devices can be used to occlude blood vessels:

- Sponges - gelatin (Gelfoam) or plastic (polyvinyl alcohol)
- Balloons
- Wire coils (steel or platinum with or without polyester strands)
- Ethanol
- Glue
- Silastic pellets

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Epilepsy (G40)

The terminology (and the basis of the classification) used for epilepsy in ICD-10-AM in G40 *Epilepsy* is a mixture of that recommended by the International League Against Epilepsy (ILAE) and terms such as ‘grand mal’ and ‘petit mal’ (first used in 1838). ‘Grand mal’ and ‘petit mal’ are not regarded by clinicians as appropriate terminology today but have been retained in ICD-10-AM because of their continued use by some clinicians and patients. A separate 3 character category is provided for status epilepticus (G41 *Status epilepticus*).

Following the current ILAE classification, the codes in G40 identify epilepsy according to aetiology (idiopathic or symptomatic) and whether it is localization-related or generalized. Within the localization-related, symptomatic codes, there is a split for simple and complex partial seizures (G40.1- and G40.2-). The difference between idiopathic and symptomatic is:

- **Idiopathic:** no known cause for the epilepsy.
- **Symptomatic:** a known cause exists for the epilepsy (eg space occupying lesion, congenital malformation of the brain, metabolic disorder, trauma, vascular disease, infectious disease). The literature suggests that the differentiation between idiopathic and symptomatic is rapidly disappearing as researchers are finding more causes for epilepsy. For example, research into mitochondrial disorders has identified some ‘causes’ for epilepsy (eg myoclonus epilepsy with ragged red fibres (MERRF)).

In ICD-10-AM Tabular List and Alphabetic Index, coders are directed towards the codes based on the ILAE classification rather than the use of the more imprecise and inappropriate terms such as ‘grand mal’ and ‘petit mal’. This is why the Index lists G40.3- *Generalized idiopathic epilepsy and epileptic syndromes* as the code for ‘Epilepsy, petit mal’.

To reinforce that the terms and codes for ‘grand mal’ and ‘petit mal’ should be avoided if at all possible, notes have been included in ICD-10-AM under G40.6- *Grand mal seizures, unspecified (with or without petit mal)* and G40.7- *Petit mal, unspecified, without grand mal seizures* in ICD-10-AM Tabular List.

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Decompression laminectomy and discectomy ([46] to [52])

Definition

Spinal (vertebral) column: The column formed by the vertebra is comprised of various levels: cervical (7), thoracic (12), lumbar (5), sacral (5) and coccygeal (4). The 5 sacral vertebra are fused to form the sacrum, and the 4 coccygeal vertebra form the coccyx. The spinal column encloses the spinal cord and meninges.

Spinal cord: Extends from foramen magnum (within the skull) to the upper part of the lumbar region. Note there is no spinal cord beyond the 1st lumbar vertebra.

Spinal nerve roots: There are 31 pairs of spinal nerves. They emerge as paired nerve roots from the anterior and posterior spinal cord. Each nerve is then formed by the union of the paired roots.

Level: Certain spinal procedures require the specification of the level at which the procedure is being performed. The level of the vertebra is the numbered vertebra, eg L4 is the 4th lumbar vertebra. As intervertebral discs lie between vertebrae, documentation of ‘L4/5’ means the disc is between L4 and L5, that is one vertebral interspace or one disc level.

Decompression: is releasing pressure either from the spinal cord or spinal nerve roots. It is necessary to read the procedural notes to determine what is being decompressed.

Laminectomy: is removing some of the lamina (a bony plate which makes up part of the vertebral arch).

Rhizolysis: is synonymous with decompression of the spinal nerve roots. This may be done by freeing tissue or removing some of the lamina.

Discectomy: is removal of an intervertebral disc which is a cartilaginous structure between each vertebra. Many disc prolapses can be excised with removal of a minimal amount of bone. A full laminectomy is usually only required for a large disc prolapse.

Spinal rhizolysis: The term spinal rhizolysis relates to decompression of spinal nerve roots as opposed to decompression of the spinal cord.

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Anterior cruciate ligament (M23.5-)

The anterior cruciate ligament (ACL) of the knee is one of four principal knee ligaments. The ACL crosses from the back of the femur to the front of the tibia. Although it acts like a strong brace for the knee, the ACL is injured more often than the posterior cruciate ligament (PCL) because it is smaller and more susceptible to twisting.

The ACL controls how far forward the tibia moves in relation to the femur. If the tibia moves too far the ACL can rupture. This tearing of the ligament results in a loud ‘pop’ and instability in the knee.

The symptoms following a tear of the ACL are variable. Usually there is swelling of the knee within a short time following the injury due to bleeding into the knee joint from torn blood vessels in the ligament. The instability caused by the torn ligament leads to a feeling of insecurity and giving way of the knee, especially when trying to change direction on the knee. The pain and swelling from the initial injury will usually resolve after 2 to 4 weeks, but the instability remains.

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Haemodialysis

13100-00 [1060] *Haemodialysis*

In haemodialysis, the blood, laden with toxins and nitrogenous wastes, is diverted from the patient with renal disease to a dialyser where the blood is cleansed and returned to the patient. The process involves:

- diffusion whereby the toxins and wastes move from the area of greater concentration (the blood) to the area of lesser concentration (the fluid in the dialyser ie the dialysate),
- osmosis whereby excess water moves from the area of greater pressure (the patient) to the area of lesser pressure (the dialysate), and
- ultrafiltration which facilitates water removal by creating a negative pressure between the blood and the dialysate.

13100-01 [1060] Intermittent haemofiltration

Haemofiltration is used to remove excess fluid.Intermittent haemofiltration treatments are given three times per week using highly permeable haemofilters. The theoretical advantage of intermittent haemofiltration is a higher removal rate of larger molecular weight substances which are removed poorly by dialysis.

Intermittent haemofiltration is sometimes referred to as intermittent ultrafiltration which is most often used just prior to dialysis. A dialysis machine is used but dialysis solution is not circulated through the machine and a negative pressure is generated in the ultrafiltrate compartment, effecting ultrafiltration.

13100-02 [1060] Continuous haemofiltration

Continuous haemofiltration is a method of temporarily replacing kidney function.

It is used at the beside in intensive care units for patients whose kidneys are unable to handle their high acute metabolic or nutritional needs.

Blood is circulated through a small volume, low resistance filter by the patient's own arterial pressure rather than that of the blood pump used in haemodialysis. Blood flows from an artery, via an arteriovenous fistula or an arterial catheter, to a haemofilter where excess fluids, electrolytes and nitrogenous waste products are removed by ultrafiltration. The blood then returns to the patient's circulation via the venous arm of the arteriovenous fistula or a venous catheter. Intravenous fluids may be administered to replace fluid removed by the procedure.

The process is continuous and slow, making it particularly suitable for patients with unstable cardiovascular systems. Continuous haemofiltration should be specifically documented in the medical record to assign the appropriate code.

13100-03 [1060] Intermittent haemodiafiltration

Intermittent haemodiafiltration is a hybrid between haemofiltration and haemodialysis, combining diffusion and convection. Blood flow is accelerated to twice that of conventional dialysis; also called high-flux haemodiafiltration. Intermittent haemodiafiltration is performed approximately three times per week in patients with chronic renal failure.

13100-04 [1060] Continuous haemodiafiltration

The definition for continuous haemodiafiltration is the same as above, except that it is performed continuously, usually in intensive care units. Candidates for this type of treatment have acute renal failure with unstable cardiovascular systems. Specific machines have been adapted for haemofiltration, haemodialysis and haemodiafiltration, they include:

- **CVVH:** Continuous Veno-Venous haemofiltration, provides solute removal by convection, and patient fluid removal if desired.
- **CVVHD:** Continuous Veno-Venous Haemodialysis, provides solute removal by diffusion, and patient fluid removal if desired.
- **CVVHDF:** Continuous Veno-Venous Haemodiafiltration, provides solute removal by diffusion and convection simultaneously, and patient fluid removal if desired as per intermittent haemodiafiltration

13100-05 [1060] *Haemoperfusion*

Haemoperfusion is the continuous circulation of blood outside the body through a material such as charcoal for the removal of toxins from the blood stream. A dialysis machine is used for this procedure. Haemoperfusion is rarely performed.

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Short gestation and low birth weight (P07)

More than one code from category P07 *Disorders related to short gestation and low birth weight, not elsewhere classified* can be assigned for an episode of care. For example: P07.3- *Other preterm infants* can be assigned with P07.1- *Other low birth weight*.

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Peritoneal dialysis ([1061])

Peritoneal dialysis uses the lining of the abdominal cavity, called the peritoneal membrane, to clean waste from the blood. The peritoneal cavity is filled with dialysis solution via a catheter which is surgically placed. Over several hours, the solution draws waste out of the membrane's blood vessels as it is washed around the peritoneal cavity. The fluid is then drained out of the body and replaced with new fluid, starting the process over again. There are two types of peritoneal dialysis:

1. **Continuous Ambulatory Peritoneal Dialysis (CAPD)**

   This type of dialysis is performed continuously by the patient on an outpatient basis. Fluid is run into the abdomen, where it is left for four to eight hours (the dwell period). The drainage bag is clamped, folded and held in the person's clothing during this time. When the dwell period is over, the catheter to the drainage bag is unclamped and the dialysate fluid is drained by gravity. Generally 4 bag changes a day, 7 days a week are required. Continuous cycling peritoneal dialysis (CCPD) is similar to CAPD but takes place at night, using a machine to make several fluid exchanges automatically. The last exchange before the patient rises is allowed to dwell for the day, avoiding the interruption of daily activities for maintenance of the system.

   As this dialysis is continuous, it allows for a freer diet and fluid allowance than other forms of dialysis.

2. **Intermittent Peritoneal Dialysis (IPD)**

   This involves the use of an IPD machine to which the patient is attached for about 12 hours, 3 times a week. The machine runs fluid in and out of the abdomen every 20 minutes. This treatment can be performed overnight whilst the patient is asleep.

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Readmitted for jaundice

ACS 1615 *Specific interventions for the sick neonate* states that the diagnosis of jaundice should only be coded when phototherapy is given for > 12 hours. Clinical coders have asked us what to do in the event that a patient is readmitted after the birth episode with a diagnosis of jaundice. This is a good example of where the clinical coder needs to use the 'coders creed' and use some common sense: if the clinician has diagnosed jaundice of the neonate as the principal diagnosis then the clinical coder should assign the appropriate code because if the standard is followed then no diagnosis code can be assigned! Standard 1615 deals only with the more common occurrence of jaundice occurring during the birth episode. The standard is designed to ensure that only the significant cases of jaundice (ie those treated with phototherapy) are captured in morbidity collections.

In the rare case that an infant is readmitted for jaundice and no phototherapy is given, jaundice should be coded as the principal diagnosis. When the infants age is < 29 days, see Volume 2 Index *'Jaundice, fetus or newborn'*. When the infants age is >28 days, see the main term *'Jaundice'* in the Index.

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