IHACPA

National Coding Advice

Coding Rules and FAQs for ICD-10-AM/ACHI/ACS Twelfth Edition

Current at 1 October 2024

National Coding Advice – Coding Rules and FAQs for ICD-10-AM/ACHI/ACS Twelfth Edition

Contents

How to use this document

The ICD-10-AM/ACHI/ACS classification system is used for classifying admitted patient care and comprises the following:

- International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM)
- Australian Classification of Health Interventions (ACHI)
- Australian Coding Standards (ACS).

The National Coding Advice document contains Coding Rules and responses to frequently asked questions (FAQs) (principally from new edition education) that are published to facilitate nationally consistent assignment of ICD-10-AM and ACHI codes in the implemented edition of ICD-10-AM/ACHI/ACS.

Structure of the National Coding Advice document

This document contains all current National Coding Advice relevant for ICD-10-AM/ACHI/ACS Twelfth Edition and is structured in the following sections:

- **Coding Rules for provisional assignment**. This section contains Coding Rules that provide guidelines on the assignment of:
    - ICD-10-AM codes in the ranges U00–U49 *Provisional assignment of new diseases of uncertain aetiology or emergency use* and U75–U77 *Provisional assignment of diseases of national significance*
    - ACHI codes in blocks **[8888]** *Provisional assignment of new or emerging health technologies* and **[8889]** *Provisional assignment of emergency use interventions*
- **Coding Rules and FAQs**. This section contains Coding Rules and FAQs in descending date order of publication.

Coding Rules for provisional assignment

Published 16 September 2024

Ref No: Q3913 | Published On: 16-Sep-2024 | Status: Current

Bone grafting with biomimetic haematoma (placeholder code activation)

Q:

What codes are assigned for implantation of a biomimetic haematoma with synthetic and autologous bone grafts?

A:

After a fracture, bone repair begins with the formation of a haematoma to initiate bone healing. In larger bone defects, the haematoma structure may be compromised and spontaneous bone union will not occur (Glatt & Tetsworth 2023).

Biomimetic haematomas mimic structural and biological properties of naturally occurring fracture haematomas. A biomimetic hematoma is prepared in the operating theatre using autologous blood, calcium and thrombin. It may be further engineered with synthetic bone grafting material (such as recombinant bone morphogenetic protein-2 (rhBMP-2)) or implanted with an autologous bone graft. Once implanted at the fracture site, the sequential phases of bone healing are initiated by the slow release of growth factors from the biomimetic haematoma (Glatt & Tetsworth 2023).

This intervention cannot be uniquely classified in ACHI and was approved by the Independent Health and Aged Care Pricing Authority's Classifications Clinical Advisory Group for activation of a placeholder code. This will facilitate data collection for potential classification development in the future.

Biomimetic haematoma

Assign first a code for the bone graft from block **[1417]**, **[1435]**, **[1488]**, **[1513]** or **[1569]**, with

88000-06 **[8888]** *Provisional use of 88000-06 [Biomimetic haematoma]*

Follow the ACHI Alphabetic Index at lead term 'Graft' and assign the site code, with internal fixation if required.

Also assign 92060-00 **[1893]** *Administration of autologous blood* when the intervention includes mixing the biomimetic haematoma implant with autologous blood.

References:

Glatt, V. & Tetsworth, K. 2023, 'Biomimetic Hematoma as a Novel Delivery Vehicle for rhBMP-2 to Potentiate the Healing of Nonunions and Bone Defects', *Journal of Orthopaedic Trauma*, vol. 37, no.11S, pp: S33-S39.

Ref No: Q3935 | Published On: 16-Sep-2024 | Status: Current

Transcatheter caval valve implantation (placeholder code activation)

Q:

What code is assigned for the implantation of bioprosthetic valves in the vena cava to treat tricuspid valve regurgitation?

A:

Caval valve implantation is a transcatheter approach to treat severe symptomatic tricuspid regurgitation in patients with right-sided cardiac failure, who are unsuitable for other surgical interventions (Badwan et al. 2023).

The procedure involves implanting one or two bioprosthetic valves contained within an expandable stent, in the inferior and/or superior vena cava. Whilst the intervention aims to treat tricuspid regurgitation, the intervention is not performed on the tricuspid valve.

Where two valves are implanted in the vena cava, for treatment of tricuspid regurgitation, the procedure is known as bicaval valve implantation.

This intervention cannot be uniquely classified in ACHI and was approved by the Independent Health and Aged Care Pricing Authority's Classifications Clinical Advisory Group for activation of a placeholder code. This will facilitate data collection for potential classification development in the future.

Transcatheter caval valve (including bicaval valve) implantation

Assign first:

38456-17 **[635]** *Other intrathoracic procedures on tricuspid valve without cardiopulmonary bypass*

with

88000-05 **[8888]** *Provisional use of 88000-05 [8888] [Transcatheter caval valve implantation]*

Follow the ACHI Alphabetic Index:

Procedure

- tricuspid valve (intrathoracic) (without cardiopulmonary bypass) NEC 38456-17 **[635]**

References:

Badwan, O.Z., Skoza, W., Mirzai, S., Bansal, A., Braghieri, L., Karmali, R.H., Nero, N, Harb, S.C., Puri, R. & Kapadia, S. 2023, 'Clinical Outcomes After Caval Valve Implantation for Severe Symptomatic Tricuspid Regurgitation: A Meta-Analysis, *The American Journal of Cardiology*, vol. 205 pp. 84-86.

Published 15 March 2024

Ref No: Q3893 | Published On: 15-Mar-2024 | Status: Current

Transcatheter tricuspid valve repair (placeholder code activation)

Q:

What code is assigned for transcatheter tricuspid valve repair?

A:

Transcatheter tricuspid valve repair (TTVR/TTR) is a minimally invasive intervention to repair a malfunctioning tricuspid valve using a device (for example Mitraclip®). The device is inserted through a catheter and positioned by grasping one or more leaflets of tricuspid valve via a transjugular or transfemoral approach. The device required to repair the leaflets is determined by the valve's anatomy and the mechanism of the tricuspid regurgitation (Barker & Goel 2023).

This intervention cannot be uniquely classified in ACHI and was approved by the Independent Health and Aged Care Pricing Authority's Classifications Clinical Advisory Group for activation of a placeholder code. This will facilitate data collection for potential classification development in the future.

Transcatheter tricuspid valve repair

Assign first:

38480-02 **[632]** *Repair of tricuspid valve, 1 leaflet* **or**

38481-02 **[632]** *Repair of tricuspid valve, 2 or more leaflets* **with**

88000-04 **[8888]** *Provisional use of 88000-04 [8888] [Transcatheter tricuspid valve repair]*

Follow the ACHI Alphabetic Index:

Valvuloplasty

- heart (without valve replacement)

…

- - tricuspid valve (open)

…

- - - leaflet (1) 38480-02 **[632]**

- - - - 2 or more leaflets 38481-02 **[632]**

References

Barker, C.M. & Goel, K. 2023, 'Transcatheter tricuspid interventions: Past, present, and future', *Methodist DeBakey Cardiovascular Journal*, vol. 19, no 3, pp. 57–66.

Published 15 September 2023

Ref No: Q3780 | Published On: 15-Sep-2023 | Status: Current

Percutaneous left ventricular assist device - Impella® device (placeholder code activation)

Q:

What code is assigned for insertion of an Impella® device?

A:

The Impella® device is an intravascular microaxial blood pump also described as a percutaneous left ventricular assist device that is inserted via the femoral artery (Yastrebov et al 2020).

A ventricular assist device (VAD) mechanically pumps blood from the lower chambers (ventricles) of the heart to the rest of the body (Mayo Clinic 2022). VADs are implanted for various reasons, including treating acute myocardial infarction complicated by cardiogenic shock, enabling angioplasty in high risk coronary disease, and treatment of cardiomyopathy and postcardiotomy syndrome (Glazier & Kaki 2019).

The Impella® device can be used during a high risk percutaneous coronary intervention (PCI). It can be inserted and then removed at the end of a procedure or can be left in-situ as a short term solution to aid recovery or whilst awaiting open heart surgery or a heart transplant.

Those left in-situ, will normally be removed anywhere up to eight days later in the Intensive Care unit.

This intervention cannot be uniquely classified in ACHI and was approved by the Independent Health and Aged Care Pricing Authority's Classifications Clinical Advisory Group for activation of a placeholder code. This will facilitate data collection for potential classification development in the future.

Insertion of percutaneous left ventricular assist device (Impella® device)

Assign first 38615-00 **[608]** *Insertion of left ventricular assist device* with:

88000-01 **[8888]** *Provisional use of 88000-01 [8888] [Insertion of percutaneous ventricular assist device]*

Follow the ACHI Alphabetic Index:

Insertion

- ventricular assist device
- - left 38615-00 **[608]**

Where the Impella® device is used for circulatory support in conjunction with a percutaneous coronary intervention (PCI) or other intervention, assign first a code for the PCI or other intervention.

References:

Glazier, J.J. & Kaki, A. 2019, 'The impella device: historical background, clinical applications and future directions', International Journal of Angiology, vol. 28, no.2, pp. 118-123.

Mayo Clinic, 2022, Ventricular assist device (VAD), viewed 20 August 2023, https://www.mayoclinic.org/tests-procedures/ventricular-assist-device/about/pac-20384529

Yastrebov K., Brunel L., Paterson H.S., Williams Z.A., Wise I.K., Burrows C.S., & Bannon P.G. 2020, 'Implantation of Impella CP left ventricular assist device under the guidance of three-dimensional intracardiac echocardiography', viewed 25 August 2023, https://pubmed.ncbi.nlm.nih.gov/33060679/.

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Uterine transplantation and allogeneic procurement (placeholder code activation)

Q:

What is the correct code to assign for a uterus transplantation? What is the correct code to assign for allogeneic procurement of a uterus?

A:

Uterine transplantation is still at the experimental stage in Australia with various challenges and standardisation of technology still to be resolved.

The intervention is performed for patients with absolute uterine factor infertility resulting from an absent or underdeveloped uterus, a surgically removed uterus or uterine injuries as a result of childbirth complications (Kisu 2021).

Uterus transplantation is experimental and cannot be uniquely classified in ACHI and so a placeholder code has been activated to classify this procedure. It has not been activated under the *New Health Technology Policy*.

Transplantation of uterus

Assign first 90436-00 **[1273]** *Other procedures on uterus* for uterine transplant, with:

88000-02 **[8888]** *Provisional use of 88000-02 [8888] [Transplantation of uterus]*

Follow the ACHI Alphabetic Index:

Procedure

- uterus NEC 90436-00 **[1273]**

In accordance with ACS 0030 *Organ, tissue and cell procurement and transplantation/Allogeneic donation/Classification/3. Patients receiving the transplanted organ(s)/tissue/cells*, do not assign a code for the removal of the dysfunctional uterus if performed.

Allogeneic procurement of uterus

Assign a code from block **[1268]** *Abdominal hysterectomy* or **[1269]** *Vaginal hysterectomy* as appropriate for the procurement of a uterus.

Follow the ACHI Alphabetic Index at the lead term *Hysterectomy*.

References:

Kisu, I. 2021, 'Uterus transplantation: Challenges and the dawn of a new organ transplantation', *Transplantology*, vol.2, pp. 208-209.

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Personalised external aortic root support (placeholder code activation)

Q:

What code is assigned for personalised external aortic root support (PEARS)?

A:

Personalised external aortic root support (PEARS) is an alternative to aortic root replacement procedure. It is performed to control dilation in the aortic root by placing a 'personalised' mesh graft around the aorta without the need for incision into the blood vessel. Since the vessel and the valve remain intact, the surgery is more straightforward and there is no need for the patient to take anticoagulant drugs (eXstent Limited, n.d). PEARS is performed off pump for aortic dilation/aneurysm in patients with Marfan Syndrome as well as part of a Ross procedure or arterial switch operation.

PEARS cannot be uniquely classified in ACHI and was approved by the Independent Health and Aged Care Pricing Authority's Classifications Clinical Advisory Group for activation of a placeholder code. This will facilitate data collection for potential classification development in the future.

Assign first 38456-19 **[681]** *Other intrathoracic procedures on arteries of the heart without cardiopulmonary bypass* when PEARS is performed, with:

88000-03 **[8888]** *Provisional use of 88000-03 [8888] [Personalised external aortic root support]*

Follow the ACHI Alphabetic Index:

Procedure

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

References:

eXstent Limited. n.d. *ExoVasc® personalised external aortic root support*, viewed 24 August 2023, https://exstent.com/.

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Transapical transcatheter mitral valve replacement (placeholder code activation)

Q:

What code is assigned for transapical transcatheter mitral valve replacement?

A:

Transapical transcatheter mitral valve replacement (TMVR) involves a left lateral mini-thoracotomy and transapical delivery of a mitral valve bioprosthesis (across the apex of the heart), via a catheter.

This intervention cannot be uniquely classified in ACHI and was approved by IHACPA's Classifications Clinical Advisory Group for activation of a placeholder code. This will facilitate data collection for potential classification development in the future.

Assign first 38488-09 **[628]** *Percutaneous replacement of mitral valve with bioprosthesis* when transapical TMVR is performed, with:

88000-00 **[8888]** *Provisional use of 88000-00 [8888] [Transapical transcatheter mitral valve replacement]*

Follow the ACHI Alphabetic Index:

Replacement
…
- valve
…
- - heart
…
- - - mitral
- - - - with
- - - - - bioprosthesis 38488-03 **[628]**
- - - - - - percutaneous 38488-09 **[628]**

Frequently Asked Questions (FAQs)

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Twelfth Edition FAQ: Abortion complicated by sepsis

Q:

What code is assigned when sepsis without further specification, is documented as complicating an abortion?

A:

Codes in categories O03–O07 with fourth characters .0 and .5, and O08.0 *Genital tract and pelvic infection and sepsis following abortion and ectopic and molar pregnancy,* classify complications of abortion and have been expanded for Twelfth Edition to include the concept of sepsis. These codes classify multiple concepts (that is, infection **and** sepsis), therefore an additional code is assigned to specify whether the abortion is complicated by an infection or sepsis.

Where sepsis is documented as complicating an abortion but the type of sepsis has not been specified, assign A41.9 *Sepsis, unspecified* in addition to the code from categories O03–O07 or O08.0 in accordance with the *Instructional* note:

> *Use additional code (Chapter 1) to identify sepsis — see Alphabetic Index: Sepsis/by type*

Follow the ICD-10-AM Alphabetic Index:

Sepsis (cryptogenic) (gangrenous) NEC A41.9.

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Twelfth Edition FAQ: Antimicrobial drug resistance

Q:

Does 'resistance' need to be documented by the clinician in the episode of care to assign a code for resistance to antimicrobial drugs?

A:

ACS 0112 *Infection with drug resistant microorganisms* states:

> *Assign codes from block Z14–Z16* Resistance to antimicrobial drugs *where antibiotic or other antimicrobial resistance is documented*

Codes from block Z14–Z16 are assigned in addition to an infection code, to identify drug resistance. Drug ‘resistance’ must be documented by the clinician in the health care record.

Where a clinician transcribes information (copied by hand or transferred electronically) from a pathology result into the progress notes, the entry is part of the clinician’s documentation within the body of the current episode of care.

ACS 0010 *Clinical documentation and general abstraction guidelines* states:

> *…all information from test results and medication charts should be qualified with clinical documentation within the current episode of care.*

Use the pathology results to identify the specific drug(s), but do not assign Z14–Z16 based on pathology results alone.

Do not assign codes from block Z14–Z16 based on documentation of drug susceptibility, to imply or inform the classification of drug resistance.

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Twelfth Edition FAQ: Carrier of extended spectrum beta-lactamase (ESBL) producing organism

Q:

What code is assigned for carrier of a specified ESBL producing organism (eg confirmed by pathology) without specification of drug resistance?

A:

ACS 0112 *Infection with drug resistant microorganisms/Classification/Carrier status or colonisation without infection* states:

> *Where documentation indicates the presence of a drug resistant microorganism, but the patient does not have an infection caused by that organism, assign:*
>
> - *a code from category Z22* Carrier of infectious disease *in accordance with ACS 0001 or ACS 0002*
> - *one or more codes from block Z14–Z16 to identify resistance to antimicrobial drugs.*

U93 *Extended spectrum beta-lactamase [ESBL] producing organism* alone does not identify drug resistance. U93 is assigned in addition to a code to identify antimicrobial drug resistance from categories Z14–Z15. Follow the *Instructional* note at U93:

> *Code first resistance to antimicrobial drug (Z14–Z15).*

Do not assign U93 without first assigning a code from categories Z14–Z15.

Where resistance to an antimicrobial drug is not documented, and carrier of ESBL is specified, assign Z22.3 *Carrier of other specified bacterial diseases* to identify that the patient is a carrier of an infectious organism. The guidelines for ACS 0112 **do not apply**.

Where resistance to an antimicrobial drug is documented, and carrier of ESBL is specified, apply the guidelines in ACS 0112 and assign:

Z22.3 *Carrier of other specified bacterial diseases*
One or more codes from block Z14–Z16 to identify resistance to antimicrobial drugs
U93 *Extended spectrum beta-lactamase [ESBL] producing organism*.

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Twelfth Edition FAQ: Intersection of general and specialty standards

Q:

What process is followed when a general and specialty standard intersect when assigning codes for an episode of care?

A:

The *ACS Introduction/Basic structure and principles of the ACS/General and specialty standards* states:

> *The first two chapters of the ACS, General standards for diseases and General standards for interventions, contain general descriptions and guidelines that apply to code assignment across all episodes of care.*
>
> …
>
> *The sections on general standards are followed by chapters for specialty standards…*
> *The specialty standards may provide guidance on specific diagnoses, interventions or other related variables*
>
> …
>
> *Note that ACS are not mutually exclusive, and multiple standards may apply to an episode of care. Apply first the general standards for diseases and interventions (such as ACS 0001* Principal diagnosis*, ACS 0002* Additional diagnoses*, ACS 0010* Clinical documentation and general abstraction guidelines*), then apply the guidelines in the specialty standards that may take precedence over the general standards. There may also be a cross reference (ie see ACS) within an ACS to indicate that there may be applicable guidelines in another ACS.*

Example 1:

Question: ACS 0236 *Neoplasm coding and sequencing* states that the neoplasm must meet the criteria in ACS 0002 *Additional diagnoses*, however ACS 0002/*Other guidelines related to additional diagnosis criteria/Problems and underlying conditions* would appear to support the coding of the neoplasm. Does the specialty standard ACS 0236 take precedence over ACS 0002?

Answer: ACS 0236 *Neoplasm coding and sequencing* states:

> *If the episode of care is for treatment of a condition other than neoplasm (eg neoplasm related or neoplasm treatment related conditions), assign a code for the neoplasm(s) in accordance with ACS 0002* Additional diagnoses*…*

Where the episode of care is for treatment of a condition other than neoplasm, ACS 0236 instructs that a code for the neoplasm is assigned where it meets the additional diagnosis criteria in ACS 0002 (eg *Commencement of treatment, diagnostic interventions, increased clinical care, problems and underlying conditions*).

Example 2:

Question: ACS 0236 *Neoplasm coding and sequencing* indicates that codes for secondary sites are only assigned if the site is documented. Does this specialty standard override ACS 0010 *Clinical documentation and general abstraction guidelines*?

Answer: ACS 0236 *Neoplasm coding and sequencing* states:

> *Assign code(s) for secondary (metastatic) sites that are documented by the clinician in the current episode of care, see also ACS 0010* Clinical documentation and general abstraction guidelines.

ACS 0236 instructs that in an episode of care, codes for secondary sites are only assigned if the secondary site is documented. However, a cross reference to ACS 0010 is provided so the episode of care also needs to be considered in light of the abstraction guidelines including (but not limited to):

- for classification purposes, the primary sources of information are located within the current episode of care
- it may be necessary to access sources of information outside of the current episode of care to clarify ambiguous documentation within the current episode of care. For example, where a documentation indicates metastatic neoplasm without specification of the secondary (metastatic) site(s), apply the guidelines in ACS 0010/*Abstraction from other sources of information* to determine the site(s) of the metastases.
- the guideline relating to multiple same-day episodes for repeated treatments, occasioned by a single referral. For example, where there is a series of same-day episodes for repeated treatments (eg pharmacotherapy for a neoplasm) that has been occasioned by a single referral requesting admission, the referral information may be used as part of the source documentation for all the related repeated treatment episodes of care.

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Twelfth Edition FAQ: Peritoneal dialysis peritonitis

Q:

What codes are assigned for peritoneal dialysis peritonitis?

A:

Codes in category K65 *Peritonitis* have been expanded for Twelfth Edition to include the concepts of primary and secondary peritonitis. Secondary peritonitis is peritonitis due to another condition or external cause and includes peritoneal dialysis peritonitis.

ACS 1904 *Procedural complications* for Twelfth Edition states:

> *Assign an additional diagnosis code from Chapters 1 to 18 where it provides further specificity regarding the condition/complication.* ***Do not*** *assign an additional code from Chapters 1 to 18 to provide specificity for the anatomical site alone.*

For peritoneal dialysis peritonitis, this means an additional code is assigned to specify the type of peritonitis.

Therefore, for peritoneal dialysis peritonitis assign T85.71 *Infection and inflammatory reaction due to peritoneal dialysis catheter* and K65.29 *Secondary peritonitis, not elsewhere classified.*

Follow the ICD-10-AM Alphabetic Index:

Complication

- dialysis

- - catheter

- - - peritoneal

- - - - infection or inflammation T85.71

Peritonitis

- due to

- - peritoneal dialysis K65.29

See the *Instructional* note at code T85.71:

> *Use additional code (K65.29) to identify secondary peritonitis.*

Also assign external cause and place of occurrence codes.

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Twelfth Edition FAQ: Personal history of coronavirus disease 2019

Q:

Is a code for personal history of coronavirus disease 2019 (COVID-19) assigned when it is documented on a Risk/Infection Disease Screening tool?

A:

ACS 0010 *Clinical documentation and general abstraction guidelines/Test results and medication charts* states:

> *Do not use test result values, descriptions, health risk screening (assessment) tools, medication charts, symbols and abbreviations from clinical documentation in isolation to assign diagnosis codes. For example:*
>
> *…*
>
> - *documented components of the health risk (assessment) tools (eg Malnutrition Universal Screening Tool) are not considered diagnoses for classification purposes.*

Where personal history of COVID-19 is confirmed by documentation from the treating clinician within the episode of care, such as part of a patient history, assign U07.3 *Personal history of coronavirus disease 2019 [COVID-19]*.

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Twelfth Edition FAQ: Referrals requesting admission

Q:

When is a referral requesting admission considered a primary source of information within the current episode of care?

A:

Abstraction must first focus on, and prioritise, the primary sources of information from **within** the episode of care.

ACS 0010 *Clinical documentation and general abstraction guidelines* states:

> ***ABSTRACTION IN THE CURRENT EPISODE OF CARE***
>
> *For* classification *purposes,* ***the primary sources of information are located within the current episode of care.***
>
> …
>
> *Facilities and jurisdictions have a wide range of health information systems and documentation practices, both electronic and paper based. To identify and understand how documents relate to the current episode of care, clinical coders must be familiar and competent with their organisation's health information systems.*

Information (including referral letters) **outside** of the current episode may inform code assignment in accordance with ACS 0010 *Clinical documentation and general abstraction guidelines/ Abstraction from other sources of information* to determine reason for admission or where conditions documented in the current episode require further clarification or specificity.

However, referrals requesting an admission are considered a primary source of information for the current episode of care **when** they:

- occasion the current episode of care, **and**
- contain the most current admission information available for the episode of care.

Also note the specific guideline for multiple same-day episodes for repeated treatments, occasioned by a single referral in ACS 0010 *Clinical documentation and general abstraction guidelines/Abstraction from other sources of information* which states:

> **ABSTRACTION FROM OTHER SOURCES OF INFORMATION**
>
> …
>
> • *Multiple same-day episodes for repeated treatments, occasioned by a single referral. In this circumstance, the original referral information may be used as source documentation for all the related episodes of care, such as same-day episodes for provision of pharmacotherapy, electroconvulsive therapy and immunoglobulin therapy.*

Example 1:

A patient has been referred for a same-day admission, occasioned by a single referral.

A patient is referred by a GP (general practitioner) for a same-day colonoscopy and the GP referral for admission contains information about chronic conditions (eg COPD, CKD Stage 3) and diabetes mellitus. Where the GP referral has occasioned the episode of care and is the most current admission information available, it is a primary source of information within the health care record.

Example 2:

A patient has been referred for a series of same-day episodes for repeated treatments, occasioned by a single referral.

Where there is a series of same-day episodes for repeated treatments (eg pharmacotherapy for a neoplasm) that has been occasioned by a single referral for admission, the referral information may be used as part of the source documentation for all the related episodes of care.

However, where updated information becomes available in subsequent episodes of repeated treatment, the current episode of care documentation is used for abstraction purposes, such as a new diagnosis of metastatic sites after the date of the original referral.

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Twelfth Edition FAQ: Secondary (metastatic) sites

Q:

What documentation can be used if the episode of care states a 'metastatic' neoplasm without specifying the site(s) of the secondary (metastatic) neoplasm(s)?

A:

ACS 0236 *Neoplasm coding and sequencing* states:

> *Assign code(s) for secondary (metastatic) sites that are documented by the clinician in the current episode of care, see also ACS 0010* Clinical documentation and general abstraction guidelines.

ACS 0010 *Clinical documentation and general abstraction guidelines/Abstraction from other sources of information* states:

> *In addition to the above circumstances, it may also be necessary for clinical coders to access sources of information outside the current episode of care to inform code assignment by:*
>
> *…*
>
> • *gaining specificity on diagnoses documented within the current episode of care*
>
> *…*

Where a (primary) metastatic neoplasm is documented without specification of the secondary (metastatic) site(s), apply the guidelines in ACS 0010 *Abstraction from other sources of information* to determine the site(s) of the metastases from outside the episode of care. Where determination is not possible, assign C79.9 *Secondary malignant neoplasm, unspecified site*.

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Twelfth Edition FAQ: Sepsis without a positive blood culture

Q:

Is a positive blood culture required to assign a specific type of sepsis code?

A:

ACS 0110 *Sepsis and septic shock* does not specify that positive blood cultures are required to assign a sepsis code.

If the type of sepsis is not documented, but the underlying infection/source of sepsis has an agent specified, then the causal relationship applies to both the sepsis and the underlying source of infection.

For example, sepsis due to pneumonia due to *Streptococcus pneumoniae,* apply the guidelines in ACS 0110 *Sepsis and septic shock* and assign:

A40.3 *Sepsis due to Streptococcus pneumoniae*

J13 *Pneumonia due to Streptococcus pneumoniae*

If the type of sepsis is not documented, and the underlying infection/source of sepsis is not specified, then a causal relationship does not apply to the sepsis.

For example: sepsis with pneumonia due to *Streptococcus pneumoniae,* apply the guidelines in ACS 0110 to assign A41.9 *Sepsis, unspecified.*

Also apply the guidelines in ACS 0002 *Additional diagnoses* and assign J13 *Pneumonia due to Streptococcus pneumoniae*.

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Twelfth Edition FAQ: Symptomatic versus asymptomatic coronavirus disease 2019

Q:

How are codes for symptomatic and asymptomatic coronavirus disease 2019 (COVID-19) distinguished?

A:

COVID-19 may be present with no clinical indications (asymptomatic) or there may be a variety of clinical indications (symptomatic) ranging from mild symptoms to more serious manifestations.

Where COVID-19 has been confirmed by laboratory testing, assign a code from category U07.1 *Coronavirus disease 2019 [COVID-19], virus identified* as follows:

- U07.11 *Coronavirus disease 2019 [COVID-19], virus identified, asymptomatic* where there are no symptoms or manifestations, or where there are symptoms/manifestations that have not been linked to COVID-19 in the clinical documentation.
- U07.12 *Coronavirus disease 2019 [COVID-19], virus identified, symptomatic* where either symptoms (eg fever, cough, lethargy) or manifestations (eg URTI, pneumonia) are present either before or during the episode of care and have been clinically linked to COVID-19.

Assign a diagnosis code for a manifestation of COVID-19 from chapters other than Chapter 18 when it meets the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*.

Do not assign additional diagnosis codes for symptoms classified to Chapter 18 *Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified* (R00–R99).

The principal diagnosis should be determined according to ACS 0001 *Principal diagnosis*.

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Ref No: TN1601 | Published On: 15-Sep-2022 | Status: Current

Twelfth Edition FAQ: Testing for severe acute respiratory syndrome coronavirus 2

Q:

Is a code for testing for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) assigned from laboratory test results alone?

A:

ACS 0113 *Coronavirus disease 2019 (COVID-19)/COVID-19 table/96273-00* ***[1866]*** *Testing for severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2]* states:

- *Assign 96273-00* ***[1866]*** *where laboratory testing (eg polymerase chain reaction (PCR), serology) has been performed during an episode of care to identify a SARS-CoV-2 infection.*

ACS 0010 *Clinical documentation and general abstraction guidelines/Test results and medication charts* states:

- *… all information from test results and medication charts should be qualified with clinical documentation within the current episode of care.*

Therefore, do not assign 96273-00 **[1866]** *Testing for severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2]* based on the presence of a test result alone; testing for COVID-19 must be specified in the clinical documentation within the current episode of care irrespective of the reason for the test.

Published 15 September 2022,
for implementation 01 October 2022.

Ref No: TN1601 | Published On: 15-Sep-2022 | Status: Current

Twelfth Edition FAQ: Vaccination against coronavirus disease 2019

Q:

Can a code from block **[1882]** *Prophylactic vaccination or inoculation against certain viral diseases* be assigned more than once if multiple vaccinations against coronavirus disease 2019 (COVID-19) are administered in an episode of care?

A:

Where a vaccine against COVID-19 is administered more than once in an episode of care, assign the vaccination as many times as performed.

Follow the ACHI Alphabetic Index:

Vaccination (against) (prophylactic)

…

- coronavirus disease 2019 (COVID-19) 92157 **[1882]**

Assign a code for the type of vaccine administered in accordance with the documentation in the health care record. Coders should be guided by the clinical documentation to assign the appropriate code from the ACHI Tabular List.

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Ref No: TN1601 | Published On: 15-Sep-2022 | Status: Current

Twelfth Edition FAQ: Z25.2 *Need for immunisation against coronavirus disease 2019 [COVID-19]* in an obstetric episode of care

Q:

Is it necessary to assign Z25.2 *Need for immunisation against coronavirus disease 2019 [COVID-19]* in an obstetric episode of care?

A:

It was not intended that Z25.2 *Need for immunisation against coronavirus disease 2019 [COVID-19]* be assigned in admitted episodes of care as assignment of the intervention code is sufficient to classify this concept.

However, ACS 1500 *Diagnosis sequencing in delivery episodes of care/Other additional diagnoses in obstetric episodes of care* states:

> *Assign the following codes when documented (as applicable to the episode of care):*
>
> *…*
>
> - *Prophylactic vaccination/need for immunisation – see ICD-10-AM Alphabetic Index:* Vaccination/prophylactic *and ACHI Alphabetic Index:* Vaccination

Therefore, where documentation indicates that a patient is immunised against coronavirus disease 2019 in an antenatal or delivery episode of care, assign Z25.2 *Need for immunisation against coronavirus disease 2019 [COVID-19]* as an additional diagnosis code.

Follow the ICD-10-AM Alphabetic Index:

Vaccination

- prophylactic (against)

- - coronavirus disease 2019 (COVID-19) Z25.2

Published 15 September 2022,
for implementation 01 October 2022.

Coding Rules

Published 16 September 2024

Ref No: Q3792 | Published On: 16-Sep-2024 | Status: Current

Haemorrhoids with multiple degrees

Q:

What code(s) should be assigned for multiple degrees of haemorrhoids?

A:

While there is nothing that explicitly precludes the assignment of multiple codes to reflect different stages of haemorrhoids in ICD-10-AM, assign one code for the most severe haemorrhoid grade, even if different procedures are performed for different grades of haemorrhoids.

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

Ref No: Q3779 | Published On: 16-Sep-2024 | Status: Current

Intrapleural lysis

Q:

What code is assigned for intrapleural lysis?

A:

Intrapleural lysis (intrapleural fibrinolysis or fibrinolytic therapy) is the instillation of fibrinolytic agents (eg tissue type plasminogen activator, thrombolytic agent and deoxyribonuclease (an enzyme that breaks down DNA)) via an intercostal catheter connected to an underwater seal drainage. It is performed to dissolve fibrin bands or loculations and improve pleural fluid drainage in complex pleural effusions or empyema. The drain is clamped after instillation and then released to allow drainage of fibrin bands. The intervention may be repeated for up to three consecutive days (Jones 2020; Kwan 2024).

Assign 38456-35 **[558]** *Other closed procedures on lung or pleura* for intrapleural lysis.

Follow ACHI Alphabetic Index:

Procedure

- pleura

- - closed (percutaneous) 38456-35 **[558]**

Do not assign codes for intercostal catheterisation/drainage and instillation of the fibrinolytic agents, as these are components of intrapleural lysis (as per ACS 0016 *General procedure guidelines/Procedure components*).

Amendments will be considered for a future edition.

References:

Jones, C. 2020, *Adult protocol for intrapleural (IP) alteplase and dornase alfa for the treatment of empyema*, Luton& Dunstable University Hospital, August 2020, viewed 6 March 2024, www.bedsformulary.nhs.uk/docs/IP%20Alteplase%20DNase%20protocol%20Final%202.pdf.

Kwan, B. 2024, *Intra-Pleural Fibrinolysis - Medical Management of Empyema*, South Eastern Sydney Local Health District Procedure, April 2024, viewed 29 July 2024, www.seslhd.health.nsw.gov.au/sites/default/files/documents/SESLHDPR%20631%20-%20Intra-Pleural%20Fibrinolysis%20-%20Medical%20Management%20of%20Empyema_0.pdf#:~:text=Intra-pleural%20fibrinolysis%20is%20aimed%20at%20dissolving%20the%20fibrin,aid%20the%20drainage%20of%20the%20effusion%20%2F%20collection.

Ref No: Q3905 | Published On: 16-Sep-2024 | Status: Current

Repair of slipped ribs

Q:

What code is assigned for the repair of slipped ribs with an internal fixation device?

A:

Slipping rib syndrome (SRS) occurs when the costal cartilage securing ribs 8, 9 and/or 10 breaks and allows the rib(s) to partially dislocate and move abnormally. Until recently, the only surgical treatment for slipped ribs was resection of the displaced ribs (Madeka et al. 2023).

Surgical techniques to treat SRS are continually evolving and less invasive techniques to stabilise the movement of the slipping rib(s) with an internal fixation device (such as sutures or plates) are now being explored. The slipped ribs are moved back into their natural position and reconnected to the other ribs and the costal arch. One technique, known as the Hansen technique, uses sutures to fix the rib (Madeka et al. 2023; Hansen et al. 2020).

Assign 47921-00 **[1554]** *Insertion of internal fixation device, not elsewhere classified* for repair of slipped rib where internal fixation is used to stabilise movement (for example the Hansen technique).

Follow the ACHI Alphabetic Index:

Fixation

- bone

- - internal

- - - specified site NEC 47921-00 **[1554]**

Amendments will be considered for a future edition.

References:

Hansen, A. J., Toker, A., Hayanga,J., Buenaventura, P., Spear, C. & Abbas, G. 2020, 'Minimally Invasive Repair of Adult Slipped Rib Syndrome Without Costal Cartilage Excision', *The Annals of Thoracic Surgery*, vol. 110, no. 3, pp. 1030-1035.

Madeka, I., Alaparthi, S., Moreta, M., Peterson, S., Mojica, J. J., Roedl, J. & Okusanya, O. 2023, 'A Review of Slipping Rib Syndrome: Diagnostic and Treatment pdates to a Rare and Challenging Problem', *Journal of clinical medicine*, vol. 12(24), 7671, viewed 8 August 2024, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10743651.

Ref No: Q3934 | Published On: 16-Sep-2024 | Status: Current

Sleeve procedures for obesity

Q:

What codes are assigned for single-anastomosis duodeno-ileal bypass with sleeve gastrectomy (SADI-S) and single anastomosis stomach–ileal bypass with sleeve gastrectomy (SASI-S)?

A:

Single anastomosis duodeno-ileal bypass with sleeve gastrectomy (SADI-S) is based on the principles of biliopancreatic diversion-duodenal switch (BPD-DS). The procedure involves a sleeve gastrectomy followed by a single end-to-side duodeno-ileal bypass. A loop of small intestine situated at 200–300 cm from the ileocecal valve is anastomosed to the duodenum arising from the pylorus to restore the continuity of the gut (Pennestri et al. 2022).

Clinical advice confirms that SADI-S is a simplified modification of BPD-DS, therefore assign 30512-02 **[889]** *Biliopancreatic diversion [BPD]* or 30512-01 **[889]** *Laparoscopic biliopancreatic diversion [LBPD]* when SADI-S is performed.

Follow the ACHI Alphabetic Index:

Biliopancreatic diversion (BPD), for obesity (open) 30512-02 **[889]**

- laparoscopic 30512-01 **[889]**

Single anastomosis stomach–ileal bypass with sleeve gastrectomy (SASI-S) is a procedure that evolved from the Santoro method. The difference being that instead of creating a Roux-en-Y loop, an omega loop connects the gastric sleeve and the ileum. The SASI-S procedure combines the benefits of sleeve gastrectomy and intestinal bypass with a reduced risk of nutritional deficiency (Tarnowski et al. 2022; Mercy Bariatrics 2024).

Clinical advice confirms that SASI-S is a simplified modification of the loop procedure, therefore assign 30512-00 **[889]** *Gastric bypass* or 30512-03 **[889]** *Laparoscopic gastric bypass* when SASI-S is performed.

Follow the ACHI Alphabetic Index:

Bypass

- gastric

- - for obesity (banded) (loop) (mini gastric) (ring) (Roux-en-Y) 30512-00 **[889]**

- - - laparoscopic 30512-03 **[889]**

Also assign 30514-01 **[889]** *Revision procedure for obesity* where an intervention is performed as a revision of previous obesity surgery.

References:

Mercy Bariatrics 2024, *Single Anastomosis Stomach-Ileal Bypass with Sleeve Gastrectomy (SASI-S)*, Perth, viewed 18 July 2024, https://mercybariatrics.com.au/obesity-surgery-2/surgery-options/sasi-s/.

Tarnowski, W., Barski, K., Jaworski, P., Binda, A., Kudlicka, E., Wąsowski, M. & Jankowski, P. 2022, 'Single anastomosis sleeve ileal bypass (SASI): a single-center initial report', *Videosurgery and other Miniinvasive Techniques*, vol.17, no.2, pp.365-371.

Pennestrì, F., Sessa, L., Prioli, F., Salvi, G., Gallucci, P., Ciccoritti, L., Greco, F., De Crea, C. & Raffaelli, M. 2022, 'Single anastomosis duodenal-ileal bypass with sleeve gastrectomy (SADI-S): experience from a high-bariatric volume center', *Langenbeck's Achieves of Surgery*, vol. 407, no. 5, pp.1851-1862.

Ref No: Q3731 | Published On: 16-Sep-2024 | Status: Current

Third stage external ear reconstruction

Q:

What code is assigned in a third stage of a multistage external ear reconstruction?

A:

Staged external ear reconstructions are commonly used for microtia. Microtia is a congenital abnormality of the external ear, ranging from absence or minimal cartilage resembling an ear (The Microtia Clinic n.d.).

In the first stage of an autologous reconstruction, cartilage is removed from the chest wall and then carved into a framework that resembles an ear. The newly formed ear is then inserted under the skin into a pocket where the previous ear cartilage was removed. The surrounding skin is then suctioned to encourage draping over the cartilage framework and the skin closed. The second stage involves elevating the newly created ear into place, usually performed several months following the first stage. Sometimes a third stage is required for minor adjustments, such as removing excess skin or to obtain better symmetry (RCH n.d.).

ACHI only provides codes to classify the first and second stages of an external ear reconstruction, as historically this has been done as a two staged procedure.

In the absence of a specific code to classify the third stage, assign codes for the specific interventions performed (such as debridement or skin graft) for a third stage external ear reconstruction.

Amendments will be considered for a future edition.

References:

Royal Children's Hospital (RCH), *Complex ear problems and microtia*, RCH Melbourne, viewed 2 September 2024, https://www.rch.org.au/plastic/operative-considerations/Complex_ear_problems_and_Microtia/.

The Microtia Clinic 2022, *Ear anatomy*, Sydney, viewed 2 September 2024, http://www.microtia.com.au/ear-reconstruction.html.

Coding Rules

Published 17 June 2024

Ref No: Q3773 | Published On: 17-Jun 2024 | Status: Current

Biodegradable temporising matrix

Q:

What code is assigned for biodegradable temporising matrix?

A:

Biodegradable temporising matrix (BTM) is a biosynthetic skin substitute which consists of a wound-facing biodegradable polymer foam, bonded to a non-biodegradable transparent sealing membrane (Frost et al. 2022).

Assign one of the following codes for application of BTM:

90672-00 **[1640]** *Synthetic skin graft* **or**

90672-01 **[1640]** *Synthetic skin graft to burn*

Follow the ACHI Alphabetic Index:

Graft

- skin
- - synthetic 90672-00 **[1640]**
- - - for burn 90672-01 **[1640]**

Amendments will be considered for a future edition.

References:

Frost, S.R., Deodhar, A. & Offer, G.J. 2022, 'A novel use for the biodegradable temporizing matrix', *European Journal of Plastic Surgery*, vol. 45, no. 6, pp. 1015–20.

Ref No: Q3866 | Published On: 17-Jun-2024 | Status: Current

COF assignment for previously existing condition

Q:

What condition onset flag (COF) is allocated for a previously existing condition that is exacerbated or manifests during the current episode of care?

A:

ACS 0048 *Condition onset flag* states:

> The condition onset flag (COF) is a means of differentiating those conditions which arise during, from those arising before, an admitted patient episode of care…
>
> **COF 2. Condition not noted as arising during the episode of admitted patient care**
>
> **Definition**
>
> A condition previously existing or suspected on admission such as the presenting problem, a comorbidity or chronic disease.
>
> Examples of inclusions:
>
> …
>
> - a previously existing condition that is exacerbated during the current episode of admitted patient care (eg atrial fibrillation, unstable angina)
>
> …

For example:

1. Urinary tract infection (UTI) arising in an episode care where a multi-resistant organism (MRO) is also noted

Antimicrobial resistance (AMR) is a natural process that happens over time through genetic changes in pathogens. Its emergence and spread is accelerated by human activity, mainly the misuse and overuse of antimicrobials to treat, prevent or control infections in humans, animals and plants (World Health Organization 2023).

Assign COF 1 for a UTI arising during the admitted episode of care.

Assign COF 2 for the MRO status, as it is unlikely and impossible to determine if the resistance developed during the episode of care.

2. For an episode of care that notes a background of paroxysmal atrial fibrillation (AF) on admission, that subsequently manifests during the episode of care

Assign COF 2 if a background of paroxysmal AF is noted but is not present on admission, then manifests during the admitted episode of care (that is, AF was not newly arising during the episode of admitted patent care, it was a pre-existing condition).

Reference:

World Health Organization 2023, *Antimicrobial resistance,* WHO, viewed 15 April 2024, https://www.who.int/news-room/fact-sheets/detail/antimicrobial-resistance.

Ref No: Q3749 | Published On: 17-Jun-2024 | Status: Current

Headstrike without injury or concussion

Q:

What code is assigned for headstrike without further specification?

A:

Headstrike implies a direct blow or hit to the head from a fall or other accident, and may or may not result in a head injury. Clinical assessments and imaging tests such as a CT scan may be performed to exclude a head injury.

Assign one of the following codes for headstrike without further specification:

Z04.1 *Examination and observation following transport accident* **or**

Z04.2 *Examination and observation following work accident* **or**

Z04.3 *Examination and observation following other accident.*

Also assign external cause, place of occurrence and activity codes.

Follow the ICD-10-AM Alphabetic Index:

Examination (for) (general) (of) (routine)
- following
- - accident
- - - specified (classifiable to W00–X59) NEC Z04.3
- - - transport (classifiable to V00–V99) Z04.1
- - - work (classifiable to V00–X59) Z04.2
- - motor vehicle accident Z04.1

Amendments will be considered for a future edition.

Ref No: Q3768 | Published On: 17-Jun-2024 | Status: Current

Palmar abscess and drainage

Q:

What codes are assigned for palmar abscess and drainage?

A:

A palm (palmar) abscess can occur in any of the deep palmar compartments (spaces) of the hand. One or more of these spaces can become infected even from a small puncture wound. The deep palmar spaces of the hand include the middle palmar, hypothenar and thenar spaces (Steinberg 2022).

Assign L02.41 *Cutaneous abscess, furuncle and carbuncle of upper limb* for a palm (palmar) abscess.

Follow the ICD-10-AM Alphabetic Index:

Abscess (embolic) (infective) (metastatic) (multiple) (pyogenic) (septic)

- palmar (space) L02.41

Note that 'space' is a nonessential modifier in the ICD-10-AM Alphabetic Index at *Abscess/palmar*.

For drainage of a palmar abscess assign 46519-00 **[1440]** *Incision and drainage of middle palmar, thenar or hypothenar spaces of hand*.

Follow the ACHI Alphabetic Index:

Drainage

- abscess — see also *Drainage/by site*

…

- hand
- - via incision
- - - middle palmar space 46519-00 **[1440]**

References

Steinberg, D. 2022, 'Palm abscess - musculoskeletal and connective tissue disorders', *MSD Manual Professional Edition,* viewed 16 April 2024, https://www.msdmanuals.com/professional/musculoskeletal-and-connective-tissue-disorders/hand-disorders/palm-abscess.

Ref No: Q3785 | Published On: 17-Jun-2024 | Status: Current

Pneumonitis due to vaping

Q:

What codes are assigned for pneumonitis secondary to vaping?

A:

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) (ICD-11 for Mortality and Morbidity Statistics, 2024).

Assign the following codes for pneumonitis due to vaping:

J68.0 *Bronchitis and pneumonitis due to chemicals, gases, fumes and vapours*

U07.0 *Vaping related disorder*

Follow the ICD-10-AM Alphabetic Index:

Pneumonitis

- due to

- - gases, fumes or vapours (inhalation) J68.0

Vaping related disorder U07.0

Sequence codes in accordance with the *Instructional* note at U07.0:

Code first manifestation(s)

Amendments regarding vaping related disorder are proposed for Thirteenth Edition.

References:

Bell. D. 2022, *Vaping-associated lung disease*, Radiopedia, viewed 22 May 2024, https://radiopaedia.org/articles/vaping-associated-lung-disease-2?lang=us.

ICD-11 Foundation 2020, *Vaping related disorder*, viewed 22 May 2024, https://icd.who.int/dev11/f/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f1880731274

Ref No: Q3729 | Published On: 17-Jun-2024 | Status: Current

Staged revision of knee joint replacement

Q:

What codes are assigned for a one or two stage revision of a knee joint replacement?

A:

A knee joint replacement may require a staged revision where the implant is completely removed, and either replaced during the same operative episode after the joint is washed out (one stage intervention), or in a subsequent operative episode (two stage intervention).

In a two stage intervention, the implant is removed, the joint is washed out and a temporary antibiotic cement spacer placed in the knee which will remain for several weeks to treat any infection (stage one). When the infection has cleared, stage two will be performed to remove the antibiotic spacer and insert a new prosthesis (American Academy of Orthopaedic Surgeons 2021).

Assign 49527-00 **[1524]** *Revision of arthroplasty of knee* where revision of knee joint replacement is performed, regardless of whether a one or two stage intervention is performed.

Follow the ACHI Alphabetic Index:

Revision (partial) (total)

- joint replacement (prosthesis) (with removal of prosthesis)

- - knee 49527-00 **[1524]**

Amendments to ACHI may be considered for a future edition.

See also Coding Rule *Revision of prosthetic device*.

References:

American Academy of Orthopaedic Surgeons 2021, *Revision total knee replacement*, May 2021, viewed 16 April 2024, https://orthoinfo.aaos.org/en/treatment/revision-total-knee-replacement

Coding Rules

Published 15 March 2024

Ref No: Q3730 | Published On: 15-Mar-2024 | Status: Current

Closure of a postoperative urethrocutaneous fistula

Q:

What code is assigned for closure of a postoperative urethrocutaneous fistula unrelated to hypospadias?

A:

A urethrocutaneous fistula (opening between the urethra and the skin) may occur either at birth (congenital) or develop later as a result of an infection, injury, or as a complication of surgery (acquired). Surgery is usually required to close the fistula (Cleveland Clinic 2018).

Assign 90364-00 **[1122]** *Other repair of urethra* for closure of a postoperative urethrocutaneous fistula not elsewhere classified (NEC) (eg unrelated to hypospadias repair).

Follow the ACHI Alphabetic Index:

Repair

- urethra NEC 90364-00 **[1122]**

Amendments will be considered for a future edition.

References:

Cleveland Clinic 2018, *Urethrocutaneous fistula,* Cleveland Clinic, viewed 25 January 2024, https://my.clevelandclinic.org/health/diseases/17768-urethrocutaneous-fistula.

Ref No: Q3733 | Published On: 15-Mar-2024 | Status: Current

Gestational diabetes with hypoglycaemia

Q:

What codes are assigned for gestational diabetes mellitus with hypoglycaemia?

A:

Gestational diabetes mellitus (GDM) is defined as any degree of glucose intolerance with onset or first recognition during pregnancy. The definition applies regardless of whether insulin or only diet modification is used for treatment or whether the condition persists after pregnancy (WHO 2023).

ACS 1500 *Diagnosis sequencing in obstetric episodes of care* states:

> *"Assign codes for other conditions/complications (pregnancy, childbirth, puerperal or nonobstetric) from Chapter 15* Pregnancy, childbirth and the puerperium *that meet the criteria for an additional diagnosis in ACS 0002* Additional diagnoses*. Assign a code from another chapter where it adds specificity to the Chapter 15 code, or as per any* Instructional *notes*."

Assign the following for GDM with hypoglycaemia:

O24.4- *Diabetes mellitus arising during pregnancy* **and**

E16.2 *Hypoglycaemia, unspecified*

Follow the ICD-10-AM Alphabetic Index:

Diabetes, diabetic (controlled) (mellitus) (without complication)
- gestational O24.4-

Hypoglycaemia (spontaneous) E16.2

Assign O24.4- with a fifth character in accordance with the *Instructional* note at subcategory O24.4.

Amendments will be considered for a future edition.

References:

World Health Organization (WHO) 2023, *International Classification of Diseases Eleventh Revision (ICD-11) for Mortality and Morbidity Statistics (Version: 01/2024)*, World Health Organization (WHO), Geneva, viewed 15 January 2024, https://icd.who.int/browse/2024-01/mms/en#1320503631.

Ref No: Q3744 | Published On: 15-Mar-2024 | Status: Current

Insertion of inflatable artificial erection device

Q:

What codes are assigned for insertion of inflatable artificial erection device?

A:

Artificial erection devices are used in the treatment of erectile dysfunction and Peyronie disease. The devices may also be used in gender affirming surgery (Cavayero & McIntosh 2022; Hellstrom 2022).

Artificial erection devices contain three main components: inflatable penile rods, a pump and a reservoir. Insertion of inflatable artificial erection device involves implantation of two flexible cylinders (inflatable penile rods) into each corporal body of the penis, a pump placed in the scrotum and a fluid reservoir implanted under the abdominal wall. Alternatively, a combined pump and fluid reservoir may be placed in the scrotum (Cavayero & McIntosh 2022; Hellstrom 2022).

Assign:

37426-01 *Insertion of artificial erection device, inflatable* **and**

37429-00 *Insertion of pump and pressure regulating reservoir of artificial erection device*.

Follow ACHI Alphabetic Index:

Insertion

- erection device, artificial (inflatable) 37426-01 **[1191]**
- - pump 37429-00 **[1191]**
- - - with pressure regulating reservoir 37429-00 **[1191]**

Amendments will be considered for a future edition.

References:

Cavayero, C. T. & McIntosh, G. V. 2022, Penile prosthesis implantation, in: *StatPearls* Treasure Island Florida: StatPearls Publishing, viewed 12 January 2024, https://www.ncbi.nlm.nih.gov/books/NBK563292/.

Hellstrom, W. J. G. 2022, *Penile prosthesis implantation*, Medscape Drugs & Diseases, viewed 12 January 2024, https://emedicine.medscape.com/article/446761-overview#a4.

Ref No: Q3743 | Published On: 15-Mar-2024 | Status: Current

Internal fixation of spine, one level

Q:

What code is assigned for internal fixation of the spine, one level?

A:

The *Note* at ACHI block **[1390]** *Internal fixation of spine* describes segmental internal fixation:

> *Segmental internal fixation* – involves placement of implants at the upper and lower extremities of the spinal fusion and at multiple intervening sites.

The Medicare Benefits Schedule (MBS) does not use the term 'segmental', but describes:

51021 – *Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, one motion segment* (MBS Online 2024).

A motion segment consists of two adjacent vertebral bodies, an intervertebral disc and two facet joints (Almeer et al. 2020).

For classification purposes in ACHI, internal fixation (IF) of two adjacent vertebrae (for example T4/T5) is classified as segmental IF of one level (motion segment).

Assign 51021-00 **[1390]** *Segmental internal fixation of spine, 1 or 2 levels*.

Follow the ACHI Alphabetic Index:

Fixation

- bone

- - internal

- - - spine

- - - - segmental (cage) (hook) (plate) (rods) (screw(s)) (wire loop)

- - - - - 1 or 2 levels 51021-00 **[1390]**

Amendments will be considered for a future edition.

References:

Almeer, G., Azzopardia, C., Kho, J., Gupta, H., James, S.L., & Botchua. R. 2020, 'Anatomy and pathology of facet joint', *Journal of Orthopaedics,* vol. 22, pp. 109–117.

Australian Government Department of Health and Aged Care (DoHAC) 2024, *Medicare Benefits Schedule - Item 51021*, viewed 12 January 2024, https://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&q=51021&qt=ItemID.

Ref No: Q3707 | Published On: 15-Mar-2024 | Status: Updated | Updated on: 16-Sep-2024

Malignant pleural effusion due to acute myeloid leukaemia

Q:

What codes are assigned for malignant pleural effusion due to acute myeloid leukaemia?

A:

A patient with acute myeloid leukaemia may develop pleural effusions, most commonly due to infection. In rare instances the pleural effusion may be caused by leukaemic infiltration, also known as a malignant pleural effusion (DeMarco et al. 2020; Wang et al. 2021).

In ICD-10-AM, there is nothing to preclude the assignment of malignant pleural effusion in AML, therefore assign the following codes:

C78.2 *Secondary malignant neoplasm of pleura* as principal diagnosis (without a morphology code)

A code from category C92 *Myeloid leukaemia*

A morphology code from M984–M993 *Myeloid leukaemias* (M9840/3–M9931/3).

Follow the ICD-10-AM Alphabetic Index:

Effusion

- pleura, pleurisy, pleuritic, pleuropericardial

- - malignant NEC C78.2

Leukaemia

- myeloid

- - acute …

Assign the morphology code once only, in accordance with ACS 0025 *Double coding*.

Although category C78 classifies secondary malignant neoplasms of respiratory and digestive organs, malignant pleural effusion, not elsewhere classified is classified to C78.2 in this category and is appropriate to assign for malignant pleural effusion due to acute myeloid leukaemia.

Amendments will be considered for a future edition.

References

DeMarco, B., Al-Qadi, M.O., Carson, S.S. & Ghosh, S. 2020, 'Leukemic pleural effusion in acute myeloid leukemia', In *C35. Causes of pleural effusions: case reports (pp. A4863-A4863*). American Thoracic Society, viewed 12 January 2024, https://www.atsjournals.org/doi/abs/10.1164/ajrccm-conference.2020.201.1_MeetingAbstracts.A4863.

Wang, S., Chen, C., Liang, S., Yeh, S. & Cheng, W. 2021, 'Acute myeloid leukemia with leukemic pleural effusion and high levels of pleural adenosine deaminase: A case report and review of literature'. *Open Medicine*, vol. 16, no.1, pp. 387-396.

Ref No: Q3741 | Published On: 15-Mar-2024 | Status: Current

Shockwave intravascular lithotripsy

Q:

What code is assigned for shockwave intravascular lithotripsy?

A:

Shockwave intravascular lithotripsy (S-IVL) is performed for the treatment of severely calcified plaques in coronary and peripheral arterial vessels. A balloon angioplasty catheter with lithotripsy emitters is delivered to the plaque site. Acoustic shock waves are then emitted to break up the calcified plaques (Kereiakes et al. 2021). The procedure is often performed to facilitate the insertion of a transluminal stent (Kassimis et al. 2020).

Assign a code from one of the following blocks for S-IVL:

[670] *Transluminal coronary angioplasty* **or**

[671] *Transluminal coronary angioplasty with stenting* **or**

[754] *Transluminal balloon angioplasty*.

Follow the ACHI Alphabetic Index:

Angioplasty

- transluminal balloon
- - coronary artery
- - - with
- - - - multiple stents
- - - - - multiple arteries (percutaneous) 38306-02 **[671]**
- - - - - single artery (percutaneous) 38306-01 **[671]**
- - - - single stent (percutaneous) 38306-00 **[671]**
- - - 1 vessel (percutaneous) 38300-00 **[670]**
- - - 2 or more vessels 38303-00 **[670]**
- - peripheral vessel (percutaneous) 35303-06 **[754]**
- - - with
- - - - multiple stents 35309-07 **[754]**
- - - - single stent 35309-06 **[754]**

Amendments will be considered for a future edition.

References:

Kassimis, G., Didagelos, M., De Maria, G., Kontogiannis, N., Karamasis, G. V., Katsikis, A., Sularz, A., Karvounis, H., Kanonidis, I., Krokidis, M., Ziakas, A. & Banning, A. 2020. 'Shockwave Intravascular Lithotripsy for the Treatment of Severe Vascular Calcification', *Angiology*, vol. 71, no. 8, pp. 677–688.

Kereiakes, D., Virmani, R., Hokama, J., Illindala, U., Mena-Hurtado, C., Holden, A., Hill, J., Lyden, S. & Ali, Z. 2021, 'Principles of Intravascular Lithotripsy for Calcific Plaque Modification', *Journal of the American College of Cardiology: Cardiovascular Interventions,* vol. 14, no. 12, pp. 1275–1292.

Coding Rules

Published 15 December 2023

Ref No: Q3786 | Published On: 15-Dec-2023 | Status: Current

Assignment of mandatory codes in same-day episodes, including where coding is autogenerated

Q:

Does assignment of mandatory codes (eg tobacco use, supplementary codes, coronavirus disease 2019 (COVID-19)) apply to same-day episodes of care, including where coding may be autogenerated (eg same-day dialysis)?

A:

There is no exception to the rule that certain conditions require mandatory code assignment, in accordance with ACS 0002 *Additional diagnoses/Additional diagnosis reporting referred to in other standards.*

ACS 0002 applies irrespective of whether the episode of care is multi-day or same-day.

Where autogenerated coding is used (such as for dialysis episodes) and the full record is not available to inform the coding process, it may not be possible for health care facilities to comply in this circumstance.

Ref No: Q3845 | Published On: 15-Dec-2023 | Status: Current

Coronary microvascular disease

Q:

What code is assigned for coronary microvascular disease?

A:

Coronary microvascular disease (CMD) is where smaller coronary artery walls are damaged, impairing the function of the artery and limiting blood flow to the heart muscle. Unlike coronary artery disease in larger coronary arteries, the disease is not caused by plaque deposits, however patients often experience similar symptoms of angina and shortness of breath (Sinha et al. 2020).

Assign I51.6 *Cardiovascular disease, unspecified* for coronary microvascular disease.

Follow the ICD-10-AM Alphabetic Index:

Disease, diseased

- cardiovascular I51.6

Amendments will be considered for a future edition.

References:

Sinha, A., Rahman, H. & Perera, D. 2020. 'Coronary microvascular disease: current concepts of pathophysiology, diagnosis and management', *Cardiovascular endocrinology and metabolism*, vol. 10, no. 1, pp. 22-30.

Ref No: Q3751 | Published On: 15-Dec-2023 | Status: Current

Elevated D-dimer

Q:

What code is assigned for an elevated D-dimer level?

A:

D-dimers are protein fragments produced when the body breaks down blood clots (thrombus). In healthy individuals they are detectable in low levels. Elevated levels of D-dimer may indicate a patient has a thromboembolism such as a pulmonary embolism (PE) or deep vein thrombosis (DVT). Elevated levels can also occur as a result of a surgical procedure, severe immune reaction, cancer and pregnancy complications (Linkins & Takach Lapner 2017).

D-dimer testing is commonly used to exclude DVT and PE and to inform decisions on continuing or stopping anticoagulation treatments. If a D-dimer level is elevated, further testing is usually performed such as a venous ultrasound to detect DVT.

If the condition causing the elevated D-dimer level is identified following further investigation, assign a code for the condition, not the abnormal test result.

Assign R79.89 *Other specified abnormal findings of blood chemistry* when elevated D-dimer is documented in the absence of any underlying cause and meets the criteria of ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*.

Follow the ICD-10-AM Alphabetic Index:

Abnormal, abnormality, abnormalities

- chemistry, blood

- - specified NEC R79.89

Amendments will be considered for a future edition.

References:

Linkins, L-A. & Takach Lapner, S. 2017, 'Review of D-dimer testing: Good, Bad, and Ugly', *International Journal of Laboratory Hematology*, vol. 39, issue S1, pp.98–103.

Ref No: Q3852 | Published On: 15-Dec-2023 | Status: Current

Functional coronary angiogram

Q:

What code is assigned for functional coronary angiography that includes the use of vasodilators?

A:

Functional coronary angiograms (FCA) also known as coronary reactivity tests (CRT) (Rai et al. 2021) are used to diagnose vascular dysfunction in smaller coronary arteries, even when no obstructive coronary artery disease is present. Abnormal vascular function is associated with adverse cardiovascular events including angina, myocardial infarction and sudden cardiac death (Kumar et al. 2021, Phan et al. 2009).

During the angiogram, the reactivity of the arteries to vasodilators such as adenosine, acetylcholine and nitroglycerine is assessed by measuring variables such as coronary flow rate (CFR), coronary blood flow and hyperaemic microvascular resistance index (HMR) (Kumar et al. 2021, Rai et al. 2021).

Assign 38241-00 **[668]** *Coronary artery blood flow measurement* for FCA.

Follow the ACHI Alphabetic Index:

Study

- coronary artery flow (coronary flow reserve) (fractional flow reserve) 38241-00 **[668]**

Amendments will be considered for a future edition.

References:

Kumar, S., Mehta, P. K., Eshtehardi, P., Hung, O. Y., Koh, J. S., Kumar, A., Al-Badri, A., Rabah, R., D'Souza, M., Gupta, S., McDaniel, M., Vaccarino, V., Douglas, J., Mavromatis, K., Lee, J. M., Quyyumi, A., & Samady, H. 2021, 'Functional coronary angiography in symptomatic patients with no obstructive coronary artery disease', *Catheterization and cardiovascular interventions: official journal of the Society for Cardiac Angiography & Interventions,* vol. 98, no 5, pp. 827-835.

Phan, A., Shufelt, C. & Merz, C.N.B. 2009, 'Persistent Chest Pain and No Obstructive Coronary Artery Disease', *Journal of the American Medical Association,* vol. 301, no. 14, pp.1468–1474.

Rai, B., Shukla, J., Henry, T.D., & Quesada, O. 2021, 'Angiogenic CD34 Stem Cell Therapy in Coronary Microvascular Repair—A Systematic Review', *Cells,* vol 10, no. 5, p. 113.

Ref No: Q3841 | Published On: 15-Dec-2023 | Status: Current

Genital reconfiguration surgery

Q:

What principal diagnosis is assigned for a patient admitted for genital reconfiguration surgery?

A:

Gender affirming surgery refers to a variety of procedures that some trans or gender diverse people may have to affirm their gender. Surgery to change the genitals is called genital reconfiguration surgery. These surgeries can include (but are not limited to) orchiectomy, vulvoplasty, shortening or lengthening the urethra, vaginoplasty, hysterectomy, salpino-oophorectomy, vaginectomy, metoidioplasty and/or phalloplasty (Healthdirect Australia 2022).

Assign Z41.89 *Other procedures for purposes other than remedying health state* as the principal diagnosis where a patient is admitted for genital reconfiguration surgery.

Follow the ICD-10-AM Alphabetic Index:

Procedure (admission for) (surgical)

- for purpose other than remedying health state

- - specified NEC Z41.89

Assign also F64 *Gender incongruence* as an additional diagnosis for gender dysphoria.

See also Coding Rule *Chest masculinisation surgery for gender dysphoria* that provides advice to assign Z41.1 *Other plastic surgery for unacceptable cosmetic appearance* as principal diagnosis for chest masculinisation surgery.

Amendments may be considered for a future edition.

References:

Healthdirect Australia 2022, *Gender affirming surgery*, Healthdirect Australia, viewed 14 November 2023, https://www.healthdirect.gov.au/gender-affirming-surgery.

Ref No: Q3870 | Published On: 15-Dec-2023 | Status: Current

Percutaneous cholecystostomy

Q:

What codes are assigned for a leaking cholecystostomy and mechanical complications of cholecystostomy?

A:

Percutaneous cholecystostomy (PC) is used in the treatment of various gallbladder conditions including acute cholecystitis and cholangitis. PC is a minimally invasive, non surgical, image-guided intervention to place a drain in the gallbladder. It is performed to drain and decompress the gallbladder, thereby preventing perforation and sepsis. It can act as a bridge to surgery, but it may also serve as a definitive treatment for some patients (Arkoudis et al. 2023).

Clinical advice confirmed that leakage and mechanical complications of cholecystostomy are complications of a digestive system stoma.

Assign the following codes even though there are currently no supporting Alphabetic Index entries:

- K91.43 *Leak of stoma of digestive system* for cholecystostomy (tube) leak
- K91.49 *Malfunction of stoma of the digestive system, not elsewhere classified* for mechanical complications of a cholecystostomy (tube).

Amendments are being progressed for ICD-10-AM Thirteenth Edition.

References:

Arkoudis, N., Moschovaki-Zeiger, O., Reppas, L., Grigoriadis, S., Alexopoulou, E., Brountzos, E., Kelekis, N. & Spiliopoulos, S. 2023, 'Percutaneous cholecystostomy: techniques and applications', *Abdominal radiology*, Vol. 48, pp.3229-3242, viewed 13 November 2023, https://link.springer.com/article/10.1007/s00261-023-03982-2.

Ref No: Q3630 | Published On: 15-Dec-2023 | Status: Current

Same-day surveillance of diverticulitis

Q:

What code is assigned for a same-day colonoscopy for diverticulitis surveillance, where only diverticulosis is found?

A:

Diverticular disease is a broad term that encompasses a range of presentations and complications of diverticulosis. Diverticulosis is the presence of mucosal and submucosal herniations or “pockets” known as diverticula, and a percentage of individuals with diverticula may go on to develop diverticulitis (McSweeney & Srinath 2017; You et al. 2019).

Diverticulitis is an inflammatory condition of the colon that is thought to be caused by perforation of one of the individual diverticula sacs. Diverticulosis itself is very common and most people will have no symptoms from it, so a finding of diverticulosis on its own generally has minimal consequence. Diverticulitis itself may or may not be chronic (American Society of Colon and Rectal Surgeons 2020).

Chronic diverticulitis is the condition where patients may have repeated attacks of diverticulitis or may have a prolonged course of a single attack of diverticulitis. In most instances, even complicated diverticulitis resolves quickly and completely with treatment (WebMD 2023).

However, there is an increased risk of colorectal cancer (CRC) in patients with acute diverticulitis and screening colonoscopy is recommended to identify potential CRC (Meyer et al. 2018). Following an episode of acute diverticulitis, the purpose of the colonoscopy is to exclude neoplasia (McSweeney & Srinath 2017).

While diverticulosis is a chronic incurable condition it is not routinely surveilled or regularly followed up. In diagnostic endoscopy it may only be an incidental finding and when surveillance colonoscopy is performed following acute diverticulitis it is an expected finding.

ICD-10-AM has expanded category K57 *Diverticular disease of intestine* to distinguish between diverticulosis and diverticulitis so when classifying these conditions clinical coders must consider the circumstances of the presentation in the admitted episode of care; noting also that the terms surveillance and follow-up may be used interchangeably.

ACS 0052 *Same-day endoscopy – surveillance* 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 (see Examples 3, 4 and 5)*

Therefore, assign Z12.1 *Special screening examination for neoplasm of intestinal tract* as the principal diagnosis where a patient is admitted for a same-day colonoscopy for diverticulitis surveillance and no CRC is detected.

Follow the ICD-10-AM Alphabetic Index:

Screening (for)

- neoplasm (of)

- - intestinal tract NEC Z12.1

Assign an additional diagnosis for any condition(s) found at endoscopy that meets the criteria in ACS 0002 *Additional diagnoses*.

Do not apply the guidelines for surveillance of a pre-existing condition (i.e. chronic incurable condition), or routine follow-up examination after treatment.

Amendments will be considered for a future edition.

References:

American Society of Colon and Rectal Surgeons 2020, *Diverticular Disease Expanded Information*, viewed 29 November 2023, https://fascrs.org/patients/diseases-and-conditions/a-z/diverticular-disease-expanded-version.

McSweeney, W & Srinath, H. 2017, 'Diverticular disease practice points', *Australian Family Physician*, viewed 29 November 2023, https://www.racgp.org.au/afp/2017/november/diverticular-disease-practice-points.

Meyer, J., Buchs, N. C., & Ris, F. 2018, 'Risk of colorectal cancer in patients with diverticular disease', *World journal of clinical oncology*, vol.9, no.6, pp.119–122.

You, H., Sweeny, A., Cooper, M. L., Von Papen, M. & Innes, J. 2019, 'The management of diverticulitis: a review of the guidelines', *The Medical Journal of Australia*, vol. 211, no. 9, pp. 421-427.

WebMD 2023, *Diverticulitis*, viewed 29 November 2023, https://www.webmd.com/digestive-disorders/understanding-diverticulitis-basics.

Ref No: Q3848 | Published On: 15-Dec-2023 | Status: Current

Voluntary assisted dying

Q:

What principal diagnosis code is assigned for admission for voluntary assisted dying?

A:

Voluntary assisted dying (VAD) is when someone chooses medical assistance to end their life due to an advanced medical condition (Healthdirect Australia 2023). Over the past six years all states in Australia have enacted legislation to enable VAD.

The VAD substance or medicine may be self-administered or practitioner administered. Where a patient is admitted for administration of the VAD substance, assign the underlying condition as the principal diagnosis.

Do not assign codes from block **[1920]** *Administration of pharmacotherapy* even when administration of the VAD substance is the principal reason for admission in a same-day episode of care.

Amendments are being progressed for ICD-10-AM Thirteenth Edition.

References

Healthdirect Australia 2023, *Voluntary assisted dying*, Healthdirect, Sydney, viewed 30 November 2023, https://www.healthdirect.gov.au/voluntary-assisted-dying.

Coding Rules

Published 15 September 2023

Ref No: Q3712 | Published On: 15-Sep-2023 | Status: Current

Acute liver injury

Q:

What code is assigned for acute liver injury?

A:

Acute liver injury (ALI) is severe acute hepatocyte necrosis with marked liver test abnormalities and significant coagulopathy in patients without preexisting chronic liver disease. It may progress to acute liver failure when signs of hepatic encephalopathy occur with abnormal liver function and impaired coagulation. Causes of ALI may include drug toxicity (eg acetaminophen (paracetamol, N-acetyl-p-aminophenol (APAP), mushroom poisoning), autoimmune hepatitis and Wilson's disease (Grabowska et al. 2019; Koch et al. 2017).

Assign K76.9 *Liver disease, unspecified* for acute liver injury NOS (not otherwise specified) (ie not stated as due to a specified cause such as drug toxicity).

Follow the ICD-10-AM Alphabetic Index:

Disease, diseased

- liver (chronic) (organic) K76.9

Assign K71.1 *Toxic liver disease with hepatic necrosis* for ALI specified as due to drug toxicity or poisoning (see also ACS 1901 *Poisoning*, ACS 1902 *Adverse effects* and ACS 1903 *Two or more drugs taken in combination*).

Follow the ICD-10-AM Alphabetic Index:

Disease, diseased

- liver (chronic) (organic)
- - toxic
- - - with
- - - - hepatic
- - - - - necrosis K71.1

Amendments will be considered for a future edition.

References:

Grabowska, M. A., Wójcicki, M., Raszeja-Wyszomirska, J., Szydłowska-Jakimiuk, M., Piotuch, B. & Milkiewicz, P. 2019, 'Acute liver injury, acute liver failure and acute on chronic liver failure: A clinical spectrum of poisoning due to *Gyromitra esculenta*', *Annals of Hepatology*, vol. 18, iss. 3, pp. 514-516.

Koch, D. G., Speiser, J. L., Durkalski, V., Fontana, R. J., Davern, T., McGuire, B., Stravitz, R. T., Larson, A. M., Liou, I., Fix, O., Schilsky, M. L., McCashland, T., Hay, J. E., Murray, N., Shaikh, O. S., Ganger, D., Zaman, A., Han, S. B., Chung, R. T., Brown, R. S., Munoz Jr, S., Reddy, K. R., Rossaro, L., Satyanarayana, R., Hanje, A. J., Olson, J., Subramanian, R. M., Karvellas, C., Hameed, B., Sherker, A. H., Lee, W. M. & Reuben, A. 2017, 'The natural history of severe acute liver injury', *The American journal of gastroenterology*, vol. 112, no. 9, pp. 1389–1396.

Ref No: Q3706 | Published On: 15-Sep-2023 | Status: Current

Alcohol use disorder

Q:

What codes are assigned for mild, moderate or severe alcohol use disorder?

A:

In the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR), substance abuse and dependence categories have been replaced with an overarching new category of *Substance use disorder*. The category *Alcohol use disorder* (AUD) includes subdivisions for mild, moderate or severe AUD to specify the severity of the alcohol use disorder. Mild alcohol use disorder is equivalent to harmful use, while moderate and severe alcohol use disorder is equivalent to dependence syndrome (APA 2022).

Assign one of the following codes for alcohol use disorder:

- F10.1 *Mental and behavioural disorders due to use of alcohol, harmful use* for 'mild alcohol use disorder'
- F10.2 *Mental and behavioural disorders due to use of alcohol, dependence syndrome* for 'moderate alcohol use disorder' or 'severe alcohol use disorder'.

Follow the ICD-10-AM Alphabetic Index:

Disorder (of)

- use

- - alcohol

- - - dependence F10.2

- - - harmful F10.1

Where alcohol use disorder without further specificity is documented, seek clinical clarification to determine the severity of alcohol use disorder. Assign F10.1 *Mental and behavioural disorders due to use of alcohol, harmful use* where clinical consultation is not possible.

See also ACS 0503 *Drug, alcohol and tobacco use disorders*.

Amendments may be considered for a future edition.

References:

American Psychiatric Association 2022, *Diagnostic and statistical manual of mental disorders, Fifth Edition, Text Revision*, American Psychiatric Association, Arlington, VA, United States of America.

Ref No: Q3686 | Published On: 15-Sep-2023 | Status: Supersedes Q3102

CPR related injuries

Q:

Are injuries (eg fractures) due to CPR (cardiopulmonary resuscitation) classified as procedural complications?

A:

Skeletal chest injuries, such as rib and sternum fractures, are an unintentional event due to CPR. Some patients (eg the elderly) are more susceptible to fractures as a result of CPR. While special training is required to learn the correct techniques for CPR, it may be performed by medical or nonmedical persons within or outside a health facility.

ACS 1904 *Procedural complications* provides guidelines for code assignment where there is a complication of surgical and medical care, however does not include injuries that occurred due to care performed by members of the public outside a clinical setting.

Analysis of code assignment since the implementation of ICD-10-AM Tenth Edition demonstrates inconsistency and lack of specificity in relation to identifying the injury and CPR event. Therefore, the Independent Health and Aged Care Pricing Authority (IHACPA) recommends that the specific injury code (eg fracture) with an external cause and place of occurrence codes will better identify CPR injuries.

For example, where four or more rib fractures are specified as due to CPR, assign the following codes:

S22.44 *Multiple rib fractures, involving four or more ribs*

Follow the ICD-10-AM Alphabetic Index:

Fracture

- rib

- - multiple

- - - involving

- - - - 4 or more ribs S22.44

Also assign external cause of injury and place of occurrence codes:

Y65.8 *Other specified unintentional events during surgical and medical care*

Y92.- *Place of occurrence.*

Where the injury occurred in a clinical setting (eg ambulance, health facility), assign:

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 injury occurred in the community (ie a nonclinical setting), assign a place of occurrence code from the ICD-10-AM Alphabetic Index: Section II *External Cause of Injury* at the lead term *Place of occurrence of external cause*.

Do not follow the ICD-10-AM Alphabetic Index at *Complication/musculoskeletal/intraoperative or postprocedural/specified NEC* to assign M96.8 *Other intraoperative or postprocedural disorders of musculoskeletal system* in this instance.

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

Ref No: Q3801 | Published On: 15-Sep-2023 | Status: Current

Malignant diffuse leptomeningeal glioneuronal tumour

Q:

What codes are assigned for malignant diffuse leptomeningeal glioneuronal tumour?

A:

Diffuse leptomeningeal glioneuronal tumour (DLGNT) is classified with a morphology behaviour code /1 *Uncertain whether benign or malignant.* ICD-10-AM aligns with ICD-O-3 and does not list a morphology code for DLGNT with a primary malignant (/3) behaviour.

Assign the following codes where malignant DLGNT of the brain is specified:

C71.9 *Malignant neoplasm of brain, unspecified*
M9509/1 *Papillary glioneuronal tumour*

Follow the ICD-10-AM Alphabetic Index:

Neoplasm, neoplastic

- brain NEC (Malignant, primary) C71.9

Tumour

- glioneuronal (papillary) (rosette-forming) (M9509/1)

Sequence topography and morphology codes in accordance with ACS 0233 *Morphology* and ACS 0236 *Neoplasm coding and sequencing.*

Amendments will be considered for a future edition.

Ref No: Q3702 | Published On: 15-Sep-2023 | Status: Current

Malignant neoplasm in transplanted organ/tissue

Q:

What codes are assigned when a malignant neoplasm is identified in a transplanted organ/tissue?

A:

For a malignant neoplasm identified in a transplanted organ/tissue, assign a topography code for the site where the neoplasm was found (ie the transplantation site), not the site where the organ/tissue originated. This follows the principle for classification of neoplasms of ectopic tissue as specified in ICD-10-AM Chapter 2 *Neoplasms Note/6* that states:

> *Malignant neoplasms of ectopic tissue are classified to the site where they are found, eg ectopic pancreatic malignant neoplasms of ovary are classified to C56* Malignant neoplasm of ovary.

Assign an additional diagnosis code to identify the transplantation status, in accordance with ACS 0002 *Additional diagnoses/Family and personal history, and certain conditions influencing health status* which states:

> *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 the following blocks and categories when they are documented as being related to a condition being managed or an intervention being performed in the current episode of care:*
>
> *…*
>
> - *Certain conditions influencing health status (eg acquired absence, presence of, dependence on): Z89, Z90, Z93–Z99.*

Example

Malignant neoplasm identified in a colon conduit used for reconstruction post oesophagectomy (ie section of colon transplanted to replace the oesophagus). Pathology from a conduit biopsy and referral letter state: *colonic adenocarcinoma/adenocarcinoma with colorectal immunophenotype.*

Assign:

C15.9 *Malignant neoplasm of oesophagus, unspecified*
M8140/3 *Adenocarcinoma NOS*
Z94.8 *Other transplanted organ and tissue status*

Follow the ICD-10-AM Alphabetic Index:

Adenocarcinoma NEC (M8140/3) — *see also Neoplasm/malignant*

Neoplasm, neoplastic

- oesophagus (Malignant, Primary) C15.9

Transplant(ed) (status)

- intestine Z94.8

Amendments will be considered for a future edition.

Ref No: Q3688 | Published On: 15-Sep-2023 | Status: Current

Partial gastrectomy without anastomosis

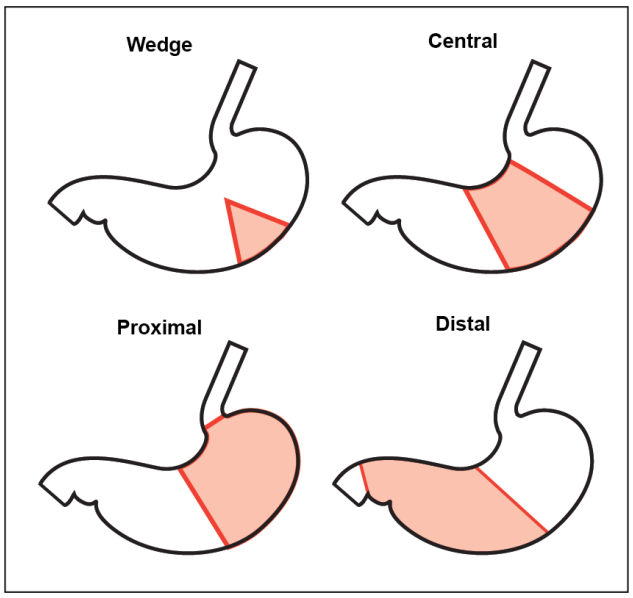
Q:

What code is assigned for partial gastrectomy without anastomosis?

A:

Partial gastrectomy is excision of part of the stomach. Surgical intestinal anastomosis is performed to establish communication between (ie join) two formerly distant portions of the intestine (eg after excision of a diseased part) (Vikram 2022). Anastomosis following partial gastrectomy describes which parts of the stomach and/or upper gastrointestinal tract are joined together after gastrectomy.

Type of partial gastrectomy	Description
Wedge gastrectomy	• a triangle-shaped section of the greater curvature of the stomach is excised • the wound is sutured closed
Central gastrectomy	• a band through the middle of the stomach is excised • anastomosis of the two remaining sections of the stomach (ie anastomosis of the upper portion of the stomach to the lower portion of the stomach (gastro-gastrostomy))
Proximal gastrectomy	• excision of the upper portion of the stomach • anastomosis of the oesophagus to the lower portion of the stomach (ie oesophagogastric anastomosis)
Distal gastrectomy	• excision of the lower portion of the stomach • anastomosis of the upper portion of the stomach to the duodenum (gastroduodenal anastomosis) or jejunum (gastrojejunal anastomosis) (Canadian Gastric Cancer Association 2021).



Assign 30520-00 **[880]** *Local excision of lesion of stomach* for partial gastrectomy without gastroduodenal, gastrojejunal or oesophagogastric anastomosis (eg wedge or central gastrectomy).

Also assign 30375-31 **[881]** *Gastro-gastrostomy* for central gastrectomy.

Follow the ACHI Alphabetic Index:

Excision — *see also Removal*

…

- lesion(s)

- - stomach (local) (wedge) 30520-00 **[880]**

Gastrogastrostomy 30375-31 **[881]**

Do not follow the *Excludes* note at 30520-00 **[880]** as it relates to partial gastrectomy with gastroduodenal, gastrojejunal or oesophagogastric anastomosis.

Amendments will be considered for a future edition.

References:

Canadian Gastric Cancer Association 2021, *Gastrectomy*, viewed 20 July 2023, http://gastriccancer.ca/patient/informational-resources/gastrectoy/.

Vikram, K. 2022, 'Intestinal anastomosis', *Medscape*, viewed 20 July 2023, https://emedicine.medscape.com/article/1892319-overview#:~:text=Intestinal%20anastomosis%20is%20a%20surgical,pathologic%20condition%20affecting%20the%20bowel.

Ref No: Q3716 | Published On: 15-Sep-2023 | Status: Current

Spontaneous abortion with resulting liveborn fetus

Q:

What codes are assigned for a spontaneous abortion with resulting liveborn fetus?

A:

A live birth is defined as the complete expulsion or extraction of a product of conception, irrespective of the duration of pregnancy, which shows any evidence of life. An extremely preterm infant may be born live but may not be viable outside of the uterus. The major factor in determining viability is gestational age. With active intervention, most infants born at 26 weeks and above have a high likelihood of survival, and virtually none below 22 weeks will survive (Barfield & Committee on Fetus and Newborn 2016; Mercurio & Drago 2022).

The *Glossary description/definition* at O03 *Spontaneous abortion* states:

> *Spontaneous expulsion of products of conception* ***before fetal viability*** *(less than 20 completed weeks (140 days) gestation and/or fetal weight less than 400g).*

ICD-10-AM and the Australian Coding Standards (ACS) do not currently provide guidance for the rare scenario where a specified spontaneous abortion results in expulsion of a liveborn infant. However, ACS 1511 *Termination of pregnancy (abortion)* lists classification guidelines for medical abortion that includes an option for liveborn infant:

> ***ICD-10-AM CODES FOR MEDICAL ABORTION***
>
> *Assign:*
>
> - *O04.- Medical abortion (as the principal diagnosis)*
> - *O09.- Duration of pregnancy*
> - *a code to indicate the reason for the medical abortion, if known*
> - *a code from O80–O84 Delivery – only if the medical abortion is performed after fetal viability*
> - *O60.3 Preterm delivery without spontaneous labour – only if the medical abortion is performed after fetal viability*
> - *Z37.- Outcome of delivery – if the medical abortion is performed after fetal viability (regardless of outcome), or* ***before fetal viability if the outcome is a liveborn infant***

Assign the following codes for spontaneous abortion, resulting in expulsion of a single liveborn infant, to fully describe the episode of care:

O03.- *Spontaneous abortion* (as the principal diagnosis) — with fifth character to indicate incomplete or complete/unspecified abortion.

O09.- *Duration of pregnancy* — in accordance with the *Instructional* note at category O03 *Spontaneous abortion.*

Z37.0 *Single live birth* — to identify the outcome of delivery.

Follow the ICD-10-AM Alphabetic Index:

Abortion
- spontaneous O03.-

Outcome of delivery
- single
- - liveborn Z37.0

A delivery code (ie O80 *Single spontaneous delivery*) is not assigned as this scenario occurs **before fetal viability**. Note also the *Excludes* note at O80:

> ***Excludes:*** *pregnancy with abortive outcome before fetal viability (O00–O08).*

Amendments will be considered for a future edition.

References:

Barfield, W.D. & Committee on Fetus and Newborn 2016, 'Standard Terminology for Fetal, Infant, and Perinatal Deaths', *Pediatrics*, viewed 31 August 2023, https://pediatrics.aappublications.org/content/137/5/e20160551.

Mercurio, M.R. & Drago, M. 2022, *Periviable birth (Limit of viability),* Uptodate, viewed 31 August 2023, https://www.uptodate.com/contents/periviable-birth-limit-of-viability.

Ref No: Q3774 | Published On: 15-Sep-2023 | Status: Current

Sunken flap syndrome

Q:

What codes are assigned for sunken flap syndrome?

A:

Sunken flap syndrome, also known as sinking flap syndrome, paradoxical brain herniation or syndrome of the trephined is typically seen as a rare complication of large craniectomies prior to cranioplasty. It can occur several weeks to several months following a craniectomy and is thought to be caused by atmospheric pressure exceeding intracranial pressure. It consists of a sunken scalp above the bone defect with potential cortical compression leading to neurologic changes (eg headache, motor deficits, cognitive decline or seizures) as well as autonomic dysfunction. (Cassagne & Claes 2022; Oviatt et al. 2021).

Assign G97.8 *Other intraoperative or postprocedural disorders of nervous system* as sunken flap syndrome is a known rare complication of large craniectomies (ie the relationship is inherent) and it involves neurological symptoms (ie is related to a body system).

Follow the ICD-10-AM Alphabetic Index:

Complications(s) (from) (of)

- nervous system

- - intraoperative or postprocedural

- - - specified NEC G97.8

Assign additional diagnoses codes from Chapters 1 to 18 to identify symptoms/manifestations, with U91 *Syndrome, not elsewhere classified* in accordance with the guidelines in ACS 0005 *Syndromes.*

Also assign the following external cause codes:

Y83.8 *Other surgical operation*

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

or

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

Assign Z90.0 *Acquired absence of part of head and neck* as an additional diagnosis in accordance with ACS 0002 *Additional diagnoses/Family and personal history, and certain conditions influencing health status,* as the craniectomy status is related to the condition being managed.

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

References:

Cassagne. M. & Claes, A-S. 2022, 'Sinking skin flap syndrome, a rare complication of craniectomy', *Journal of the Belgian Society of Radiology*, vol. 106, no. 1, pp. 52.

Ovaitt, A., Fort, M., Withrow. K. & Hughley, B. 2021, 'Sinking skin flap syndrome in head and neck reconstruction: a case report', *Otolaryngology Case Reports*, vol. 21, no. 1, pp. 1000330.

Ref No: Q3754 | Published On: 15-Sep-2023 | Status: Current

Vaginal natural orifice transluminal endoscopic surgery (vNOTES) hysterectomy

Q:

What codes are assigned for a vNOTES hysterectomy?

A:

Natural orifice transluminal endoscopic surgery (NOTES) uses minimally invasive instruments, performed via a range of approaches such as the stomach, oesophagus, bladder, rectum and vagina (Jallad & Walters 2017).

vNOTES refers to **vaginal** natural orifice transluminal endoscopic surgery. The procedure involves inserting a device through an incision in the vagina and into the peritoneal cavity, which is inflated with carbon dioxide to enable visualisation of the uterus, fallopian tubes and ovaries. Surgical instruments required to perform a hysterectomy, along with a camera, are inserted along various openings in the vNOTES device. Once the uterus is dissected and removed transvaginally, the vNOTES device is also removed, and the peritoneal cavity deflated (Arizona Gynecology Consultants 2020). This emerging technology combines the benefits of a laparoscopic and traditional vaginal hysterectomy (Applied Medical 2023).

Assign the following codes where a vNOTES hysterectomy is performed:

35657-00 **[1269]** *Vaginal hysterectomy*

96234-01 **[1923]** *Percutaneous endoscopic-assisted intervention, not elsewhere classified*

Follow the ACHI Alphabetic Index:

Hysterectomy

- vaginal 35657-00 **[1269]**

Intervention

- percutaneous endoscopic-assisted NEC 96234-01 **[1923]**

Amendments will be considered for a future edition.

References:

Applied Medical 2022, vNotes: The next evolution in minimally invasive gynecologic surgery, viewed 12 September 2023, https://www.appliedmedical.com/vnotes.

Arizona Gynecology Consultants 2022, A new minimally invasive hysterectomy procedure, viewed 12 September 2023, https://azgyn.com/blog/new-hysterectomy-procedure/.

Jallad, K., & Walters, M. 2017, 'Natural orifice transluminal endoscopic surgery (NOTES) in gynecology', Clinical Obstetrics and Gynecology, vol. 60, no.2, pp. 324-329, viewed 12 September 2023, https://pubmed.ncbi.nlm.nih.gov/28221179/.

Coding Rules

Published 15 June 2023

Ref No: Q3693 | Published On: 15-Jun-2023 | Status: Current

Debridement of skin wound using wound care products

Q:

What code is assigned for skin debridement using surface level wound care products (eg Debrisoft® pad)?

A:

Debridement is an intervention for treating a skin wound. It involves thoroughly cleaning the wound and removing all hyperkeratotic (thickened skin or callus), infected, and nonviable (necrotic or dead) tissue, foreign debris, and residual material from dressings. Debridement can be accomplished either surgically (using a scalpel or special scissors) or nonsurgically (using special dressings and gels). Nonsurgical debridement may include such types as autolytic, enzymatic, mechanical debridement and maggot therapy (University of California San Francisco 2021).

Debrisoft® is a wound care product designed for mechanical debridement of wounds (Lohmann & Rauscher Australia n.d.).

Wound debridement using a surface level mechanical debridement product (eg Debrisoft® pad) is classified as nonexcisional (nonsurgical) debridement.

Assign 96255-00 **[1601]** *Wound management, not elsewhere classified* in accordance with the guidelines in ACS 0042 *Procedures normally not coded.*

Follow the ACHI Alphabetic Index:

Debridement (autolytic) (biosurgery) (chemical) (electrosurgery) (enzymes) (hydrosurgery) (laser) (plasma scalpel) (thermal) (ultrasonic) (water jet or scalpel) (whirlpool)

- skin (excisional) (subcutaneous tissue)

- - nonexcisional 96255-00 **[1601]**

…

- wound

- - skin (subcutaneous tissue) — *see Debridement/skin*

Amendments will be considered for a future edition.

References:

Lohmann & Rauscher Australia n.d., *Wound Care*, viewed 28 April 2023, <https://www.lohmann-rauscher.com/au-en/products/wound-care/debridement/debrisoft-pad/>.

University of California San Francisco 2023, *Debridement,* Department of Surgery Debridement, viewed 28 April 2023, <https://surgery.ucsf.edu/conditions--procedures/debridement.aspx>.

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for implementation 01 July 2023.

Ref No: Q3616 | Published On: 15-Jun-2023 | Status: Current

Hypotension due to anaesthesia

Q:

What codes are assigned for hypotension due to anaesthesia?

A:

ICD-10-AM classifies complications of anaesthesia and anaesthetics properly administered to code range T88.2–T88.59 as 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.

Complications due to the anaesthetic procedure or anaesthetic drugs properly administered that are not classified elsewhere are classified to category T88.59 *Complications of anaesthesia, not elsewhere classified.*

Therefore, for hypotension specified as due to anaesthesia, assign:

T88.59 *Complications of anaesthesia, not elsewhere classified*.

I95.8 *Other hypotension*

Y48.- *Anaesthetics and therapeutic gases*

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

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

Follow the ICD-10-AM Alphabetic Index Section I *Alphabetic index of diseases and nature of injury*:

Complication(s) (from) (of)

- anaesthesia, anaesthetic NEC T88.59

- - due to

- - - correct substance properly administered T88.59

Hypotension (arterial) (constitutional)

- specified NEC I95.8

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

Complication(s)

- anaesthetic NEC Y48.4

- - general Y48.2

- - inhaled Y48.0

- - local Y48.3

- - parenteral Y48.1

- - therapeutic gases Y48.5

I95.8 *Other hypotension* is assigned to provide further specificity of the condition in accordance with the guidelines in ACS 1904 *Procedural complications/classification of procedural complications (diagnosis codes)*.

Note that clinical advice confirmed that in this scenario hypotension is not always a result of drugs and the underlying cause is not always clear. Therefore I95.2 *Hypotension due to drugs* is not assigned.

Y48.- is assigned because it provides specificity as to the type of anaesthesia that has caused the complication.

Also assign 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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for implementation 01 July 2023.

Ref No: Q3683 | Published On: 15-Jun-2023 | Status: Current

Injection of steroid into the trachea

Q:

What code is assigned for injection of steroid into the trachea?

A:

The trachea is composed of cartilage, with muscle and connective tissue (soft tissue) in the back part of each ring, and a mucosal lining (Webmd 2021).

Assign 18360-01 **[1552]** *Administration of agent into soft tissue, not elsewhere classified* for injection of steroid into the trachea not otherwise specified (NOS).

Follow the ACHI Alphabetic Index:

Administration

- specified site

- - soft tissue NEC 18360-01 **[1552]**

Amendments will be considered for a future edition.

Reference

Hoffman, M. 2021, *Human anatomy: picture of the trachea*, viewed 26 April 2023, <https://www.webmd.com/lung/picture-of-the-trachea>.

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Ref No: Q3723 | Published On: 15-Jun-2023 | Status: Current

Lymphocele following femoral cannulation

Q:

What codes are assigned for a lymphocele following a femoral cannulation?

A:

A lymphocele is a collection of lymph in the tissues which follows injury to, or operation upon, lymph nodes or ducts (University of Oxford 2015). Femoral vessels are a common and reliable site for cannula insertion and can be accessed either percutaneously or by a femoral cutdown procedure. Lymphocele formation is a specific complication of femoral cannulation due to inflammation or lymphatic disruption at the site of cannulation (Salna et al. 2018).

ACS 1904 *Procedural complications* states:

> *Conditions…should be assigned procedural complication codes only if they meet the following criteria:*
>
> - *Certain conditions where the relationship is inherent in the diagnosis*
>
> *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…*

Clinical advice confirms that formation of a lymphocele is a known (usually late) complication of a femoral cannulation intervention, and the relationship is inherent in the diagnosis. Therefore, as a femoral lymphocele involves the lymphatic system (ie it is related to a body system), assign I97.83 *Postprocedural lymphocele, lymphoedema and chylothorax*.

Follow the ICD-10-AM Alphabetic Index:

Lymphocele I89.8

- postprocedural I97.83

Do not assign an additional code from Chapters 1 to 18 as it does not add specificity.

Also assign the following external cause codes:

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

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

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

Do not follow the ICD-10-AM Alphabetic Index at *Complication/vascular/device, implant or graft/infusion catheter/specified NEC* to assign T82.89 *Other specified complications of cardiac and vascular prosthetic devices, implants and grafts*, as lymphocele following a femoral cannulation is a complication related to a body system.

Amendments to this area will be considered for a future edition.

References:

Salna, M., Takayama, H., Garan, A. R., Kurlansky, P., Farr, M. A., Colombo, P. C., Imahiyerobo, T., Morrissey, N., Naka, Y., & Takeda, K. 2018, 'Incidence and risk factors of groin lymphocele formation after venoarterial extracorporeal membrane oxygenation in cardiogenic shock patients', *Journal of vascular surgery*, vol. 67, no.2, pp.542–548.

University of Oxford 2015, Oxford Concise Medical Dictionary, 9th edn, Oxford University Press, Oxford.

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Ref No: Q3580 | Published On: 15-Jun-2023 | Status: Current

Mini-laparotomy

Q:

What is the correct code assignment for a mini-laparotomy performed during a minimally invasive procedure?

A:

Mini-laparotomy, also known as minimally incised laparotomy, can be performed as a solo procedure on reproductive organs, or as an assistive technique in laparoscopic procedures. Examples of mini-laparotomy as an assistive technique include laparoscopic hysterectomy or laparoscopic hemicolectomy to facilitate removal of an organ or specimen that is too large for the laparoscope (Shaltout et al. 2022).

Clinical advice confirms that where a mini-laparotomy is performed as an assistive technique during a laparoscopic procedure, the procedure is still considered minimally invasive. The mini-laparotomy is an inherent part of the laparoscopic procedure and is considered a procedural component.

Assign the appropriate laparoscopic codes to classify the procedure performed where mini-laparotomy is performed as an assistive technique during the procedure. Do not assign an additional code for the mini-laparotomy.

For example, where a laparoscopic abdominal hysterectomy with mini-laparotomy and laparoscopic bilateral salpingectomy is performed assign the following codes:

35653-07 **[1268]** *Laparoscopic total abdominal hysterectomy*

35638-10 **[1251]** *Laparoscopic salpingectomy, bilateral*

Follow the ACHI Alphabetic Index:

Hysterectomy (abdominal) (total)

- laparoscopic NEC 35653-07 **[1268]**

Salpingectomy

- bilateral

- - laparoscopic (total) 35638-10 **[1251]**

Amendments may be considered for a future edition.

Reference:

Shaltout, M. F., Maged, A. M., Abdella, R., Sediek, M. M., Dahab, S., Elsherbini, M. M., Elkomy, R. O., & Zaki, S. S. 2022, 'Laparoscopic guided minilaparotomy: a modified technique for management of benign large ovarian cysts', *BMC women's health*, vol. 22, no. 1, pp. 269.

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Ref No: Q3750 | Published On: 15-Jun-2023 | Status: Current

Postembolisation syndrome

Q:

What codes are assigned for postembolisation syndrome (PES)?

A:

Postembolisation syndrome (PES) commonly occurs following transarterial embolisation or chemoembolisation for conditions such as liver lesions or uterine fibroids. Symptoms of PES include pain, fever, nausea/vomiting, fatigue and possibly infection. It is thought that PES is caused by an inflammatory response to necrotic tissue, leading to the release of breakdown products, inflammatory mediators, and vasoactive substances from the embolised tissue. Treatment includes administering intravenous fluids and symptomatic pain relief (Faisil 2022, Rasuli 2020).

PES is a known complication following embolisation interventions, and the relationship is inherent in the diagnosis.

Assign T81.89 *Other complications following a procedure, not elsewhere classified* to classify PES. Apply the guidelines in ACS 1904 and also assign D89.89 *Other specified disorders involving the immune mechanism, not elsewhere classified* to add specificity to the condition/complication and identify that PES results from an immune inflammatory response to the embolised tissue.

Follow the ICD-10-AM Alphabetic Index:

Complication(s) (from) (of)

- postprocedural T81.9

- - specified NEC T81.89

Disorder (of)

- immune mechanism (immunity)

- - specified type NEC D89.89

Apply the guidelines in ACS 0005 *Syndromes* and assign

U91 *Syndrome, not elsewhere classified*.

Also assign the following external cause codes:

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

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

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

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

References:

Faisil, A. 2022, *Post embolization syndrome: all you need to know about it*, Daily Medicos, viewed 1 May 2023, <https://dailymedicos.com/post-embolization-syndrome-causes-symptoms-diagnosis-treatment/>.

Rasuli, B. 2020, *Post-embolization syndrome*, Radiopedia, viewed 1 May 2023, <https://radiopaedia.org/articles/post-embolisation-syndrome-1>.

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for implementation 01 July 2023.

Ref No: Q3680 | Published On: 15-Jun-2023 | Status: Current

Suspected urinary tract infection

Q:

Is a code for urinary tract infection (UTI) assigned if 'dysuria ?UTI' is documented and antibiotics are administered for the UTI, but there is no clarifying documentation in the health care record?

A:

ACS 0012 *Suspected conditions* states:

> *Where clinical documentation clearly indicates uncertainty about the final diagnosis at discharge, assign a code based on the following criteria:*
>
> • *If a single condition is suspected, assign a code for the suspected condition*
>
> *…*

The guideline in ACS 0012 stating 'final diagnosis at discharge' is not intended to be interpreted as 'documented on the discharge summary' only. ACS 0012 guidelines apply to conditions that are suspected but not confirmed from the time they are documented in the health care record to the time of discharge.

Where 'dysuria ?UTI' is documented and antibiotics are administered for the '?UTI', but there is no clarifying documentation or evidence in the health care record to confirm or rule out an UTI, assign N39.0 *Urinary tract infection, site not specified.*

Follow the ICD-10-AM Alphabetic Index:

Infection, infected

- urinary (tract) NEC N39.0

Amendments will be considered for a future edition.

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for implementation 01 July 2023.

Ref No: Q3446 | Published On: 15-Jun-2023 | Status: Current

Therapeutic mammoplasty

Q:

What is the correct code to assign for therapeutic mammoplasty performed with excision of breast lesion?

A:

Therapeutic mammoplasty is an oncoplastic procedure that uses the principles of local tissue rearrangement with glandular re-approximation or manipulation at the site of the defect, in addition to other reconstructive procedures such as therapeutic mastopexy and reduction mammoplasty to reshape the breast (Molina et al. 2020, Aggarwal et al. 2016).

However, the term 'therapeutic mammoplasty' may also be used more broadly to describe or encompass a wider range of breast conserving surgery or reconstruction techniques that are determined by individual factors such as size and location of tumour and the tumour to breast size ratio.

Terms such as *crescent*, *batwing*, *hemibatwing* describe the operative technique (incisional shape) of the mammoplasty and do not affect code assignment.

The operation report should be used to assign appropriate codes for specified procedures such as (but not limited to) excision of lesion, mastopexy and reduction mammoplasty.

Clinical advice confirmed that for therapeutic mammoplasty without further specification, neither augmentation nor reduction mammoplasty should be assumed and clinical clarification sought.

Assign the following codes for an excision of lesion of breast performed with therapeutic mammoplasty (without further specification):

31500-00 **[1744]** *Excision of lesion of breast*

90720-00 **[1759]** *Other procedures on breast*

Follow the ACHI Alphabetic Index:

Excision

- lesion(s)

- - breast (complete) (local) (wide) 31500-00 **[1744]**

Procedure

- breast NEC 90720-00 **[1759]**

Amendments will be considered for a future edition.

References:

Aggarwal, S., Marla, S., Nyanhongo, D., Kotecha, S., & Basu, N.N. 2016, 'Current Practice of Therapeutic Mammaplasty: A Survey of Oncoplastic Breast Surgeons in England', *International journal of surgical oncology*, vol. 2016, 1947876.

Molina, B.J., Shelby, R.D., & Janis J.E. 2020, 'Key Areas for Development in Oncoplastic Breast Reconstruction', *Plastic and reconstructive surgery*. Global open, vol. 8, no.12, e3273.

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for implementation 01 July 2023.

Ref No: Q3672 | Published On: 15-Jun-2023 | Status: Supersedes Q3610

Thrombosis or embolism following insertion of cardiac or vascular device, implant or graft

Q:

What code(s) are assigned for thrombosis or embolism (eg vena cava thrombosis, deep vein thrombosis or pulmonary embolism) following cardiac or vascular implant or graft?

A:

Thrombosis or embolism are medical conditions that commonly occur postoperatively. Where these conditions arise following the use of cardiac or vascular devices (such as central or peripheral vascular catheters), they are not always solely related to the procedure or device but are related to the complex interaction between the disease process and the procedure (that is, the cause may be multifactorial).

ACS 1904 *Procedural complications* describes two types of relationships for conditions arising during or in the period following a procedure:

- the terms 'secondary to' or 'due to' infer a causal relationship
- terms such as 'intraoperative', 'post operative' or 'postprocedural' only infer timing of an event.

Where a thrombosis or embolism is specified as occurring after a prosthetic device, implant or graft procedure using terms that only indicate temporality (timing) such as ***following, intraoperative, post operative or postprocedural,*** it is not classified to categories T82-T85. The cause of the condition may be multifactorial, and in these circumstances a causal relationship cannot be assumed, it must be explicitly documented.

The *Excludes* note at T82.82 (also at T83.82, T84.82 and T85.84) further reflects this rationale in relation to embolism and thrombosis:

Excludes: *postprocedural:*

- *deep venous thrombosis (I80.-)*
- *pulmonary embolism (I26.-)*

Where a thrombosis or embolism is specified as **'due to'** or **'secondary to'** a procedure for cardiac and vascular device, implant or graft as a procedural complication, assign T82.82 *Embolism and thrombosis following insertion of cardiac and vascular prosthetic devices, implants and grafts*, except where directed elsewhere by the ICD-10-AM Alphabetic Index. Also assign an additional code from Chapters 1 to 18 where it provides further specificity regarding the condition/complication (ie identifying whether the condition is a thrombosis or an embolism) not the anatomical site alone.

EXAMPLE 1:

Pulmonary embolism (PE) due to insertion of cardiac and vascular device

Assign the following codes:

T82.82 *Embolism and thrombosis following insertion of cardiac and vascular prosthetic devices, implants and grafts* **and**

I26.0 *Pulmonary embolism with mention of acute cor pulmonale* **or**

I26.9 *Pulmonary embolism without mention of acute cor pulmonale*

Follow the ICD-10-AM Alphabetic Index:

Complication(s) (from) (of)

- vascular

- - device, implant or graft

- - - embolism T82.82

Embolism

- pulmonary (artery) (vein) I26.9

- - with acute cor pulmonale I26.0

Also assign external cause and place of occurrence codes.

A code from category I26.- *Pulmonary embolism* is assigned to provide further specificity of the condition (ie embolism with or without 'cor pulmonale') not the anatomical site alone.

Note: Do not apply the *Excludes* note at T82.82 where a PE has an established causal relationship due to the insertion of a device, implant or graft.

EXAMPLE 2:

Vena cava thrombus due to insertion of cardiac and vascular device

Assign T82.82 *Embolism and thrombosis following insertion of cardiac and vascular prosthetic devices, implants and grafts* for vena cava thrombus documented as **due to** a central or peripheral vascular catheter.

Follow the ICD-10-AM Alphabetic Index:

Complication(s) (from) (of)

- vascular

- - device, implant or graft

- - - thrombosis T82.82

Also assign external cause and place of occurrence codes.

T82.82 contains sufficient specificity regarding the complicating condition (ie embolism or thrombosis), therefore do not assign I82.2 *Embolism and thrombosis of vena cava* as it only provides specificity of the anatomical site.

EXAMPLE 3

Deep vein thrombosis (DVT) of lower limb following insertion of a vascular device

Assign the following code:

I80.20 *Phlebitis and thrombophlebitis of deep vessels of lower extremities, not elsewhere classified*

Follow the ICD-10-AM Alphabetic Index:

Thrombosis, thrombotic

- deep (lower extremity) NEC I80.20

If the lower leg DVT is specified as following a procedure it is not classified as a procedural complication of a cardiac or vascular device, implant or graft. The *Excludes* note at T82.82 supports this rationale and is applied (ie the timing of the DVT is 'postprocedural' but without an established causal relationship to a device, implant or graft).

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

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for implementation 01 July 2023.

Coding Rules

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Cannabis hyperemesis syndrome

Q:

What codes are assigned for cannabis hyperemesis syndrome?

A:

Cannabis hyperemesis syndrome is cyclical nausea and vomiting associated with chronic regular cannabis use. The symptoms are temporarily relieved by having hot baths with resolution of symptoms after cannabis cessation. Cannabis hyperemesis generally does not occur in patients taking medicinal cannabis (Arnold 2021; Sorensen et al. 2017).

Assign the following codes for cannabis hyperemesis syndrome:

R11 *Nausea and vomiting*

F12.1 *Mental and behavioural disorders due to use of cannabinoids, harmful use*

Follow the ICD-10-AM Alphabetic Index:

Hyperemesis *(see also Vomiting)* R11

Disorder (of)

- use

- - drug(s)

- - - cannabis, cannabinoids F12.-

(with fourth character .1 *harmful use* — see subdivisions in ICD-10-AM Tabular List block F10–F19).

In the absence of a single ICD-10-AM code to classify all the elements of cannabis hyperemesis syndrome also assign U91 *Syndrome, not elsewhere classified*, in accordance with the guidelines in ACS 0005 *Syndromes*.

Amendments will be considered for a future edition.

References:

Arnold, J.C. 2021, A primer on medicinal cannabis safety and potential adverse effects, *Australian Journal of General Practice*, vol. 50, no. 6, pp.345-350.

Sorensen, C.J., DeSanto, K., Borgelt, L., Phillips, K.T., & Monte, A.A. 2017, Cannabinoid Hyperemesis Syndrome: Diagnosis, Pathophysiology, and Treatment-a Systematic Review. *Journal of medical toxicology: official journal of the American College of Medical Toxicology*, vol.13, no.1, pp.71–87.

Published 16 March 2023,
for implementation 01 April 2023.

Ref No: Q3701 | Published On: 16-Mar-2023 | Status: Current

Clonidine and saline suppression tests

Q:

What codes are assigned for clonidine suppression test and saline suppression test?

A:

Clonidine suppression test is performed to diagnose phaeochromocytoma, paragangliomas and catecholamine producing tumours that cause paroxysmal or persistent hypertension. A baseline blood sample for plasma catecholamines is taken before clonidine is given orally. Increased levels of plasma catecholamines and their metabolites in follow up blood samples strongly suggest the presence of a phaeochromocytoma (RCPA 2019).

Saline suppression test is performed to diagnose primary aldosteronism where excessive amounts of aldosterone is secreted causing hypertension. A baseline blood sample for aldosterone and renin is taken before saline is administered intravenously. Post infusion plasma aldosterone levels are used to determine a diagnosis of primary hyperaldosteronism (Chrousos 2020).

Assign 92204-00 **[1866]** *Diagnostic tests, measures or investigations, not elsewhere classified* when either clonidine suppression test or saline suppression test is performed, in accordance with the guidelines in ACS 0042 *Procedures normally not coded* (ie when the test is the principal reason for admission in a same-day episode of care).

Follow the ACHI Alphabetic Index:

Test, testing (for) 92204-00 **[1866]**

Do not assign additional codes for components of the tests (such as collection of blood and drug administration) in accordance with the guidelines in ACS 0016 *General procedure guidelines*.

References:

Chrousos, G. P. 2020, *Hyperaldosteronism workup*, *Medscape*, viewed 10 November 2021, <https://emedicine.medscape.com/article/920713-workup#c6>.

The Royal College of Pathologists of Australasia (RCPA) 2019, *Clonidine suppression test*, viewed 31 January 2023, <https://www.rcpa.edu.au/Manuals/RCPA-Manual/Pathology-Tests/C/Clonidine-suppression-test>.

Published 16 March 2023,
for implementation 01 April 2023.

Ref No: Q3619 | Published On: 16-Mar-2023 | Status: Current

External cause code assignment for knocked over by a wave

Q:

What external cause code is assigned to classify knocked over (dumped) by a wave?

A:

There are many instances of injuries to beachgoers resulting from impacts due to plunging and dumping waves, either at the shore-break or on shallow sandbars, as well as impacts with board craft and other swimmers. Collectively, these incidents are known as surf zone injuries and can require extensive medical care, particularly in the case of severe spinal injuries (UNSW Beach Safety Research Group, 2020).

Unlike rip currents or deep water, which pose a risk of drowning, surf zone hazards can cause blunt trauma when beachgoers are hit by a wave and slammed into the sand. Injuries range from simple sprains to extremity fractures, blunt organ trauma and fractures of the cervical spine (University of Delaware, 2013).

Assign W16.0 *Diving or jumping into water striking or hitting bottom* where it is specified that the external cause of an injury was being knocked over (dumped) by a wave and striking the bottom.

Follow the ICD-10-AM Alphabetic Index Section II *External Causes of Injury*:

Striking against

- bottom (when jumping or diving into water) W16.0

Assign W16.2 *Diving or jumping into water striking or hitting water surface* for injuries specified as due to being ‘dumped’ or knocked over by a wave without mention of striking the bottom.

Follow the ICD-10-AM Alphabetic Index Section II *External Causes of Injury*:

Striking against

- water surface (with injury other than drowning or submersion) W16.2

Amendments will be considered for a future edition.

References:

University of Delaware 2013, *UDaily: Injured at the beach*, Newark, DE 19716, USA, viewed 31 January 2023, <https://www1.udel.edu/udaily/2013/jun/surf-zone-injuries-060313.html>.

UNSW Beach Safety Research Group 2020, *Surf Zone Injuries*, Sydney, Australia, viewed 31 January 2023, <https://www.beachsafetyresearch.com/surf-zone-injuries>.

**Published 16 March 2023,
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IHACPA

Ref No: Q3569 | Published On: 16-Mar-2023 | Status: Current

Iron deficiency anaemia with chronic normocytic anaemia

Q:

What codes are assigned for iron deficiency anaemia with chronic normocytic anaemia?

A:

Anaemia is the reduction in the quality of the oxygen carrying haemoglobin in the blood. There are many causes such as anaemias due to loss of blood (haemorrhagic anaemia), the lack of iron (iron deficiency anaemia), and the increased destruction of red blood cells (haemolytic anaemias). Anaemia can be classified based on the size of the red blood cells which may be large (macrocytic anaemia), small (microcytic anaemia) or normal sized (normocytic anaemia) (University of Oxford 2015).

Assign D64.9 *Anaemia, unspecified* to classify (chronic) normocytic anaemia NOS.

Follow the ICD-10-AM Alphabetic Index:

Anaemia

- normocytic (infection) D64.9

Assign D50.8 *Other iron deficiency anaemias* to classify iron deficiency anaemia **with** chronic normocytic anaemia. Do not assign D64.9 *Anaemia, unspecified* as an additional diagnosis code as it does not provide further specificity.

Follow the ICD-10-AM Alphabetic Index:

Anaemia

- iron deficiency
- - specified type NEC D50.8

References:

University of Oxford 2015, *Oxford Concise Medical Dictionary*, 9th edn, Oxford University Press, Oxford.

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Ref No: Q3687 | Published On: 16-Mar-2023 | Status: Current

Lumbar puncture headache following epidural or spinal anaesthesia

Q:

What code is assigned for lumbar puncture headache following epidural or spinal anaesthesia?

A:

A spinal (lumbar puncture) headache occurs when there is leakage of cerebrospinal fluid (CSF) (following lumbar or spinal puncture) from the needle insertion site, causing a change in CSF pressure (WebMD 2022). Spinal headaches are a fairly common complication in those who undergo a spinal tap or spinal anaesthesia, and most resolve on their own with no treatment (Mayo Clinic 2022).

Assign G97.11 *Headache following spinal and lumbar puncture* for lumbar puncture headache following an epidural or spinal anaesthesia.

Follow the ICD-10-AM Alphabetic Index:

Headache
- lumbar puncture G97.11

G97.1 *Reaction to spinal and lumbar puncture, not elsewhere classified* has the following *Excludes* note:

> ***Excludes:*** that due to anaesthesia (T88.5-)

This *Excludes* note does not apply to lumbar puncture headaches given they are caused by a change in CSF pressure and not the anaesthesia.

Assign Y84.8 *Other medical procedures as the cause of abnormal reaction, or of later complication, without mention of unintentional events at the time of the procedure* to identify that the external cause was the lumbar puncture procedure (ie not the anaesthesia).

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
- - specified Y84.8

Also assign a place of occurrence code.

Amendments will be considered for a future edition.

References:

Mayo Clinic 2022, *Spinal headaches*, viewed 31 January 2023, <https://www.mayoclinic.org/diseases-conditions/spinal-headaches/symptoms-causes/syc-20377913>.

WebMD 2022, *Spinal headaches*, viewed 31 January 2023, <https://www.webmd.com/migraines-headaches/pain-management-spinal-headaches>.

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Ref No: Q3677 | Published On: 16-Mar-2023 | Status: Current

Replacement of polyethylene liner of knee prosthesis

Q:

What code is assigned for replacement of polyethylene liner (poly liner) of a knee prosthesis?

A:

A total knee implant system (knee prosthesis) is made up of three components:

- femoral component
- polyethylene spacer/liner
- tibial component (AESCULAP Implant Systems 2022).

A polyethylene liner (poly liner) may require replacement for reasons such as infection, wear or tear.

Revision of a knee replacement involves removal of some or all parts of the original prosthesis and replacement with new ones (OrthoInfo 2021).

Where a component (eg poly liner) of a knee replacement is replaced, assign 49527-00 **[1524]** *Revision of arthroplasty of knee*.

Follow the ACHI Alphabetic Index:

Removal

- prosthesis, prosthetic device

- - knee (without replacement)

- - - with

- - - - revision of joint replacement (hemi) (total) 49527-00 **[1524]**

Amendments will be considered for a future edition.

References:

AESCULAP Implant Systems 2022, *Types of Knee Implants*, viewed 31 January 2023, <https://www.aesculapimplantsystems.com/en/patients/about-your-knee/types-of-knee-implants.html>.

OrthoInfo 2021, *Revision of total knee replacement*, viewed 31 January 2023, <https://orthoinfo.aaos.org/en/treatment/revision-total-knee-replacement>.

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Ref No: Q3734 | Published On: 16-Mar-2023 | Status: Current

Use of the terminology ‘related to’

Q:

Does the terminology ‘related to’ imply a causal relationship between conditions?

A:

The ACS 0010 *Clinical documentation and general abstraction guidelines* states:

> *Accurate clinical documentation is the responsibility of the treating clinician*
>
> …
>
> *Personnel undertaking the clinical coding process cannot presume diagnoses or conditions that are not supported by clinical documentation…*
>
> …
>
> *Seek clinical clarification if a causal relationship between two conditions is unclear in documentation for the episode of care.*

While the terminology ‘related to’ indicates a condition is co-morbid, it does not specify how conditions are related. For the purposes of classification, ‘related to’ cannot be used to assume a causal relationship unless the relationship is specified within ICD-10-AM (eg. transfusion related acute lung injury (TRALI)).

The World Health Organization guidelines for ICD-10 state that aetiology should be specified with terminology that indicates a causal relationship such as ‘due to’ or similar (WHO 2016).

Where a causal relationship is not stated by the clinician, and ICD-10-AM has not linked the conditions, a causal relationship cannot be assumed. However, those undertaking clinical coding must engage with clinicians to best understand the clinical documentation and to familiarise themselves with the terminology used by clinicians in their health service.

References:

World Health Organization (WHO) 2016, *International statistical classification of diseases and related health problems. 10th revision: Volume 2 Instruction manual, 4.3.4 Effect of connecting terms,* viewed 2 February 2023, <https://icd.who.int/browse10/Content/statichtml/ICD10Volume2_en_2019.pdf>.

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for implementation 01 April 2023.

Coding Rules

Published 15 December 2022

Ref No: Q3653 | Published On: 15-Dec-2022 | Status: Current

Admission for preoperative workup with no risk factors

Q:

What is the principal diagnosis in an admission for preoperative workup with no risk factors specified?

A:

Where there is an admission for preoperative (preop) work-up, but **no risk factors** are specified as the reason for the investigations, assign as principal diagnosis the condition that necessitated the admission (ie requires surgery) in accordance with ACS 0001 *Principal diagnosis*:

> *The principal diagnosis is defined as:*
>
> *"The diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care…"*

Assign additional diagnosis codes for any investigation findings, in accordance with ACS 0002 *Additional diagnoses.*

Scenario 1:

Patient with known liver cirrhosis admitted for pre-transplant work-up. Multiple systems are evaluated with no abnormalities found. Care included cardiology assessment and angiography, psychological assessment, dietary assessment and education, renal function tests.

Assign:

K74.6 *Other and unspecified cirrhosis of liver*

ACHI codes as appropriate.

Follow the ICD-10-AM Alphabetic Index:

Cirrhosis, cirrhotic (hepatic)

- liver (chronic) (hepatolienal) (hypertrophic) (nodular) (splenomegalic) K74.6

Scenario 2:

Patient with known cerebral aneurysm admitted for pre-op workup, including magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA) of the brain, digital subtraction technique (DSA) angiography, social work assessment (regarding accommodation for rural patient), and respiratory and renal function assessments.

Assign:

I67.1 *Cerebral aneurysm, nonruptured*

ACHI codes as appropriate.

Follow the ICD-10-AM Alphabetic Index:

Aneurysm

- brain I67.1

- cerebral — *see Aneurysm/brain*

See also Coding Rules *Principal diagnosis for prophylactic PEG insertion prior to oropharyngeal radiation therapy, Principal diagnosis for insertion of fiducial markers (use of Z51.4 Preparatory care for subsequent treatment, not elsewhere classified)* and *Brachytherapy planning*.

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Ref No: Q3590 | Published On: 15-Dec-2022 | Status: Current

Atrial and ventricular bigeminy

Q:

What codes are assigned for atrial and ventricular bigeminy?

A:

Bigeminy is a pattern of heart beats, where each normal heartbeat is followed by a beat that arrives too quickly. Where these early heartbeats originate from ventricles, they are known as premature ventricular contractions. If they originate in the atria, they're called premature atrial contractions (Healthline 2017). Premature atrial and ventricular contractions may also be known as ectopic beats (Simpson et al. 2017).

Clinical advice confirms that atrial and ventricular bigeminy are classified to category I49 *Other cardiac arrhythmias*.

Assign I49.1 *Atrial premature depolarisation* to classify atrial bigeminy.

Assign I49.3 *Ventricular premature depolarisation* to classify ventricular bigeminy.

Where bigeminy is not further specified assign I49.4 *Other and unspecified premature depolarisation*.

Follow the ICD-10-AM Alphabetic Index:

Ectopic, ectopia (congenital)

…

- beats I49.4

- - atrial I49.1

- - ventricular I49.3

Amendments will be considered for a future edition.

References:

Healthline 2017, *Bigeminy: What You Should Know*, viewed 11 November 2022, <https://www.healthline.com/health/bigeminy>.

Simpson, R.F.G., Langtree, J., & Mitchell, A.R.J. 2017, 'Ectopic Beats: How Many Count?', *European Medical Journal Cardiology*, viewed 11 November 2022, <https://www.emjreviews.com/cardiology/article/ectopic-beats-how-many-count/>.

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Ref No: Q3709 | Published On: 15-Dec-2022 | Status: Current

Cardiac implantable electronic devices

Q:

When is a status code for the presence of a cardiac implantable electronic device (such as a pacemaker or defibrillator) assigned?

A:

The development of complex cardiac implantable electronic devices (CIEDs) over the last two decades, has resulted in substantially improved life quality and survival for patients with cardiovascular disease. Despite the development of specific shielding of electronic devices, and a preference for device bipolar sensing, electromagnetic interference (EMI) may still occur with certain settings. Important medical sources of EMI include monopolar electrosurgery, bipolar electrosurgery, radiation therapy, radiofrequency ablation, magnetic resonance imaging and cardioversion/defibrillation (Boriani 2022, Ozkartal 2022).

Patients with CIEDs are at risk from EMI when undergoing certain procedures, as described above, requiring peri-operative assessment, monitoring and/or management of CIED function in procedure planning and implementation.

ACS 0002 *Additional diagnoses/Family and personal history, and certain conditions influencing health status* states:

> *Assign additional diagnosis codes for a personal or family history of diseases and disorders, or statuses (eg…) classified to the following blocks and categories when they are documented as being related to …an intervention being performed in the current episode of care:*
>
> *…*
>
> - *Certain conditions influencing health status (eg…, presence of, …): Z89, Z90, Z93–Z99*

The presence of CIED influences the health status of patients undergoing clinical interventions.

ACS 0016 *General procedure guidelines* state:

> *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 admitted patient care setting"*

Where an intervention is performed that meets the definition in ACS 0016 *General procedure guidelines,* assign Z95.0 *Presence of cardiac device* to identify that the patient's CIED function is at risk from intervention related EMI.

Where a CIED requires adjustment during the episode of care, apply the guidelines in ACS 0936 *Cardiac pacemakers and implanted defibrillators*.

References:

Steffel, J. 2022, 'Electromagnetic interference in pacemaker patients', *ESC CardioMed*. 3 edn ed. viewed 15 November 2022, <https://oxfordmedicine.com/view/10.1093/med/9780198784906.001.0001/med-9780198784906-chapter-466>.

Özkartal, T., Demarchi, A., Caputo, M., Baldi, E., Conte, G. & Auricchio, A. 2022, 'Perioperative Management of Patients with Cardiac Implantable Electronic Devices and Utility of Magnet Application', *Journal of clinical medicine*; vol. 11, no. 3, pp. 691.

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for implementation 01 January 2023.

Ref No: Q3460 | Published On: 15-Dec-2022 | Status: Current

Diathermy for control of haemorrhage due to minor liver laceration

Q:

What code is assigned for diathermy for control of haemorrhage due to minor liver laceration?

A:

Haemostasis is the process of blood clot formation at the site of vessel injury (Leung, L 2019). Diathermy is a technique that uses heat generated by high frequency electric currents, performed for interventions such as coagulation of bleeding vessels (Oxford Lexico UK Dictionary 2022).

Where a minor liver laceration occurred during a laparoscopic cholecystectomy and diathermy was used for control of haemorrhage (ie haemostasis), assign 90319-03 **[956]** *Other endoscopic procedures on liver.*

Follow the ACHI Alphabetic Index:

Procedure

- digestive system

- - liver

- - - endoscopic 90319-03 **[956]**

References:

Dictionary.com 2022, viewed 11 November 2022, <https://www.dictionary.com/browse/diathermy>.

Leung, L. 2019, *Overview of hemostasis*, viewed 11 November 2022, <https://www.uptodate.com/contents/overview-of-hemostasis?search=methods-to-achieve-hemostasis-in-&source=search_result&selectedTitle=2~150&usage_type=default&display_rank=2

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Ref No: Q3737 | Published On: 15-Dec-2022 | Status: Current

IPEX syndrome

Q:

What code is assigned for immunodysregulation polyendocrinopathy enteropathy X-linked (IPEX) syndrome?

A:

Immune dysregulation, polyendocrinopathy, enteropathy, X-linked (IPEX) syndrome is a rare disorder resulting from mutations in the FOXP3 gene which causes regulatory dysfunction in the T-cells and results in an autoimmune disorder (Barker 2022).

IPEX syndrome may manifest in enteropathy, chronic dermatitis, endocrinopathy and other organ-specific diseases such as anaemia, thrombocytopenia, hepatitis and nephritis and usually affects boys (Ben-Skowronek 2021).

ICD-10-AM does not have a unique code for IPEX syndrome. Polyglandular is a synonym for polyendocrine, therefore, assign E31.0 *Autoimmune polyglandular failure*.

Follow the ICD-10-AM Alphabetic Index:

Syndrome

- polyglandular

- - autoimmune E31.0

Amendments will be considered for a future edition.

References:

Barker, J. 2022, *IPEX Syndrome*, MSD Manual Professional version, viewed 24 November 2022, <https://www.msdmanuals.com/en-au/professional/endocrine-and-metabolic-disorders/polyglandular-deficiency-syndromes/ipex-syndrome>.

Ben-Skowronek, I. 2021, 'IPEX syndrome: genetics and treatment options', *Genes*, vol. 12, no. 3, pp.323.

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Ref No: Q3689 | Published On: 15-Dec-2022 | Status: Current

Loose orthopaedic devices, implants or prostheses

Q:

What code is assigned for loose orthopaedic devices, implants or prostheses, including internal fixation devices, metal ware and joint prostheses?

A:

When implanted orthopaedic devices such as internal fixation devices (eg pedicle screws) and joint prosthesis are subject to wear and tear or trauma, they get loose or displaced from their original fixed position. In joint replacement patients, continual repetitive movements of the implanted parts can cause small pieces of the joint prosthesis to break off. The presence of foreign prosthetic pieces generates an immune response resulting in bone destruction around the joint replacement causing the prosthesis to become separated from the bone and become loose (Della Valle 2016).

The term loose is synonymous with displacement or breakdown for orthopaedic devices, implants or prostheses, including internal fixation devices, metal ware and joint prostheses.

Assign a mechanical complication code from T84.0–T84.4 for loose orthopaedic devices, implants or prostheses, including internal fixation devices, metal ware and joint prostheses, in accordance with the *Includes* note listed at T82.0 *Mechanical complication of heart valve prosthesis*, which are applicable to codes in the range T84.0 – T84.4.

Follow the ICD-10-AM Alphabetic Index:

Displacement, displaced

- device, implant or graft *(see also Complication(s)/by site and type/mechanical)*

- - fixation, internal (orthopaedic) NEC T84.2

- - - bones of limb T84.1

…

- - joint prosthesis T84.0

…

- - orthopaedic NEC T84.4

- - - bone graft T84.3

Also assign external cause, place of occurrence and activity codes.

Amendments will be considered for a future edition.

References:

Della Valle, A.G. 2016, '*Revision Total Hip Replacement: Overview*', viewed 24 November 2022, <https://www.hss.edu/conditions_revision-total-hip-replacement-overview.asp>.

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IHACPA

Ref No: Q3593 | Published On: 15-Dec-2022 | Status: Current

Neutropenic colitis (typhlitis)

Q:

What codes are assigned for neutropenic enterocolitis?

A:

Neutropenic enterocolitis, also referred to as typhlitis, occurs mostly in patients with haematologic malignancies, other immunosuppressive causes such as acquired immune deficiency syndrome, therapy for solid tumours, and organ transplant (Xia & Zhang 2020). The pathophysiology of neutropenic enterocolitis is likely secondary to multiple underlying causes including the exposure to cytotoxic medications that disrupt the mucosal barrier, which allows bacterial translocation from the gut. Neutropenia further aggravates the risks, decreasing immunity with failure to control the transmural translocation of pathogens (Qasim & Nahas 2020).

Clinical advice confirms that neutropenic enterocolitis can be assumed to be of infectious origin and indicates a state of neutropenia.

ICD-10-AM does not have a specific code for neutropenic enterocolitis. Therefore, assign A09.0 *Other gastroenteritis and colitis of infectious origin* with D70 *Agranulocytosis* to classify neutropenic enterocolitis.

Follow the ICD-10-AM Alphabetic Index:

Enterocolitis

- infectious NEC A09.0

Neutropenia, neutropenic (congenital) (cyclic) (drug-induced) (periodic) (primary) (splenic) (toxic) D70

Where neutropenic enterocolitis is specified as an adverse effect of therapeutic drug use, apply the guidelines in ACS 1902 *Adverse effects*.

Amendments may be considered for a future edition.

References:

Qasim, A. & Nahas, J. 2020, *Neutropenic Enterocolitis (Typhlitis)*, National library of medicine, Bethesda, MD 20894, viewed 13 October 2022, https://www.ncbi.nlm.nih.gov/books/NBK551577/

Xia, R. & Zhang, X. 2020, 'Neutropenic enterocolitis: a clinico-pathological review', *World Journal of Gastrointestinal Pathophysiology*, vol. 10, no. 3, pp. 36–41.

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Ref No: Q3684 | Published On: 15-Dec-2022 | Status: Current

Open reduction and internal fixation (ORIF) of a pubic symphysis disruption/dislocation without fracture

Q:

What ACHI code is assigned for open reduction and internal fixation of a pubic symphysis disruption/dislocation without fracture?

A:

Open reduction and internal fixation (ORIF) of pubic symphysis disruption is performed for unstable pelvic ring injuries. Internal fixation devices such as reconstruction plates and screws are placed on each side to stabilise symphyseal disruption, prevent rotatory deformities and reduce pubic diastasis (Banerjee et al n.d.; Russell Jr 2020).

Assign 50106-00 **[1571]** *Joint stabilisation, not elsewhere classified* where an ORIF is performed for pubic symphysis disruption or dislocation without fracture.

Follow the ACHI Alphabetic Index:

Stabilisation

- joint 50106-00 **[1571]**

- - specified site NEC 50106-00 **[1571]**

Amendments will be considered for a future edition.

References:

Banerjee, R., Brink, P., Cimerman, M., Pohlemann, T. & Tomazevic, M. n.d. 'ORIF – Pubic symphysis plate, pubic symphysis fractures', in P. Trafton (ed.), *AO Foundation Surgery reference*, viewed 10 November 2022, <https://surgeryreference.aofoundation.org/orthopedic-trauma/adult-trauma/pelvic-ring/pubic-symphysis/orif-pubic-symphysis-plate>.

Russell Jr, G. V. 2020, *Pelvic fractures treatment & management*, Medscape, viewed 10 November 2022, <https://emedicine.medscape.com/article/1247913-treatment#d10>.

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for implementation 01 January 2023.**

Ref No: Q3745 | Published On: 15-Dec-2022 | Status: Current

Superficialisation of arteriovenous fistula

Q:

What principal diagnosis code is assigned for admission for superficialisation of an arteriovenous fistula?

A:

Superficialisation of arteriovenous (AV) fistula supports improved dialysis access and allows for prolonged utilization and more efficient dialysis treatment. In certain patient groups, such as obese patients or those with deep veins, superficialisation may be necessary to facilitate the repeated cannulation required for dialysis (Causey et al. 2010).

In brachiocephalic or brachiobasilic fistulas, superficialisation, or fistula elevation, involves an incision from the antecubital fossa to the proximal upper arm. Superficialisation is achieved through venous branch ligation and repositioning of subcutaneous fat relative to the fistula. Cannulation may commence in three to four weeks when the incision has healed (Krochmal et al. 2010).

Assign Z49.0 *Preparatory care for dialysis* for admission for superficialisation of an AV fistula.

Follow the ICD-10-AM Alphabetic Index:

Dialysis (intermittent) (treatment)

…

- preparatory care only (without treatment) Z49.0

Amendments will be considered for a future edition.

References:

Causey, M. W., Quan, R., Hamawy, A. & Singh, N. 2010, 'Superficialization of arteriovenous fistulae employing minimally invasive liposuction', *Journal of Vascular Surgery*, vol. 52, issue 5, pp.1397-1400.

Krochmal, D.J., Rebecca, A.M., Kalkbrenner, K.A., Casey, W.J., Fowl, R.J., Stone, W.M., Chapital, A.B., & Smith, A.A. 2010, 'Superficialization of deep arteriovenous access procedures in obese patients using suction-assisted lipectomy: A novel approach', *The Canadian Journal of Plastic Surgery*, vol. 18, no. 1, pp. 25-7.

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Coding Rules

Published 15 June 2022

Ref No: TN1598 | Published On: 15-Jun-2022 | Status: Supersedes TN1505

Abstraction from outside an episode of care for coding of diabetes mellitus

Q:

When can information located outside the episode of care used to add further specificity to a diabetes mellitus code?

A:

Sources of information outside an episode of care can be used to add specificity at the three character code level (E10–E14) for the type of diabetes mellitus. However, do not use these sources to assign codes for conditions, including diabetic complications, not already documented in the current episode of care.

The Australian Coding Standards (ACS) *Introduction* states:

> *Documentation within the current episode of admitted care is the primary source of information for the classification of admitted care morbidity data. Accurate classification is possible only after access to consistent and complete clinical information.*

ACS 0010 *Clinical documentation and general abstraction guidelines/Abstraction from other sources of information* provides guidance on:

- reasons to access other sources of information for classification purposes, such as where conditions documented in the current episode of care require further clarification or specificity
- health care record sources that may be used.

There are three specific guidelines that are exceptions to the general guidance for abstracting from other sources of information:

- discharge summaries encompassing more than one episode of care
- multiple same-day episodes for repeated treatments
- multiple episodes within an admitted patient stay.

Those undertaking the clinical coding function must only utilise information outside of the current episode of care in accordance with ACS 0010 *Clinical documentation and general abstraction guidelines*, or for one of the three exceptions to the general guidance.

Instructions in specialty standards such as ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia*, provide classification guidance on specialty areas but still operate within the confines of the guidance above, with regards to documentation within the current episode of care.

This information was previously published as an Eleventh Edition FAQ and has been amended for clarity.

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Ref No: TN1598 | Published On: 15-Jun-2022 | Status: Supersedes Q3062

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).

ACS 1904 *Procedural Complications/Sequelae* states:

> *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 T85.73 *Infection and inflammatory reaction due to gastrointestinal prosthetic devices, implants and grafts,* for recurrent wound infection due to mesh from a hernia repair, irrespective of whether the mesh is removed or retained.

Follow the ICD-10-AM Alphabetic Index:

Infection, infected (opportunistic)

- due to or resulting from

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

- - - gastrointestinal (bile duct) (oesophagus) T85.73

Also assign external cause of injury and place of occurrence codes.

This classification advice has been amended.

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.

Maheshwari, J. & Garg, K.M. 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.

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Ref No: TN1598 | Published On: 15-Jun-2022 | Status: Supersedes TN1505

Sequencing of complications following abortion, ectopic or molar pregnancy

Q:

Are there sequencing instructions for assigning Chapter 15 codes in obstetric episodes of care?

A:

There are no general sequencing instructions for Chapter 15 *Pregnancy, childbirth and the puerperium* codes, unless directed by an *Instructional* note in the ICD-10-AM Tabular List or an Australian Coding Standard.

ACS 1544 *Complications following abortion and ectopic and molar pregnancy/Complications following abortion* 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 is assigned as an additional diagnosis, not the principal diagnosis.

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Vacuum assisted closure (VAC) dressings

Q:

How many times is a code for VAC dressing assigned in an episode of care?

A:

Assign a code for vacuum assisted closure (VAC) dressing **once** per episode, unless a subsequent VAC dressing is undertaken in theatre, under cerebral anaesthesia. In such cases, assign the additional VAC dressing as many times as performed under cerebral anaesthesia.

See also ACS 0042 *Procedures normally not coded* and ACS 0031 *Anaesthesia.*

This information was previously published as an Eleventh Edition FAQ.

Published 15 June 2022,
for implementation 01 July 2022.

Coding Rules

Published 15 March 2022

Ref No: Q3692 | Published On: 15-Mar-2022 | Status: Updated | Updated On: 15-Jun-2022

Administration of nebulised antineoplastic agent

Q:

What code is assigned for administration of a nebulised antineoplastic agent?

A:

Nebulised pharmacotherapy with antineoplastic drugs is used in the treatment of lung cancers (Islam & Richard 2019).

Assign 96205-00 **[1920]** *Other administration of pharmacological agent, antineoplastic agent* for antineoplastic agents administered through inhalation by nebulised droplets or powder aerosols.

Follow the ACHI Alphabetic Index:

Pharmacotherapy (systemic effect)

- for

- - neoplasm (antineoplastic) (chemotherapeutic) (prophylaxis) — *code to block* [1920] *with extension -00*

- specified NEC 96205 **[1920]**

Amendments will be considered for a future edition.

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

References:
Islam, N. & Richard, D. 2019, 'Inhaled micro/nanoparticulate anticancer drug formulations: an emerging targeted drug deliver strategy for lung caners', *Current cancer drug targets*, vol. 19, no. 3, pp. 162-178(17).

Ref No: Q3649 | Published On: 15-Mar-2022 | Status: Current

Diabetes mellitus with dyslipidaemia characterised by elevated non-fasting triglycerides

Q:

Is it acceptable to use elevated non-fasting triglycerides to inform the assignment of *diabetes mellitus or intermediate hyperglycaemia with features of insulin resistance*?

A:

Non-fasting triglyceride levels for the assessment of lipid status have been in use internationally since the European Atherosclerosis Society and the European Federation of Clinical Chemistry and Laboratory Medicine released a joint consensus statement in 2016 that recommended the routine use of non-fasting specimens (Douglass Hanly Moir Pathology 2016).

In a clinical setting it has been acceptable to use non-fasting triglyceride levels of ≥ 1.7mmol/L (≥ 150 mg/dL) in a patient on drug treatment for elevated triglycerides as a criteria for diagnosis of insulin resistance syndrome (Driver et al. 2016; Harris 2013 & Lab Tests Online 2016).

Therefore, it is acceptable to use either elevated fasting or non-fasting triglycerides to inform the assignment of E11.72, E13.72, E14.72 **diabetes mellitus with features of insulin resistance* or E09.72 *Intermediate hyperglycaemia with features of insulin* resistance, in accordance with the guidelines for diabetes mellitus and intermediate hyperglycaemia with features of insulin resistance within ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia*.

Amendments will be considered for a future edition of the Australian Coding Standards.

References:

Douglass Hanly Moir Pathology 2016, *New guidance for assessment of lipid status*, viewed 29 September 2021, <https://www.dhm.com.au/media/Multisite8425/dhm_information-for-clinicians_non-fasting-lipids_201611.pdf>.

Driver, S. L., Martin, S. S., Gluckman, T. J., Clary, J. M., Blumenthal, R. S. & Stone, N. J. 2016, 'Fasting or Nonfasting Lipid Measurements: It Depends on the Question', *Journal of the American College of Cardiology*, vol. 67, no. 10, pp. 127-1234.

Harris, M. F. 2013, 'The metabolic syndrome', *Australian Family Practice*, vol. 42, no. 8, pp. 524-527.

Lab Tests Online 2016, *Metabolic syndrome*, viewed 29 September 2021, <https://www.labtestsonline.org.au/learning/index-of-conditions/metabolic>.

Ref No: Q3656 | Published On: 15-Mar-2022 | Status: Current

Faecal loading

Q:

What code is assigned for faecal loading?

A:

Faecal loading is a poorly defined term that generally refers to the volume of faecal material in the colon. It is most commonly a complication of chronic or severe constipation where inspissated hard faeces accumulate in the distal gastrointestinal tract, most commonly the rectum (Baba & Knipe 2021).

Assign K59.0 *Constipation* for faecal loading not otherwise specified (NOS) (ie where there is no evidence of obstruction), in accordance with ACS 0002 *Additional diagnoses*.

Follow the ICD-10-AM Alphabetic Index:

Retention, retained

- faecal *(see also Constipation)* K59.0

Amendments will be considered for a future edition.

References:

Baba, Y. & Knipe, H. 2020, 'Faecal Impaction', *Radiopaedia.org*, viewed 8 October 2021, <https://radiopaedia.org/articles/faecal-impaction>.

Ref No: Q3669 | Published On: 15-Mar-2022 | Status: Current

Nonmalignant neoplastic polyps detected during screening for family history of malignant neoplasm

Q:

What codes are assigned when nonmalignant neoplastic polyps are detected during same-day endoscopic screening for family history of malignant neoplasm (eg colon cancer)?

A:

Where there is a family history of malignant neoplasm of the colon, rectum or colorectum, colonoscopy is performed to screen for malignant neoplasms, in situ neoplasms or nonmalignant neoplastic polyps such as tubular, tubulovillous or villous adenomas, or benign or adenomatous polyps, which may be pre-cancerous (ie neoplasm pre-cursors) (American Cancer Society 2017).

The guidelines in ACS 0052 *Same-day endoscopy – surveillance* state:

> *Assign as principal diagnosis:*
>
> - *the condition under surveillance (follow-up/screening) if detected at screening…*
>
> …
>
> - *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…*
>
> …
>
> *Assign as additional diagnosis:*
>
> - *any condition found at endoscopy that meets the criteria in ACS 0002* Additional diagnoses…
> - *an appropriate code from block Z80–Z99* Persons with potential health hazards related to family and personal history and certain conditions influencing health status *for any personal or family history as appropriate*

Therefore, for same-day colonoscopic screening for family history of malignant neoplasm, apply the guidelines from ACS 0052 and assign as principal diagnosis:

- a code from categories C18–C20 if a malignant colon, rectal or colorectal neoplasm is detected, **or**
- a code from Chapter 2 *Neoplasms* if an in situ neoplasm or nonmalignant neoplastic polyp (ie malignant neoplasm pre-cursor) is detected, **or**
- Z12.1 *Special screening examination for neoplasm of intestinal tract* for malignant colon, rectal or colorectal neoplasm or nonmalignant neoplastic polyp, where no disease is detected or has ever been detected.

Assign an additional diagnosis code for:

- any condition (eg hyperplastic or other polyp classified to subcategory K63.5 *Polyp of colon*) that meets the criteria in ACS 0002 *Additional diagnoses*

- family history of malignant neoplasm of the colon, rectum or colorectum, Z80.0 *Family history of malignant neoplasm of digestive organs.*

Reference:

American Cancer Society 2017, *Understanding your pathology report: colon polyps (sessile or traditional serrated adenomas)*, viewed 7 December 2021, <https://www.cancer.org/treatment/understanding-your-diagnosis/tests/understanding-your-pathology-report/colon-pathology/colon-polyps-sessile-or-traditional-serrated-adenomas.html>.

Ref No: Q3678 | Published On: 15-Mar-2022 | Status: Current

Wet dressings (wrappings)

Q:

What code is assigned for wet dressings (wrappings) for treatment of conditions such as eczema, dermatitis and blisters?

A:

Wet dressings (wrappings) can be applied for acute conditions such as eczema, dermatitis and blisters. This is when the application of moisturisers and topical corticosteroids are not able to control the condition. Wet dressings can be applied to a specific part of the body or the entire body. This can be done at hospital or in the home, for short periods of time (Sydney Children's Hospitals Network and HNEkidshealth, Children, Young People & Families 2021).

A code for wet dressings is not normally assigned in accordance with ACS 0042 *Procedures normally not coded, point 7 – Dressings/wound management*, but is assigned when:

- 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)

Assign 96092-00 **[1870]** *Application, fitting, adjustment or replacement of other assistive or adaptive device, aid or equipment* where wet dressings meets the guidelines in ACS 0042.

Follow the ACHI Alphabetic Index:

Dressing (to) NEC 96092-00 **[1870]**

Amendments will be considered for a future edition.

References:

Sydney Children's Hospitals Network and HNEkidshealth, Children, Young People & Families 2021, *Factsheet Eczema: Wet dressings*, viewed 9 November 2021, <https://www.schn.health.nsw.gov.au/files/factsheets/eczema_wet_dressing-en.pdf>.

Coding Rules

Published 15 December 2021

Ref No: Q3643 | Published On: 15-Dec-2021 | Status: Updated | Updated On: 15-Jun-2022

Debridement, antibiotic and implant retention

Q:

What code is assigned for debridement, antibiotic and implant retention (DAIR)?

A:

Debridement, antibiotic and implant retention (DAIR) is an intervention to treat prosthetic joint infection occurring after total joint replacement. The intervention consists of debridement, and removal of all infected tissues and synovial membrane, obtaining tissue specimens for microbiology testing and extensive irrigation with antibacterial solution. The prosthesis is retained while removable components such as polyethylene or acetabular liners are replaced (Barros et al. 2019; Qasim et al. 2017).

DAIR is considered as a revision of a total joint replacement and does not require separate codes for each component.

Where DAIR is performed following total hip replacement, assign 49324-00 **[1492]** *Revision of arthroplasty of hip*.

Where DAIR is performed following total knee replacement, assign 49527-00 **[1524]** *Revision of arthroplasty of knee*.

Follow the ACHI Alphabetic Index:

Revision

- joint replacement (prosthesis) (with removal of prosthesis)

- - hip 49324-00 **[1492]**

- - knee 49527-00 **[1524]**

Amendments will be considered for a future edition.

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

References:

Barros, L.H, Barbosa, T.A., Esteves, J., Abreu, M., Soares, D. & Sousa, R. 2019, 'Early debridement, antibiotics and implant retention (DAIR) in patients with suspected acute infection after hip or knee arthroplasty – safe, effective and without negative functional impact' *Journal of Bone and Joint Infection*, vol. 4, no. 6, pp. 300-305, viewed 15 September 2021, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6960028/>.

Qasim, S.N., Swann, A. & Ashford, R. 2017, 'The DAIR (debridement, antibiotics and implant retention) procedure for infected total knee replacement – a literature review', *SICOT-J*, vol. 3, no. 2, viewed 15 September 2021, <https://www.sicot-j.org/articles/sicotj/full_html/2017/01/sicotj150138/sicotj150138.html>.

Ref No: Q3753 | Published On: 15-Dec-2021 | Status: Updated | Updated On: 15-Jun-2022

Monoclonal antibodies for treatment of COVID-19

Q:

What codes are assigned for monoclonal antibodies administered as treatment for COVID-19 in a same-day episode of care?

A:

Where treatment is provided for coronavirus disease 2019 (COVID-19), assign the relevant ICD-10-AM codes for COVID-19 in accordance with ACS 0113 *Coronavirus disease 2019 (COVID-19)*.

Monoclonal antibodies (mAbs) are developed in a laboratory and are designed to mimic or enhance the body's natural immune system response against an invader, such as cancer or an infection (Lloyd et al. 2021).

Sotrovimab is a type of mAbs which has been developed for the treatment of mild to moderate COVID-19 (VTAG 2021).

Assign ACHI codes for administration of mAbs in accordance with the guidelines in ACS 0042 *Procedures normally not coded.*

When mAbs are administered for the treatment of COVID-19 as the principal reason for admission in a same-day episode of care, assign a code from block **[1920]** *Administration of pharmacotherapy* with extension -02 *Anti-infective agent* where antiviral agents are an *Inclusion* term.

Follow the ACHI Alphabetic Index:

Administration

- type of agent

- - anti-infective — *code to block* **[1920]** *with extension -02*

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

References:

Lloyd, E. C., Gandhi, T. N., & Petty, L. A., 2021, 'Monoclonal Antibodies for COVID-19', *JAMA Network*, vol. 325, no. 10, pp.1015. <https://jamanetwork.com/journals/jama/fullarticle/2776307>.

Victorian therapeutics advisory group (VTAG) 2021, *Use of Sotrovimab in adults with COVID-19*, viewed 01 December 2021, <https://www.victag.org.au/1.-PATIENT-INFORMATION_use-of-Sotrovimab_in-COVID-19_V1.1_9Sept21_pdf_.pdf>.

Ref No: Q3631 | Published On: 15-Dec-2021 | Status: Current

Traumatic subdural hygroma

Q:

What code is assigned for traumatic subdural hygroma?

A:

Traumatic subdural hygroma is a collection of cerebrospinal fluid (CSF) within the subdural space. Traumatic subdural haematoma is a collection of blood or blood products in the subdural space. Head injury can cause a separation of the dura-arachnoid interface resulting in subdural hygroma. While most subdural hygromas resolve, they can progress to become chronic subdural haematomas or both conditions can occur simultaneously with varying degrees of blood, bloody CSF or clear CSF present in the subdural space (Almenzalawy et al. 2019; Lee 2009).

Traumatic subdural hygroma is classified to S06.8 *Other intracranial injuries*.

Follow the ICD-10-AM Alphabetic Index:

Injury (traumatic)

- intracranial

- - specified NEC S06.8

Also assign external cause, place of occurrence and activity codes.

Amendments will be considered for a future edition.

References:

Almenzalawy, M.A., Essa, A.E.A., Ragab, M.H. 2019, 'Subdural hygroma: Different treatment modalities and clinical outcome.', *Open Journal of Modern Neurosurgery*, vol. 9, no. 3, pp. 208-220, viewed 9 September 2021, <https://www.scirp.org/journal/paperinformation.aspx?paperid=92269>.

Lee, K.S. 2009, 'The pathogenesis and clinical significance of traumatic subdural hygroma', *Brain Injury*, vol. 12, issue 7, pp. 595-603, viewed 9 September 2021, <https://doi.org/10.1080/026990598122359>.

Coding Rules

Published 15 September 2021

Ref No: Q3705 | Published On: 15-Sep-2021 | Status: Current

Subarachnoid haemorrhage (SAH) of the posterior inferior cerebellar artery (PICA)

Q:

What code is assigned for subarachnoid haemorrhage of the posterior inferior cerebellar artery?

A:

The posterior inferior cerebellar artery (PICA) is an intracranial artery.

Assign I60.6 *Subarachnoid haemorrhage from other intracranial arteries* for subarachnoid haemorrhage of the PICA.

Follow the ICD-10-AM Alphabetic Index:

Haemorrhage, haemorrhagic

- subarachnoid (nontraumatic)

- - from

- - - intracranial artery

- - - - specified NEC I60.6

Amendments will be considered for a future edition.

Coding Rules

Published 15 June 2021

Ref No: Q3657 | Published On: 15-Jun-2021 | Status: Current

Abrasion or blister of the elbow

Q:

What codes are assigned for abrasion or blister of the elbow?

A:

Injuries of the elbow are classified in ICD-10, and hence ICD-10-AM, with injuries of the forearm in block S50–S59 *Injuries to the elbow and forearm.*

Forearm is the general term/site; elbow is a specific site of the forearm.

Superficial injuries of the elbow are either subcategories of injuries of forearm (eg S50.0 *Contusion of elbow*), or classified the same (eg S50.88 *Other superficial injuries of forearm*, S50.9 *Superficial injury of forearm, unspecified*).

Therefore, assign:

- S50.81 *Abrasion of forearm* for abrasion of the elbow
- S50.82 *Blister of forearm* for blister of the elbow

Follow the ICD-10-AM Alphabetic Index:

Abrasion *(see also Injury/superficial)*

- forearm S50.81

Blister *(see also Injury/superficial)*

- forearm S50.82

Amendments will be considered for a future edition.

Ref No: Q3685 | Published On: 15-Jun-2021 | Status: Updated | Updated On: 15-Jun-2022

Adhesions divided during caesarean section without labour

Q:

What ICD-10-AM codes are assigned for pelvic adhesions, divided during caesarean section?

A:

Classification guidelines in ACS 1506 *Fetal presentation, disproportion and abnormality of maternal pelvic organs* state:

> *Where care and/or intervention is required due to malpresentation, disproportion or abnormality of maternal pelvic organs during labour and/or delivery, regardless of when the condition is first diagnosed, assign a code from blocks O64–O66…*

ACS 1500 *Diagnosis sequencing in obstetric episodes of care* states:

> *Assign a code from another chapter where it adds specificity to the Chapter 15 code, or as per any Instructional notes.*

ACS 1521 *Conditions and injuries in pregnancy* states:

> *Assign as an additional diagnosis a code from another chapter to add specificity to the Chapter 15 code.*

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.

Assign N73.6 *Female pelvic peritoneal adhesions* as an additional diagnosis code for specificity.

Follow the ICD-10-AM Alphabetic Index:

Adhesions, adhesive (postinfective)

- pelvic, pelvis *(see also Adhesions/peritoneum)*

- peritoneum, peritoneal (male)

- - female pelvic (postpartal) (to uterus) N73.6

- - - affecting

- - - - labour or delivery O65.5

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

Ref No: Q3519 | Published On: 15-Jun-2021 | Status: Current

Amniotic membrane graft or transplantation

Q:

What is the correct code assignment for amniotic membrane graft or transplant used in the treatment of corneal and conjunctival disorders?

A:

The amniotic membrane (AM) is the inner layer of the fetal membrane and has been shown to have anti-microbial, anti-inflammatory, anti-fibrotic and anti-angiogenic properties (Malhotra & Jain 2014). AM has the potential to inhibit corneal neovascularisation and promote corneal re-epithelialisation.

Amniotic membrane transplant (AMT) is used for the treatment of ocular surface disorders when the integrity has been disrupted due to surgery, diseases or chemicals (Medical Services Advisory Committee 2020). Common ophthalmic indicators for AMT include infectious keratitis, corneal perforation, cicatricial conjunctivitis and limbal stem cell deficiency (Ting et al. 2020). Prokera Slim® is a brand of cryopreserved amniotic membrane (cAM) used for the treatment of corneal ulcers (Brocks et al. 2020).

The classification of amniotic membrane transplant differs according to the ocular site being treated:

- In the treatment of corneal disease assign 90064-00 **[173]** *Other keratoplasty*

  Follow the ACHI Alphabetic Index:

  Keratoplasty 90064-00 **[173]**

- In the treatment of conjunctival disease assign 90093-00 **[255]** *Conjunctivoplasty*

  Follow the ACHI Alphabetic Index:

  Conjunctivoplasty 90093-00 **[255]**

Amendments to ACHI will be considered for a future edition.

References:

Brocks, D., Mead, O., G., Tighe, S. & Tseng, S., C., G. 2020, 'Self-Retained Cryopreserved Amniotic Membrane for the Management of Corneal Ulcers', *Clinical Ophthalmology,* vol. 14, pp. 1437–43, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7266945/>.

Malhotra, C. & Jain, A. K. 2014, 'Human amniotic membrane transplantation: Different modalities of its use in ophthalmology', *World Journal of Transplantation*, vol. 4, no. 2, pp. 111–21, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4094946/>.

Ting, D. S. J., Henein, C., Said, D. G. & Dua, H. S. 2020, 'Effectiveness and safety of early adjuvant amniotic membrane transplant versus standard antimicrobial treatment for infectious keratitis: a systematic review protocol', *JBI Evidence Synthesis,* vol. 18, no. 8, pp. 1808–14, <https://journals.lww.com/jbisrir/FullText/2020/08000/Effectiveness_and_safety_of_early_adjuvant.16.aspx>.

Ref No: Q3502 | Published On: 15-Jun-2021 | Status: Current

Amniotic stem cell infusion

Q:

What is the correct code assignment for amniotic stem cell infusion?

A:

Human amniotic epithelial cells (hAESCs) are placental stem cells derived from the epithelial layer of the amnion (Qiu et al. 2020). They have been widely utilised in regenerative medicine due to their ability to differentiate into a number of cell types without the risk of tumorigenesis (Loukogeorgakis & De Coppi 2016). Preclinical studies have shown that hAESCs are effective for treatment of gastrointestinal, hematopoietic, cardiovascular, nervous, respiratory and urinary diseases (Loukogeorgakis & De Coppi 2016).

Assign 14203-01 **[1906]** *Direct living tissue implantation* for infusion of amniotic stem cells.

Follow the ACHI Alphabetic Index:

Implant, implantation

- living tissue

- - by

- - - direct implantation 14203-01 **[1906]**

Amendments may be considered for a future edition.

References:

Loukogeorgakis, S. P. & De Coppi, P. 2016, 'Concise Review: Amniotic Fluid Stem Cells: The Known, the Unknown, and Potential Regenerative Medicine Applications', *Stem cells*, vol. 35, no. 7, <https://stemcellsjournals.onlinelibrary.wiley.com/doi/full/10.1002/stem.2553#:~:text=The%20amniotic%20fluid%20is%20an,the%20field%20of%20regenerative%20medicine.&text=Emerging%20evidence%20from%20experimental%20models,human%20tissue%20repair%20and%20regeneration.>.

Qiu, C., Ge, Z., Cui, W., Yu, L. & Li, J. 2020, 'Human Amniotic Epithelial Stem Cells: A Promising Seed Cell for Clinical Applications.' *International Journal of Molecular Sciences*, vol. 21, no. 20, viewed 22 April 2021, <https://pubmed.ncbi.nlm.nih.gov/33086620/#:~:text=Multiple%20stem%20cell%20types%20have,cellular%20therapy%20and%20clinical%20application>.

Ref No: Q3520 | Published On: 15-Jun-2021 | Status: Current

Autoimmune necrotising myopathy

Q:

What is the correct code assignment for autoimmune necrotising myopathy?

A:

Autoimmune necrotising myopathy is a rare form of inflammatory myopathy characterised clinically by necrotic muscle fibres with absent or minimal inflammation (Khan et al. 2017).

Assign G72.4 *Inflammatory myopathy, not elsewhere classified* for autoimmune necrotising myopathy.

Follow the ICD-10-AM Alphabetic Index:

Myopathy

- inflammatory NEC G72.4

References:

Khan, N., Khalid, S., Ullah, S., Malik, M., U. & Makhoul, S. 2017, 'Necrotizing Autoimmune Myopathy: A Rare Variant of Idiopathic Inflammatory Myopathies', *Journal of Investigative Medicine High Impact Case Reports*, vol. 5, no. 2, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5476327/>.

Ref No: Q3637 | Published On: 15-Jun-2021 | Status: Current

Biceps tenodesis performed with a shoulder reconstruction

Q:

Is a biceps tenodesis considered a component of a shoulder reconstruction or should it be classified separately?

A:

Biceps tenodesis is performed to repair a tear or tendinopathy of the biceps tendon, whereas a shoulder reconstruction repairs shoulder instability where the structures surrounding the shoulder joint become overstretched or injured (Coastal orthopaedics n.d.). The shoulder joint is stabilised by the rotator cuff tendons and muscles, the bursa and the labrum (a cuff of cartilage) (Huffman 2019). However, instability of the shoulder joint can impact on and damage the biceps tendon (Kiritsis 2020).

Biceps tenodesis is not a component of a shoulder reconstruction and so when performed together assign an appropriate code for the shoulder reconstruction with an additional code for the biceps tenodesis as follows:

47963-01 **[1572]** *Tenoplasty, not elsewhere classified*

Follow the ACHI Alphabetic Index:

Tenodesis NEC 47963-01 **[1572]**

Amendments will be considered for a future edition.

References

Coastal orthopaedics (n.d.), *Shoulder reconstruction*, viewed 3 May 2021, <http://www.coastalorthopaedics.com.au/shoulder-reconstruction-coastal-orthopaedics.html>.

Hoffman, M. (2019), *Human anatomy*, WebMD, viewed 3 May 2021, <https://www.webmd.com/pain-management/picture-of-the-shoulder>.

Kiritsis, P. (2020), *Knee and Shoulder Specialist – Orthopedic Surgery*, viewed 3 May 2021, <https://www.kneeandshouldersurgery.com/shoulder-disorders/>.

Erickson, B.J., Jain, A., Cvetanovich, G.L., Nicholson, G.P., Cole, B.J., Romeo, A.A., & Verma, N.N. (2017), 'Biceps Tenodesis: An Evolution of Treatment', *Am J Orthop (Belle Mead NJ)*, Vol. 46, no. 4, E219-E223, viewed 3 May 2021, <https://pubmed.ncbi.nlm.nih.gov/28856351/>.

Ref No: Q3668 | Published On: 15-Jun-2021 | Status: Current

Dilation of ileal (anastomotic) 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).

Ileocolic anastomotic stricture 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).

As there is currently no ACHI code for endoscopic dilation of an ileal stricture, where this procedure is performed via a colonoscopy, assign 32094-00 **[917]** *Endoscopic dilation of colorectal stricture* as a best fit.

Amendments will 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>.

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>.

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>.

Ref No: Q3554 | Published On: 15-Jun-2021 | Status: Current

Goniosynechialysis

Q:

What is the correct code assignment for goniosynechialysis?

A:

Peripheral anterior synechiae (PAS) is a condition in which the iris permanently adheres to the angle, which obstructs the aqueous outflow through the trabecular meshwork, contributing to the increase of intraocular pressure (IOP) (Lee et al. 2021; Lee et al. 2006). Goniosynechialysis (GSL) is the procedure where the PAS is stripped from the angle wall to restore the aqueous outflow (Lai 2013).

Assign 42761-00 **[186]** *Division of synechiae or corneovitreal adhesions* for GSL.

Follow the ACHI Alphabetic Index:

Division

- synechiae

- - corneovitreal (laser) 42761-00 **[186]**

- - iris (anterior) (laser) (posterior) 42761-00 **[186]**

Amendments will be considered for a future edition.

References:

Lai, J. 2013, 'The Role of Goniosynechialysis in the Management of Chronic Angle-Closure Glaucoma', *Asia-Pacific Journal of Ophthalmology*, vol. 2, no. 5, pp. 277-78, <https://journals.lww.com/apjoo/fulltext/2013/09000/the_role_of_goniosynechialysis_in_the_management.1.aspx>.

Lee, J. Y., Kim, Y. Y., & Jung, H. R. 2006, 'Distribution and characteristics of peripheral anterior synechiae in primary angle-closure glaucoma', *Korean Journal of Ophthalmology*, vol. 20, no. 2, pp. 104–108, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2908823/>.

Lee, T. E., Yoo, C. & Kim, Y. Y. 2021, 'The effects of peripheral anterior synechiae on refractive outcomes after cataract surgery in eyes with primary angle-closure disease', *Medicine*, vol. 100, no. 14, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8036052/>.

Ref No: Q3667 | Published On: 15-Jun-2021 | Status: Current

Intrauterine balloon device for adhesion prevention

Q:

What code is assigned for insertion of an intrauterine balloon stent (eg Bakri® balloon) for Asherman's syndrome?

A:

Asherman's syndrome, also known as intrauterine adhesions or intrauterine synechiae, occurs when adhesions (scar tissue) form inside the uterus (Smikle et al. 2021).

Insertion of a device into the uterus (eg intrauterine balloon stent, Foley catheter, intrauterine device) is an option for re-adhesion prevention in Asherman's syndrome (Doroftie et al. 2020).

Bakri® balloon is an intrauterine balloon stent that is mainly used to treat postpartum haemorrhage, but may be used for uterine adhesion prevention. When inflated with sterile liquid, the device applies pressure to the uterine walls (Cook Medical 2020).

Where an intrauterine balloon device (eg Bakri® balloon) is inserted for adhesion prevention in Asherman's syndrome, assign 35503-00 **[1260]** *Insertion of intrauterine device [IUD]* as a best fit.

Follow the ACHI Alphabetic Index:

Insertion

- intrauterine device (IUD) 35503-00 **[1260]**

Amendments will be considered for a future edition.

References:

Cook Medical 2020, *Bakri® Postpartum balloon with rapid instillation components,* viewed 3 February 2021, <https://www.cookmedical.com/data/resources/RH-D58385-EN-F_M3_1607453195285.pdf>.

Doroftie, B., Dabuleanu, A., Ilie, O., Maftei, R., Anton, E., Simionescu, G., Matei, T., & Armeanu, T. 2020, 'Mini-Review of the New Therapeutic Possibilities in Asherman Syndrome—Where Are We after One Hundred and Twenty-Six Years?', *Diagnostics*, 10(9), 706, viewed 8 April 2021, <https://doi.org/10.3390/diagnostics10090706>.

Smikle, C., Yarrarapu, S.N.S., Khetarpal, S. 2021, *Asherman syndrome,* StatPearls Publishing LLC., National Center for Biotechnology Information, U.S. National Library of Medicine, viewed 8 April 2021, <https://www.ncbi.nlm.nih.gov/books/NBK448088/>.

Ref No: Q3670 | Published On: 15-Jun-2021 | Status: Current

Isolated pulmonary capillaritis

Q:

What code is assigned for isolated pulmonary capillaritis?

A:

Isolated (pauciimmune) pulmonary capillaritis is a small vessel vasculitis restricted to the lungs that may induce diffuse alveolar haemorrhage with dyspnoea, anaemia, chest pain, haemoptysis, bilateral and diffuse alveolar infiltrates, without any underlying systemic disease (Orphanet 2012).

Assign J84.8 *Other specified interstitial pulmonary diseases* for isolated pulmonary capillaritis.

Follow the ICD-10-AM Alphabetic Index:

Disease, diseased

- lung

- - interstitial

- - - specified NEC J84.8

Amendments will be considered for a future edition.

References:

Orphanet 2012, *Isolated pulmonary capillaritis*, viewed 20 April 2021, <https://www.orpha.net/consor/cgi-bin/OC_Exp.php?lng=en&Expert=264691>.

Ref No: Q3636 | Published On: 15-Jun-2021 | Status: Current

Laryngopharyngeal reflux (LPR)

Q:

What code is assigned for laryngopharyngeal reflux (LPR)?

A:

Laryngopharyngeal reflux (LPR) (also known as silent reflux) occurs when dysfunction of oesophageal sphincters permits gastric contents (acid) to travel up the oesophagus into the upper airway (ie larynx and pharynx), resulting in inflammation. Symptoms include voice problems, cough, throat clearing or a lump in the throat (Melbourne Voice Analysis Centre n.d.; WebMD 2020).

While LPR is a distinct entity to gastro-oesophageal reflux disease (GORD), the underlying mechanism is the same as GORD; that is, retrograde passage of gastric contents beyond the upper oesophageal sphincter (Fraser-Kirk 2017).

Therefore, assign K21.9 *Gastro-oesophageal reflux disease without oesophagitis* for laryngopharyngeal reflux NOS (not otherwise specified).

Follow the ICD-10-AM Alphabetic Index:

Reflux

- gastro-oesophageal K21.9

Amendments will be considered for a future edition.

References:

Fraser-Kirk, K. 2017 'Laryngopharyngeal reflux: A confounding cause of aerodigestive dysfunction', *Australian Family Physician*, Volume 46, No.1, January/February 2017 Pages 34-39, viewed 4 May 2021, <https://www.racgp.org.au/afp/2017/januaryfebruary/laryngopharyngeal-reflux-a-confounding-cause-of-aerodigestive-dysfunction/>.

Melbourne Voice Analysis Centre (n.d) *Laryngopharyngeal reflux*, viewed 4 May 2021, <https://mvac.com.au/laryngopharyngeal-reflux/>.

WebMD. 2020 *Laryngopharyngeal reflux (Silent reflux),* viewed 4 May 2021, <https://www.webmd.com/heartburn-gerd/guide/laryngopharyngeal-reflux-silent-reflux>.

Ref No: Q3665 | Published On: 15-Jun-2021 | Status: Current

Proopiomelanocortin (POMC) deficiency

Q:

What is the correct code assignment for proopiomelanocortin (POMC) deficiency?

A:

Proopiomelanocortin (pro-opiomelanocortin) (POMC) deficiency is a rare congenital genetic disorder. POMC deficiency is characterised by severe obesity due to hyperphagia from excessive hunger (during the first year and throughout life), and low levels of adrenocorticotropic hormone (ACTH) which may lead to adrenal insufficiency (GARD 2015; Graves et al. 2021).

To classify POMC, assign a code from subcategory E66.9- *Obesity, not elsewhere classified.* Note that fifth character 0 is assigned for patients less than 18 years of age.

Follow the ICD-10-AM Alphabetic Index:

Obesity (morbid) (simple) E66.9-

Amendments will be considered for a future edition.

References:

Genetic and Rare Diseases Information Center (GARD) 2015, *Proopiomelanocortin deficiency*, viewed 20 April 2021, <https://rarediseases.info.nih.gov/diseases/10823/proopiomelanocortin-deficiency>.

Graves, L.E., Khouri, J.M., Kristidis, P. & Verge, C.F. 2021, 'Proopiomelanocortin deficiency diagnosed in infancy in two boys and a review of the known cases', *Journal of Paediatrics and Child Health*, volume 57, issue 4, pages 484-490, viewed 20 April 2021, <https://onlinelibrary.wiley.com/doi/full/10.1111/jpc.15407>.

Coding Rules

Published 16 March 2021

Ref No: Q3624 | Published On: 16-Mar-2021 | Status: Updated | Updated On: 15-Jun-2022

Characteristics of left ventricular failure

Q:

What code is assigned for heart failure preserved ejection fraction (HFpEF), heart failure with reduced ejection fraction (HFrEF) and heart failure mid range ejection fraction (HFmrEF)?

A:

The terms systolic heart failure, diastolic heart failure, HFpEF, HFrEF and HFmrEF refer to nomenclature that describes specific characteristics of left ventricular failure (American Heart Association 2017; Atherton et al. 2018; Nadar & Tariq 2018).

Where systolic heart failure, diastolic heart failure, HFpEF, HFrEF or HFmrEF (without mention of congestion) is documented, assign I50.1 *Left ventricular failure*.

Follow the ICD-10-AM Alphabetic Index:

Failure, failed

- ventricular

- - left I50.1

For heart failure that is not further specified by clinical documentation, assign I50.9 *Heart failure, unspecified*.

Follow the ICD-10-AM Alphabetic Index:

Failure, failed

- heart (acute) (senile) (sudden) I50.9

See also Coding Rule *Congestive cardiac failure (CCF) and left ventricular failure (LVF)*.

Amendments will be considered for a future edition.

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

References:

American Heart Association 2017, *Types of heart failure*, American Heart Association, viewed 24 July 2020, https://www.heart.org/en/health-topics/heart-failure/what-is-heart-failure/types-of-heart-failure.

Atherton, J.J., Sindone, A., De Pasquale, C.G., Driscoll, A., MacDonald, P.S., Hopper, I., Kistler, P.M., Briffa, T., Wong, J., Abhayaratna, W., Thomas, L., Audehm, R., Newton, P., O'Loughlin, J., Branagan, M. & Connell, C. 2018, 'National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand: Guidelines for the prevention, detection, and management of heart failure in Australia 2018', *Heart, Lung and Circulation*, vol. 27, issue 10, pp. 1123–1208, viewed 24 July 2020, https://doi.org/10.1016/j.hlc.2018.06.1042.

Nadar, S.K. & Tariq, O. 2018, 'What is heart failure with mid-range ejection fraction? A new subgroup of patients with heart failure', *Cardiac Failure Review*, vol. 4, no. 1, pp. 6–8, viewed 24 July 2020, https://doi.org/10.15420/cfr.2018:7:2.

Published 16 March 2021,
for implementation 01 April 2021.

Ref No: Q3625 | Published On: 16-Mar-2021 | Status: Updated | Updated On: 15-Jun-2022

Delirium superimposed on dementia

Q:

What codes are assigned for dementia with delirium?

A:

Where a specified type of dementia (eg vascular dementia) is documented with delirium, assign F05.1 *Delirium superimposed on dementia*.

Follow the ICD-10-AM Alphabetic Index:

Dementia

- with

- - delirium or acute confusional state F05.1

Also assign a code for the type of dementia in accordance with the *Instructional* note at F05.1:

Code also specific type of dementia.

For example, for vascular dementia not otherwise specified (NOS) assign F01.90 *Vascular dementia, unspecified, without mention of psychological or behavioural disturbance*.

Follow the ICD-10-AM Alphabetic Index:

Dementia

- vascular (of) F01.9-

Select the fifth character 0 from the subdivisions listed under category F01 *Vascular dementia,* to identify the absence of psychological or behavioural disturbance.

Where dementia without further specification is documented with delirium, do not assign a code from subcategory F03 *Unspecified dementia.*

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

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for implementation 01 April 2021.

Ref No: Q3612 | Published On: 16-Mar-2021 | Status: Updated | Updated On: 15-Jun-2022

Medicinal cannabis

Q:

What code is assigned for personal history of medicinal cannabis use?

A:

Medicinal cannabinoids include a variety of chemical compounds, some synthetic and some extracted from the cannabis plant, which have been developed for medical use (RANZCP 2020). In Australia and New Zealand medicinal cannabis products are prescription medicines (RANZCP 2020).

Medicinal cannabis is classified the same as other prescription medication.

ACS 0002 *Additional Diagnoses/Family and personal history, and certain conditions influencing health status* states:

> *Assign additional diagnosis codes for a personal or family history of diseases and disorders, or statuses (eg…) classified to the following blocks and categories, when they are related to a condition being managed or an intervention being performed in the current episode of care.*
>
> - *Family history of diseases and disorders: Z80, Z82–Z84*
> - *Personal history of diseases and disorders: Z85–Z88, Z91–Z92*
> - *Certain conditions influencing health status (eg acquired absence, presence of, dependence on): Z89, Z90, Z93–Z99.*

Where there is documentation of long term use of prescribed medicinal cannabis that meets the above criteria in ACS 0002 *Additional diagnoses/Family and personal history, and certain conditions influencing health status*, assign Z92.28 *Personal history of long term [current] use of other medicaments*.

Follow the ICD-10-AM Alphabetic Index:

Long

- term use (current) of

- - medicaments NEC Z92.28

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

References:

The Royal Australian and New Zealand College of Psychiatrists 2020, *Therapeutic use of medicinal cannabis products*, RANZCP, viewed 14 December 2020, https://www.ranzcp.org/files/resources/college_statements/clinical_memoranda/cm-medical-use-of-cannabinoids.aspx>.

Published 16 March 2021,
for implementation 01 April 2021.

Ref No: Q3640 | Published On: 16-Mar-2021 | Status: Current

Microglandular adenosis of cervix

Q:

What code is assigned for microglandular adenosis of cervix?

A:

Microglandular adenosis (also known as microglandular hyperplasia) is a pathological finding, described as localised non-neoplastic proliferation of endocervical glands (Goyal et al. 2017).

Where microglandular adenosis of the cervix is documented and meets the criteria for code assignment in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*, assign N87.9 *Dysplasia of cervix uteri, unspecified*.

Follow the ICD-10-AM Alphabetic Index:

Hyperplasia, hyperplastic

- cervix (basal cell) (endometrium) (polypoid) (uteri) (*see also Dysplasia/cervix*) N87.9

Amendments will be considered for a future edition.

References:

Goyal, A., Alperstein, S.A., & Hoda, R.S. 2017, 'Microglandular Hyperplasia, Cytological Findings', *Cytopathology. Encyclopedia of Pathology*, 2017 Edition, viewed 12 January 2021, https://doi.org/10.1007/978-3-319-33286-4_925>.

Published 16 March 2021,
for implementation 01 April 2021.

Ref No: Q3662 | Published On: 16-Mar-2021 | Status: Updated | Updated On: 15-Jun-2022

Septic miscarriage

Q:

What code is assigned for septic miscarriage?

A:

The medical definition of 'septic' relates to infection (Cambridge Dictionary n.d.; Shiel n.d.); however, septic is also an adjective that implies 'relating to or causing sepsis'.

In ICD-10-AM the term septic mostly describes an infection or inflammation in an organ or tissue (eg septic abscess, septic arthritis, septic colitis) and is not synonymous with sepsis, which has a specific definition and clinical criteria (Singer et al. 2016).

Septic miscarriage is described as spontaneous abortion complicated by uterine (pelvic) infection (Gaufberg 2016; Mayo Clinic Health Library 2019). The infection originates in the placental tissue and fetus and may spread to the uterus, blood or organs (Oliveira et al. 2020).

Where there is documentation of septic miscarriage, assign one of the following codes based on documentation in the health care record:

O03.0 *Spontaneous abortion, incomplete, complicated by genital tract and pelvic infection and sepsis*

O03.5 *Spontaneous abortion, complete or unspecified, complicated by genital tract and pelvic infection and sepsis*

Follow the ICD-10-AM Alphabetic Index:

Miscarriage — *see also Abortion/spontaneous*

Abortion (complete) (incomplete)

- spontaneous O03.-

- - complicated by — *see also Abortion/complicated by*

- - - genital tract and pelvic infection (complete) O03.5

- - - - incomplete O03.0

Assign additional diagnosis codes in accordance with the *Instructional* notes at O03 *Spontaneous abortion* (eg duration of pregnancy, infectious agent). Do not assign a code for sepsis (or severe sepsis or septic shock) unless sepsis or septic shock are explicitly documented.

See also ACS 1544 *Complications following pregnancy with abortive outcome*.

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

References:

Cambridge Dictionary n.d. *Septic*, Cambridge University Press, viewed 17 December 2020, https://dictionary.cambridge.org/dictionary/english/septic>.

Gaufberg, S. 2016 *Abortion complications*, Medscape WebMD, viewed 17 December 2020, https://emedicine.medscape.com/article/795001-overview>.

Mayo Clinic Health Library 2019, *Miscarriage*, NCH Healthcare System, Naples, United States, viewed 17 December 2020, https://www.nchmd.org/education/mayo-health-library/details/CON-20198833>.

Oliveira, C.N.T., Oliveira, M.T.S., Oliveira, H.B.M., Silva, L.S.C., Freire, R.S., Santos Junior, M.N., Oliveira, M.V., Timenetsky, J., Campos, G.B. & Marques, L.M. 2020, 'Association of spontaneous abortion and Ureaplasma parvum detected in placental tissue', *Cambridge University Press*, viewed 11 January 2021, https://www.cambridge.org/core/journals/epidemiology-and-infection/article/association-of-spontaneous-abortion-and-ureaplasma-parvum-detected-in-placental-tissue/F4851B09BE0EDDEACE141A2EE8312C28>.

Shiel, W. n.d. *Medical definition of septic*, MedicineNet, viewed 17 December 2020, https://www.medicinenet.com/septic/definition.htm.

Singer, M., Deutschman, C.S., Seymour, C.W., Shankar-Kari, M., Annane, D., Bauer, M., Bellomo, R., Bernard, G.R., Chiche, J-D., Coopersmith, C.M.; Hotchkiss, R.S., Levy, M.M., Marshall, J.C., Martin, G.S., Opal, S.M., Rubenfeld, G.D., van der Poll, T., Vincent, J-L. & Angus, D.C. 2016, 'The third international consensus definitions for sepsis and septic shock (Sepsis 3)', *Journal of the American Medical Association*, vol. 315, no. 8, pp. 801–810, viewed 17 December 2020, https://doi.org/10.1001/jama.2016.0287.

Published 16 March 2021,
for implementation 01 April 2021.

Ref No: Q3535 | Published On: 16-Mar-2021 | Status: Current

Upper respiratory tract infection with chronic obstructive pulmonary disease

Q:

What codes are assigned for an upper respiratory tract infection (URTI) and a history of chronic obstructive pulmonary disease (COPD) without specific documentation of exacerbation of the COPD?

A:

For patients admitted with an upper respiratory tract infection (URTI) and a documented history of chronic obstructive pulmonary disease (COPD) without documentation of exacerbation of the COPD, assign J06.9 *Acute upper respiratory infection, unspecified*.

Follow the ICD-10-AM Alphabetic Index:

Infection, infected (opportunistic)

- respiratory (tract) NEC

- - upper (acute) NEC J06.9

Assign U83.2 *Chronic obstructive pulmonary disease* as an additional diagnosis if COPD does not meet the criteria for code assignment in accordance with ACS 0002 *Additional diagnoses*.

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for implementation 01 April 2021.

Ref No: Q3608 | Published On: 16-Mar-2021 | Status: Current

Vulvoscopy

Q:

What code is assigned for vulvoscopy?

A:

A colposcope is a specialist microscope that allows for examination of cervix, vagina or vulva (Cancer Council NSW 2020). A vulvoscopy is a close-up examination of the vulva using a colposcope (Cancer Council NSW 2020), which differs to a 'colposcopy' which examines the cervical surface using a colposcope (Healthdirect 2020).

Vulvoscopy performed as a component of another gynaecological procedure is not coded. There is no specific ACHI code to classify vulvoscopy performed alone.

Therefore, where vulvoscopy is performed as a standalone intervention, assign 35500-00 **[1296]** *Gynaecological examination*.

Follow the ACHI Alphabetic Index:

Examination

- gynaecological 35500-00 **[1296]**

- - with any other gynaecological procedure — *omit code*

Amendments may be considered for a future edition.

References:

Cancer Council NSW 2020, *Tests for vulvar cancer 2020*, Cancer Council NSW, Woolloomooloo, viewed 14 December 2020, https://www.cancercouncil.com.au/vulvar-cancer/diagnosis/tests/.

Healthdirect 2020, *Colposcopy*, viewed 14 December 2020, https://www.healthdirect.gov.au/colposcopy.

Published 16 March 2021,
for implementation 01 April 2021.

Coding Rules

Published 18 December 2020

Ref No: Q3527 | Published On: 18-Dec-2020 | Status: Updated | Updated On: 15-Dec-2023

Chest masculinisation surgery for gender dysphoria

Q:

What principal diagnosis is assigned for a patient admitted for chest masculinisation surgery?

A:

Individuals who experience gender dysphoria feel discomfort because their body does not match their gender identity, and this can sometimes cause distress, anxiety and emotional pain. More importantly, gender dysphoria is not considered a mental illness or condition (Healthdirect Australia 2019).

Gender confirmation or affirmation surgery aims to transition individuals who experience gender dysphoria to the gender they identify most with.

Therefore, when a patient is admitted with gender dysphoria for a bilateral mastectomy and nipple graft (ie chest masculinisation surgery), assign Z41.1 *Other plastic surgery for unacceptable cosmetic appearance* as the principal diagnosis following the guidelines in ACS 1204 *Plastic surgery*.

Follow the ICD-10-AM Alphabetic Index:

Surgery

- plastic

- - cosmetic Z41.1

Also assign F64 *Gender incongruence.*

Amendments maybe considered for a future edition.

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

References:

Healthdirect Australia 2019, Gender confirmation surgery, Healthdirect Australia, viewed 2 March 2020, https://www.healthdirect.gov.au/gender-confirmation-surgery.

Published 18 December 2020,
for implementation 01 January 2021.

Ref No: Q3579 | Published On: 18-Dec-2020 | Status: Updated | Updated On: 15-Jun-2022

Clarification of nursing scope of practice and use of nursing documentation to inform code assignment

The Australian Coding Standards (ACS) Glossary states:

> ***Scope of practice***
>
> *Scope of practice is defined by the health service organisation, and is dependent on the practitioner operating within the bounds of their qualifications, education, training, current experience and competence, and within the capability of the facility or service in which they are working (The Commission 2015).*
>
> *Clinicians document clinical findings, decisions and actions in the health care record within the scope of their practice.*

The ACS 0010 *Clinical documentation and general abstraction guidelines/Clinical documentation* states:

> *Accurate clinical documentation is the responsibility of the treating clinician.*
>
> *Generally, documentation by medical or surgical clinicians is the primary source for classification purposes. However, documentation by other clinicians may also be used to inform code assignment or add specificity where the documentation is appropriate to the clinician's scope of practice (see Example 1).*

EXAMPLE 1:

- Malnutrition documented by a dietitian
- Poor diabetic control documented by a diabetes educator
- Pressure injuries documented by a registered nurse or clinical nurse wound specialist
- Postpartum haemorrhage documented by a midwife
- Dysphagia documented by a speech pathologist
- Lactation disorder documented by a lactation consultant

Note: This is not an exhaustive list.

It is impractical to define the scope of practice of every clinician, particularly nursing, because of the wide variability in practice across metropolitan and rural regions, jurisdictions, clinical settings and governance policies.

Ultimately, responsibility for documentation lies with the treating clinician. Nursing documentation is not precluded from informing code assignment. In particular, specialist nurses, midwives, diabetes educators, mental health nurses, lactation consultants and wound consultants will document within the scope of their practice, problems and conditions that may or may not be documented by the treating medical officer.

Nursing documentation has the potential to provide specificity but needs to be balanced against what is corroborated in the clinical episode as a whole and must not rely on patient completed forms.

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

Published 18 December 2020,
for implementation 01 January 2021.

Ref No: Q3507 | Published On: 18-Dec-2020 | Status: Current

Place of occurrence for adverse effect of drug

Q:

What place of occurrence code is assigned where there has been an adverse effect of a prescribed drug?

A:

The *Note* at Y92 *Place of occurrence* states:

> *The following category is for use with categories V00–Y89, to identify the place where the injury or poisoning (external cause) occurred.*

All prescribed drugs are considered to be prescribed within the health system, so where there is an adverse reaction from a drug prescription completed outside of the hospital network (ie through a GP), it is considered 'within' the health service area.

For an adverse effect of a prescribed drug, the place of occurrence code is assigned according to where the drug was prescribed (the health facility) not where the drug was administered or where the manifestation occurred, similar to a postoperative wound infection where the place of occurrence is the health facility and not the place where the manifestation is exhibited. Assign:

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

OR

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

Example 1

Patient prescribed and administered a new antihypertensive drug in hospital A, then transferred to hospital B. In hospital B the patient developed a rash, which the clinician assessed and diagnosed as an allergic reaction to the antihypertensive drug and ordered its discontinuation.

Assign place of occurrence code Y92.23 *Health service area, not specified as this facility.*

Follow the External Causes of Injury Alphabetic Index:

Place of occurrence of external cause

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

Example 2

Patient had been using a prescribed antihypertensive drug for a number of years and was admitted to hospital to investigate unrelated abdominal pain. Due to high blood pressure readings during the episode of care, the patient's antihypertensive drug was changed. The patient subsequently developed a rash that the clinician assessed and diagnosed as an allergic reaction to the new antihypertensive drug and ordered it to be discontinued.

Assign place of occurrence code Y92.24 *Health service area, this facility.*

Follow the External Causes of Injury Alphabetic Index:

Place of occurrence of external cause

- health service area

- - this facility Y92.24

Where a patient has presented to multiple facilities between initial prescription and commencement of a drug, assign a place of occurrence code based on where the drug was prescribed.

Amendments will be considered for a future edition.

Published 18 December 2020,
for implementation 01 January 2021.

Ref No: Q3515 | Published On: 18-Dec-2020 | Status: Current

Plantar plate injury and repair

Q:

What codes are assigned for a plantar plate injury and repair?

A:

The plantar plate is a fibrocartilaginous structure. Its distal attachment is the base of the proximal phalanx and medial and lateral attachments are the collateral ligaments (Baravarian 2016). It is the primary static stabiliser of the second metatarsophalangeal joint (MPJ) performing the main role in maintaining joint stability (Nery et al. 2015). Plantar plate tear is mainly caused by abnormally high pressure on the connected MPJ region (Baravarian 2016). A plantar plate repair reconstructs the anatomic structures to restore the normal alignment of the joint (Coughlin et al. 2011).

Assign S93.5 *Sprain and strain of toe(s)* for a plantar plate injury.

Follow the ICD-10-AM Alphabetic Index:

Sprain, strain (joint) (ligament)

- metatarsophalangeal S93.5

Also assign external cause, place of occurrence and activity codes, as applicable.

ACHI code assignment is determined by the specific procedure performed. For example, assign 50106-00 **[1571]** *Joint stabilisation, not elsewhere classified* where stabilisation of the MPJ is performed.

Follow the ACHI Alphabetic Index:

Stabilisation

- joint

- - specified site NEC 50106-00 **[1571]**

Where repair of the plantar plate without further specification is documented, assign:

90595-00 **[1579]** *Other procedures on musculoskeletal system, not elsewhere classified*

Follow the ACHI Alphabetic Index:

Procedure

- musculoskeletal NEC 90595-00 **[1579]**

Amendments will be considered for a future edition.

References:

Baravarian, B. 2016, 'Expert insights on treating plantar plate tears', *PodiatryToday*, vol. 29, no. 3, viewed 16 April 2020, https://www.podiatrytoday.com/expert-insights-treating-plantar-plate-tears.

Coughlin, M.J., Baumfeld, D.S. Nery, C. 2011, 'Second MTP joint instability: Grading of the deformity and description of surgical repair of capsular insufficiency.', *Physician and Sportsmedicine*, vol. 39, no. 3, pp. 132–141, viewed 16 April 2020, https://www.ncbi.nlm.nih.gov/pubmed/22030949.

Nery, C., Coughlin, M., Baumfeld, D., Mann, T.S. Catena, F. 2015, 'How to classify plantar plate injuries: parameters from history and physical examination', *Revista Brasileira de Ortopedia*, vol. 50, no. 6, pp. 720–728, viewed 16 April 2020, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4868080/#bib0150.

Published 18 December 2020,
for implementation 01 January 2021.

Ref No: Q3484| Published On: 18-Dec-2020 | Status: Current

Guedel airway and intubation

Q:

Is insertion of 'Guedel airway' coded as intubation?

A:

A Guedel airway (or oropharyngeal airway), is an airway adjunct commonly used during cardiopulmonary resuscitation (CPR) to maintain airway patency, or used in conjunction with intubation to prevent the endotracheal tube from being bitten (Moses 2020). Under these circumstances (ie CPR and endotracheal intubation), insertion of a Guedel airway is not coded in accordance with ACS 0042 *Procedures normally not coded* and ACS 1006 *Ventilatory support.*

A Guedel airway may sometimes be used for improvement of airway hygiene (eg to facilitate airway suctioning for sputum clearance). This is an expected or inherent part of the routine nursing care plan. Where a Guedel airway is used for airway suctioning, the procedure is not coded in accordance with ACS 0016 *General procedure guidelines*, which states:

> *Many procedures may meet the …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.*

Amendments will be considered for a future edition.

References:

Moses, S. 2020, Oropharyngeal airway, Family Practice Notebook, viewed 09 September 2020, https://fpnotebook.com/er/Procedure/OrphryngIArwy.

Saskatoon Health Region Nursing Practice Committee 2016, Airway – oropharyngeal insertion, maintenance, suction, removal, Saskatoon Health Region Nursing Practice Committee Policies and Procedures, viewed 09 September 2020, https://www.saskatoonhealthregion.ca/about/NursingManual/1159.pdf.

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Ref No: Q3564 | Published On: 18-Dec-2020 | Status: Updated | Updated On: 15-Jun-2022

Postpartum haemorrhage due to caesarean section, episiotomy or perineal laceration

Q:

What codes are assigned for postpartum haemorrhage due to caesarean section (incision), episiotomy or perineal laceration?

A:

Primary postpartum haemorrhage (PPH) is described as a condition characterised by excessive loss of blood within the first 24 hours after completion of the third stage of labour for a vaginal delivery, or after a caesarean section (WHO 2019).

Secondary PPH is described as a condition characterised by excessive loss of blood between 24 hours and 12 weeks after delivery (WHO 2019).

Causes of PPH include delivery by caesarean section, perineal tear and episiotomy (Royal College of Obstetricians and Gynaecologists 2016).

Assign one of the following codes for postpartum haemorrhage, based on clinical documentation:

O72.1 *Other immediate postpartum haemorrhage*

O72.2 *Delayed and secondary postpartum haemorrhage*

Follow the ICD-10-AM Alphabetic Index:

Haemorrhage, haemorrhagic

- postpartum (24 hours or less following delivery of placenta) NEC O72.1

- - delayed or secondary (more than 24 hours post delivery of placenta) O72.2

PPH due to caesarean section (incision) or episiotomy

In addition to the PPH code, where there is documentation that PPH is due to caesarean section (incision) or episiotomy, assign:

O90.8 *Other complications of the puerperium, not elsewhere classified*

Y83.8 *Other surgical operation*

Follow the ICD-10-AM Alphabetic Index Section I *Alphabetic index of disease and nature of injury*:

Complication(s) (from) (of)

- caesarean section wound (puerperal) NEC O90.8
- obstetric
- - surgical wound (puerperal) NEC O90.8

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

Complication(s) (delayed) (medical or surgical procedure) (of or following)

- surgical operation
- - specified NEC Y83.8

Also assign a place of occurrence code.

PPH due to perineal tear

In addition to the PPH code, where there is documentation that PPH is due to a perineal tear, assign a code from category O70 *Perineal laceration during delivery.*

Follow the ICD-10-AM Alphabetic Index:

Tear, torn (traumatic)

- perineum, perineal
- - during delivery NEC O70.9
- - - 1st degree O70.0
- - - 2nd degree O70.1
- - - 3rd degree O70.2
- - - 4th degree O70.3

See also ACS 1500 *Diagnosis sequencing in obstetric episodes of care*, ACS 1548 *Puerperal/postpartum condition or complication* and ACS 1551 *Obstetric perineal lacerations/grazes.*

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

References:

Royal College of Obstetricians and Gynaecologists 2016, Heavy bleeding after birth (postpartum haemorrhage), viewed 7 May 2020, https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/pregnancy/pi-heavy-bleeding-after-birth-postpartum-haemorrhage.pdf.

World Health Organization 2019, ICD-11 Mortality and Morbidity Statistics (MMS), WHO, viewed 7 May 2020, https://icd.who.int/dev11/l-m/en.

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Malignant pericardial effusion

Q:

What is the correct code to assign for malignant pericardial effusion?

A:

Malignant pericardial effusion is generally caused by tumours of the pericardium, are usually metastatic, and rarely primary pericardial tumours (Adler et al. 2015).

Malignant pericardial effusion due to primary neoplasm is classified to C38.0 *Malignant neoplasm of heart*. Malignant pericardial effusion due to secondary neoplasm of the pericardium is classified to C79.88 *Secondary malignant neoplasm of other specified sites*.

Follow the ICD-10-AM Alphabetic Index in the Table of Neoplasms at lead term *Neoplasm, neoplastic*:

	Malignant	
	Primary	**Secondary**
Neoplasm, neoplastic		
- pericardium.....	C38.0	C79.88

It is not appropriate to assign I31.3 *Pericardial effusion (noninflammatory)* as per the *Excludes* note at the beginning of Chapter 9 *Diseases of the circulatory system (I00–I99)* which states:

> ***Excludes**: neoplasms (C00–D48)*

Amendments will be considered for a future edition.

References:

Adler, Y., Charron, P., Imazio, M., Badano, L., Baron Esquivias, G., Bogaert, J., Brucato, A., Gueret, P., Klingel, K., Lionis, C., Maisch, B., Mayosi, B., Pavie, A., Ristic, A.D., Sabate Tenas, M., Seferovic, P., Swedberg, K. Tomkowski, W. 2015, '2015 ESC guidelines for the diagnosis and management of pericardial diseases: The task force for the diagnosis and management of pericardial diseases of the European Society of Cardiology (ESC), *European Heart Journal*, vol. 36, issue 42, pp. 2921–2964, viewed 28 August 2020, https://doi.org/10.1093/eurheartj/ehv318.

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Code assignment for a staged percutaneous coronary intervention (PCI) within four weeks of an acute myocardial infarction

Q:

What codes are assigned for a staged PCI within four weeks from the onset of an acute myocardial infarction?

A:

A staged percutaneous coronary intervention (PCI) may be planned for various reasons. One common clinical reason is following acute myocardial infarction (AMI) with multi-vessel coronary artery disease (CAD). The second stage of the PCI is performed for revascularisation of noninfarct arteries to achieve an optimal outcome when this is not possible in a single stage PCI (Zhou et al. 2017). A staged PCI may also be planned for non-clinical reasons such as the facility setting and administration (Spitzer et al. 2018). The time frame between the initial PCI and the subsequent PCI may vary significantly between facilities, ranging from weeks to months (Spitzer et al. 2018).

Where a patient is re admitted for a staged PCI or bypass graft following a recent AMI, select the principal diagnosis based on documentation in the clinical record and in accordance with ACS 0001 *Principal diagnosis*. In cases where CAD is documented as the indication for the PCI, assign a code for the CAD as principal diagnosis. Assign a code from category I21 *Acute myocardial infarction* as an additional diagnosis, if the admission is within 4 weeks (28 days) from onset of the AMI. This is consistent with the guidelines in ACS 0940 *Ischaemic heart disease/3. Acute myocardial infarction (I21)/Classification* that states:

> *Codes from category I21 Acute myocardial infarction should be assigned for a patient that is either admitted or transferred for treatment of the infarction within four weeks (28 days) or less from onset of the infarction.*

Amendments will be considered for a future edition.

References:

Li, Z., Zhou, Y., Xu, Q. Chen, X. 2017, 'Staged versus one-time complete revascularization with percutaneous coronary intervention in STEMI patients with multivessel disease: A systematic review and meta-analysis', PLOS One, vol. 12, no. 1, viewed 18 August, 2020, https://doi.org/10.1371/journal.pone.0169406.

Spitzer, E., McFadden, E., Vranckx, P., de Vries, T., Ren, B., Collet, C., Onuma, Y., Garcia Garcia, H.M., Lopes, R.D., Stone, G.W., Cutlip, D.E. Serruys, P.W. 2018, 'Defining staged procedures for percutaneous coronary intervention trials: A guidance document', JACC: Cardiovascular Interventions, vol. 11, no. 9, pp. 823–832, viewed 18 August 2020, https://www.jacc.org/doi/full/10.1016/j.jcin.2018.03.044.

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Cholestasis in pregnancy

Q:

What codes are assigned for cholestasis in pregnancy?

A:

Cholestasis is described as decreased or impaired secretion of bile (hepatocellular, metabolic, functional or nonobstructive cholestasis) or mechanical obstruction of bile flow, which clinically leads to retention of the constituents of bile (eg bilirubin and bile acids) in blood (Shah John 2020). Intrahepatic cholestasis (functional cholestasis) can be due to a disease involving the liver parenchymal cells and/or the intrahepatic bile ducts. Extrahepatic cholestasis (obstructive cholestasis) is due to excretory block outside of the liver, along with the extrahepatic bile ducts (Shah John 2020).

Obstetric cholestasis

Obstetric cholestasis (intrahepatic cholestasis of pregnancy (ICP)) is a cholestatic disorder characterised by pruritus with onset in the second or third trimester of pregnancy, elevated serum aminotransferases and bile acid levels, and spontaneous relief of signs and symptoms within two to three weeks after delivery. Genetic and hormonal factors, as well as environmental effects, may contribute to the pathogenesis of ICP (WHO 2020).

ACS 1521 *Conditions and injuries in pregnancy* states:

> *Chapter 15* Pregnancy, childbirth and the puerperium *lists codes for conditions that:*
>
> - *exclusively or predominantly occur only in a pregnant patient (ie obstetric conditions/complications).*
>
> *Assign codes for these conditions/complications that meet the criteria for assignment as per ACS 0001* Principal diagnosis*, ACS 0002* Additional diagnoses *and ACS 1500* Diagnosis sequencing in obstetric episodes of care.
>
> - *may occur in any patient, but may or may not cause complications in a pregnant patient (ie nonobstetric conditions/complications).*

Obstetric cholestasis is a condition that occurs exclusively in a pregnant patient.

Assign O26.6 *Liver disorders in pregnancy, childbirth and the puerperium* alone for obstetric cholestasis.

Follow the ICD-10-AM Alphabetic Index:

Cholestasis

- obstetric (intrahepatic) (nonobstructive) O26.6

or

Pregnancy

- complicated by
- - obstetric cholestasis (intrahepatic) (nonobstructive) O26.6

Do not assign K83.1 *Obstruction of bile duct* in addition to O26.6:

- Obstetric cholestasis is not clinically caused by obstruction of the bile duct.
- The *Instructional* note at O26.6 *(Use additional code (K70–K77) to identify specific liver disorder)* does not apply as K83.1 is not classified as a liver disorder (ie K70-K77).

Obstructive/extrahepatic cholestasis in pregnancy

Obstructive cholestasis is a nonobstetric condition that may complicate pregnancy. Assign multiple codes for nonobstetric cholestasis in accordance with the guidelines in ACS 1521:

- Assign a code from Chapter 15 *Pregnancy, childbirth and the puerperium* for a nonobstetric condition complicating pregnancy as per the *Alphabetic Index* (eg *Pregnancy/complicated by* or *condition/in pregnancy or condition/in pregnancy, childbirth or puerperium)*
- Assign as an additional diagnosis a code from another chapter to add specificity to the Chapter 15 code.

Therefore, where a pregnant patient is admitted with cholestasis and documentation indicates that it is due to obstruction of the (extrahepatic) bile ducts, assign:

O99.6 *Diseases of the digestive system in pregnancy, childbirth and the puerperium*

K83.1 *Obstruction of bile duct*

Follow the ICD-10-AM Alphabetic Index:

Cholestasis (extrahepatic) (obstructive) NEC K83.1

- in pregnancy, childbirth or puerperium NEC (intrahepatic) O99.6

Where it is unclear from documentation if cholestasis in a pregnant patient is obstructive (nonobstetric) or is intrahepatic (obstetric ie is caused exclusively by the pregnancy), seek clinical clarification. When clinical advice is unavailable, assign O26.6 alone.

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

References:

Shah, R. John, S. 2020, 'Cholestatic jaundice', StatPearls, viewed 14 July 2020, https://www.ncbi.nlm.nih.gov/books/NBK482279/.

World Health Organization (WHO) 2020, Intrahepatic cholestasis of pregnancy, ICD 11 Foundation, viewed 14 July 2020, https://icd.who.int/dev11/f/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f1576251337.

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Inflammatory bowel disease

Q:

What code is assigned for inflammatory bowel disease (of unknown aetiology)?

A:

ICD-11 Mortality and Morbidity Statistics (MMS) includes a category for inflammatory bowel disease (IBD), described as 'a group of inflammatory conditions of the intestine of unknown aetiology', and classifies specific types including Crohn disease, ulcerative colitis and indeterminate colitis. Indeterminate colitis is described as:

> *a chronic inflammatory disorder of the colon, for which a definitive diagnosis of neither Crohn's disease or ulcerative colitis can be made (WHO 2020).*

IBD unclassified and IBD NOS (not otherwise specified) are synonymous terms for indeterminate colitis (Odze 2015).

Where there is documentation of IBD, assign:

- a code from category K50 *Crohn's disease [regional enteritis]* OR
- a code from category K51 *Ulcerative colitis* OR
- K52.3 *Indeterminate colitis*

Assign K52.3 *Indeterminate colitis* for unspecified inflammatory bowel disease.

Follow the ICD-10-AM Alphabetic Index:

Colitis (acute) (catarrhal) (haemorrhagic) *(see also Enteritis)*
- indeterminate K52.3

References:

Odze, R.D. 2015, 'A contemporary and critical appraisal of "indeterminate colitis"', Modern Pathology, vol. 28, pp. S30–S46, viewed 30 September 2020,https://www.nature.com/articles/modpathol2014131.

World Health Organization (WHO) 2020, Inflammatory bowel diseases, viewed 30 September 2020, https://icd.who.int/dev11/l-m/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f598093212.

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Thrombophlebitis due to central vein catheter (CVC) or intravenous catheter (IVC)

Q:

What codes are assigned for thrombophlebitis due to central vein catheter (CVC) or intravenous catheter (IVC)?

A:

In accordance with the guidelines in ACS 1904 *Procedural complications*, where a complication is related to a prosthetic device, implant or graft, assign a code from block T82–T85. Also assign an additional code from Chapters 1 to 18 where it provides further specificity regarding the condition/complication. **Do not** assign an additional code from Chapters 1 to 18 to provide specificity for the anatomical site alone.

Assign:

- T82.74 *Infection and inflammatory reaction due to central vascular catheter* for thrombophlebitis due to central vein catheter (CVC) **or**
- T82.75 *Infection and inflammatory reaction due to peripheral vascular catheter* for thrombophlebitis due to (peripheral) intravenous catheter (IVC)
- a code from category I80 *Phlebitis and thrombophlebitis* to provide specificity regarding the inflammatory reaction
- Y84.8 *Other medical procedures*
- Y92.23 *Health service area, not specified as this facility* **or** Y92.24 *Health service area, this facility*

Follow the ICD-10-AM Alphabetic Index Section I *Alphabetic index of diseases and nature of injury*:

Complication(s) (from) (of)

- vascular

- - device, implant or graft

- - - infusion catheter

- - - - infection or inflammation

- - - - - central vascular (infusion port) (PICC) (Port-A-Cath) T82.74

- - - - - peripheral vascular T82.75

See lead term *Thrombophlebitis/by site*, for example:

Thrombophlebitis

- specified site NEC I80.8

- upper extremity NEC I80.40

- - antecubital I80.41

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

Complication(s) (delayed) (medical or surgical procedure) (of or following)

- catheterisation Y84.8

Place of occurrence of external cause

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

- - this facility Y92.24

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

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Coding Rules

Published 21 September 2020

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Coding of withdrawal in specialist detoxification units

Q:

Some specialist detoxification units do not assign codes for both dependence and withdrawal, unless the withdrawal is 'clinically significant to require medical support or treatment'. Is this a correct interpretation of the guidelines in ACS 0503 *Drug, alcohol and tobacco use disorders*?

A:

Withdrawal or detoxification may result after reducing or stopping use of drugs and alcohol or undertaking certain behaviours like gambling (Alcohol and Drug Foundation n.d.; Healthdirect 2020). The process of withdrawal may be attributed to harmful use or dependence and the symptoms can vary in severity (Alcohol and Drug Foundation n.d.; Batra et al. 2016; Healthdirect 2020).

ACS 0503 *Drug, alcohol and tobacco use disorders* states:

> *Cases of dependence (syndrome) with withdrawal should be assigned both a code for the dependence (syndrome) and a code for the withdrawal (syndrome) because withdrawal is not always a feature of dependence (syndrome). Dependence is syndromal (a cluster of phenomena) and withdrawal is only one nonessential criteria for dependence.*

Therefore, where both dependence (syndrome) and withdrawal are documented in an episode of care, assign codes from block F10–F19 *Mental and behavioural disorders due to psychoactive substance use* with four character extensions .2 *dependence syndrome* and .3 *withdrawal state* or .4 *withdrawal state with delirium*.

Sequence codes as per the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*.

References:

Alcohol and Drug Foundation n.d., *Withdrawal*, viewed 26 August 2020, https://adf.org.au/reducing-risk/withdrawal/.

Batra, A., Muller, C.A., Mann, K. & Heinz, A. 2016, 'Alcohol dependence and harmful use of alcohol', *Deutsches Arzteblatt International*, vol. 113, no. 17, pp. 301–210, viewed 26 August 2020, DOI:10.3238/arztebl.2016.0301.

Healthdirect 2020, *Addiction withdrawal symptoms*, viewed 26 August 2020, https://www.healthdirect.gov.au/addiction-withdrawal-symptoms.

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Allergens and anaphylaxis

Q:

When assigning codes for anaphylactic reactions, are codes for the symptoms or manifestations of the reaction also assigned?

A:

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).

Where a patient is admitted for anaphylaxis or anaphylactic shock, in addition to an appropriate code for the anaphylaxis or anaphylactic shock:

- Assign codes for symptoms of the anaphylactic reaction classified to Chapter 18 *Symptoms signs and abnormal clinical and laboratory findings* in accordance with ACS 0001 *Principal diagnosis/Codes for symptoms, signs and ill-defined conditions* and ACS 0002 *Additional diagnoses/Symptoms, signs and ill-defined conditions* that state:

  ***ACS 0001* Principal diagnosis**

  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.*

  ***ACS 0002* Additional diagnoses**

  Care should be taken when assigning codes for symptoms, signs and ill-defined conditions from Chapter 18 Symptoms, signs and abnormal clinical and laboratory findings as additional diagnoses. Clinical coders should ensure they meet the additional diagnosis criteria in their own right.

- Assign codes for manifestations of the anaphylactic reaction classified to other chapters (eg bronchospasm) in accordance with ACS 0002 *Additional diagnoses*.

Where documentation is unclear and a clinical coder cannot determine if a symptom is significant in its own right, or a manifestation meets the criteria in ACS 0002, seek clinician advice.

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

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Lower respiratory tract infection (LRTI) with presence of chronic obstructive pulmonary disease (COPD)

Q:

What code is assigned for LRTI in a patient with COPD, where the presence of COPD does not meet the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*?

A:

For patients admitted with a lower respiratory tract infection (LRTI) in the presence of chronic obstructive pulmonary disease (COPD) that does not meet the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*, assign J44.0 *Chronic obstructive pulmonary disease with acute lower respiratory infection*.

Follow the ICD-10-AM Alphabetic Index:

Infection, infected (opportunistic)

- respiratory (tract) NEC

- - lower (acute) J22

Follow the *Excludes* note at block J20–J22 *Other acute lower respiratory infections*:

***Excludes*:** chronic obstructive pulmonary disease with acute:

…

lower respiratory infection (J44.0)

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Anaphylaxis due to bee sting

Q:

What codes are assigned for anaphylaxis due to bee sting?

A:

Where there is documentation of anaphylaxis due to bee sting, assign:

T63.4 *Toxic effect of venom of other arthropods* first, followed by

T78.2 *Anaphylaxis and anaphylactic shock, unspecified*

Y37.61 *Allergy to bees*

Follow the ICD-10-AM Alphabetic Index Section I *Alphabetic index of diseases and nature of injury*:

Bee sting (with allergic or anaphylactic shock) T63.4

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

Allergen, allergic reaction
- bees Y37.61

Follow also:

The *Instructional* note at category T63 *Toxic effect of contact with venomous animals*:

> *Use additional code (T78.2) to identify anaphylaxis and anaphylactic shock.*

The *Instructional* note at T78.2:

> *Use additional external cause code (Y37.-) to identify allergen*

Also assign a place of occurrence code.

Amendments will be considered for a future edition.

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

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Influenza with lower respiratory tract infection (LRTI)

Q:

What codes are assigned for influenza with LRTI?

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.*

Influenzal means pertaining to influenza (ie 'with' influenza), therefore, where the respiratory condition or associated manifestation is linked to influenza not otherwise specified (NOS) it classifies to category J11 *Influenza, virus not identified*.

Where there is documentation of lower respiratory tract infection with influenza NOS, assign J11.1 *Influenza with other respiratory manifestations, virus not identified*.

Follow the ICD-10-AM Alphabetic Index:

Infection, infected

- respiratory (tract)

- - influenzal *(see also Influenza)* J11.1

See also Coding Rule *Lower respiratory tract infection (LRTI) with presence of chronic obstructive pulmonary disease (COPD)*.

Amendments will be considered for a future edition.

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Ref No: Q3524 | Published On: 21-Sep-2020 | Status: Current

Radionecrosis of the brain

Q:

What codes are assigned for radionecrosis of the brain?

A:

Radionecrosis of the brain occurs when brain tissue dies due to an adverse effect of radiotherapy.

Assign:

I67.8 *Other specified cerebrovascular diseases*

Y84.2 *Radiological procedure and radiotherapy*

Place of occurrence code.

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

Necrosis, necrotic, necrotising (ischaemic)
- brain I67.8
- radiation — *see Necrosis/by site*

ICD-10-AM Alphabetic Index Section II *External cause of injury*:

Complication(s) (delayed) (medical or surgical procedure) (of or following)
- radiological procedure or therapy Y84.2

Amendments will be considered for a future edition.

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Ref No: Q3591 | Published On: 21-Sep-2020 | Status: Current

Drug-induced hepatitis

Q:

What code is assigned for drug-induced hepatitis?

A:

Noninfectious hepatitis (ie noninfectious inflammatory liver disease) is classified in ICD-10 and ICD-10-AM to block K70–K77 *Diseases of liver*.

The term ‘toxic hepatitis’ is synonymous with ‘chemical- or drug-induced’ hepatitis.

Chemical- or drug-induced hepatitis (acute, chronic or unspecified) is classified to category K71 *Toxic liver disease*:

K71.2 *Toxic liver disease with acute hepatitis*

K71.3 *Toxic liver disease with chronic persistent hepatitis*

K71.4 *Toxic liver disease with chronic lobular hepatitis*

K71.5 *Toxic liver disease with chronic active hepatitis*

K71.6 *Toxic liver disease with hepatitis, not elsewhere classified*

Assign K71.6 *Toxic liver disease with hepatitis, not elsewhere classified* for drug-induced hepatitis NOS (not otherwise specified).

Follow the ICD-10-AM Alphabetic Index:

Hepatitis

- toxic *(see also Disease/liver/toxic)* K71.6

Assign an external cause code from Chapter 20 to identify the drug, if known. See ICD-10-AM Section III *Table of drugs and chemicals*.

Assign also place of occurrence and activity codes.

Amendments will be considered for a future edition.

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Ref No: Q3573 | Published On: 21-Sep-2020 | Status: Updated | Updated On: 15-Jun-2022

Excision of mesh following vaginal or urethral erosion

Q:

What codes are assigned for excision of mesh following vaginal or urethral erosion?

A:

Mesh erosion involving the urethra is a serious complication and may require corrective surgery depending on the extent of the erosion. Therefore, assign ACHI codes in accordance with the procedure(s) performed and documented.

Follow the ACHI Alphabetic Index:

Excision

- mesh (prosthetic)

- - abdominal approach (open) (pelvis, pelvic) 35585-01 **[989]**

- - - laparoscopic 35585-00 **[989]**

- - vaginal approach 35581-00 **[1282]**

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

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Airvo™ device for high flow therapy

Q:

What code is assigned when there is documentation of Airvo™ use for high flow therapy?

A:

The Airvo™ system is a device that features a humidifier capable of delivering high flows of air/oxygen mixtures to spontaneously breathing patients via a variety of interfaces (Fisher Paykel Healthcare n.d.). The device can deliver flows of up to 60 L/minute.

Where documentation states that a high flow therapy device, such as Airvo™, is used for respiratory support and delivered via high flow nasal cannula, assign an appropriate code from block **[570]** *Noninvasive ventilatory support*.

A code for high flow therapy cannot be assigned based on delivery flow rates alone, due to variability in practice and patient requirements. Documentation must indicate 'high flow therapy' or 'high flow nasal cannula' to access an appropriate lead term, in order to be classified to block **[570]** *Noninvasive ventilatory support*.

See also Coding Rule Q2953 *High flow therapy*.

References:

Fisher Paykel Healthcare n.d., *Optiflow™ high flow therapy delivery for the entire patient journey: AIRVO™ 2 humidified high flow system*, viewed 18 December 2019, https://www.fphcare.com/au/hospital/adult-respiratory/optiflow/airvo-2-system/.

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Ref No: Q3566 | Published On: 21-Sep-2020 | Status: Current

Operculectomy

Q:

What code is assigned for operculectomy?

A:

Operculectomy is the surgical excision of excess gum mucosa (operculum) that covers a unenrupted or partially erupted tooth (American Dental Association n.d.; Rao et al. 2016).

Where operculectomy is performed assign 97377-00 **[460]** *Dental treatment involving removal or repair of soft tissue, not elsewhere classified*.

Follow the ACHI Alphabetic Index:

Removal — *see also Excision*

- operculum, dental procedure 97377-00 **[460]**

Amendments will be considered for a future edition.

References:

American Dental Association n.d., *Operculectomy*, American Dental Association, viewed 27 July 2020, https://www.ada.org/en/publications/cdt/glossary-of-dental-clinical-and-administrative-terms.

Rao, B.H.S., Rai, B.G. Sinha, S.S. 2016, 'Comparison of healing process of operculectomy with laser and surgical knife – a clinical study', *International Journal of Current Research*, vol. 8, issue 1, pp. 25368–25373, viewed 29 July 2020, http://www.journalcra.com/sites/default/files/issue-pdf/12146.pdf?_ga=2.166512377.658322849.1595994854-1287072610.1595994854.

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Open wound with artery, nerve and/or tendon injury

Q:

What is the principal diagnosis in scenarios where the principal diagnosis is documented as 'open wound' or 'laceration' in the discharge summary and the operation report further describes repair of underlying structures such as tendon, artery or nerve?

A:

ACS 1908 *Open wound with artery, nerve and/or tendon damage* provides guidelines about how to capture the severity of a laceration where surgery may be required. Injury details such as the type, depth and underlying structures damaged or repaired is often found in the operation report.

ACS 0010 *Clinical documentation and general abstraction guidelines* states:

> *Before classifying any documented clinical concept, the clinical coder must verify the presence and consistency of information on the front sheet and/or the discharge summary (or equivalent) by reviewing pertinent documents/data within the body of the current episode of care.*

The discharge summary and the body of the clinical notes should be used together to identify the specificity or severity of the laceration and inform code assignment. Classification decisions are not based solely on the discharge summary.

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

Published 21 September 2020,
for implementation 01 October 2020.

Coding Rules

Published 22 June 2020

Ref No: Q3478 | Published On: 22-Jun-2020 | Status: Current

Fracture of femoral neck due to osteoporosis and fall

Q:

What codes are assigned for fracture of femoral neck due to osteoporosis and fall?

A:

Osteoporosis is a progressive metabolic bone disease where bones become thin, weak and fragile. As a result, a minor bump or fall can cause a fracture. Osteoporosis related fractures occur in the hip, wrist or spine most commonly (Mayo Clinic 2019). Fall is the most common cause for hip fractures from osteoporosis (Osteoporosis Canada n.d.).

Where fracture of femoral neck is documented as due to unspecified osteoporosis and a fall, assign M80.95 *Unspecified osteoporosis with pathological fracture, pelvic region and thigh*.

Follow the ICD-10-AM Alphabetic Index:

Fracture

- pathological (cause unknown)

- - with osteoporosis M80.9-

Select the fifth character for the site of fracture from the *Site of Musculoskeletal Involvement* list at the beginning of Chapter 13 *Diseases of the musculoskeletal system and connective tissue*.

Also assign appropriate external cause codes.

An S code from Chapter 19 is not assigned because pathological fractures are specifically excluded in Chapter 19.

> *The blocks of the S section as well as T00–T14 and T90–T98 contain injuries at the three character level classified by type as follows:*
>
> ***Fracture***
>
> …
>
> **Excludes**: *fracture:*
> • *pathological:*
> • *NOS (M84.4)*
> • *with osteoporosis (M80.-)*
> • *stress (M84.3-)*
> *malunion of fracture (M84.0)*
> *non union of fracture [pseudoarthrosis] (M84.1)*

References:

Mayo Clinic 2019, *Osteoporosis*, viewed 10 March 2020, https://www.mayoclinic.org/diseases-conditions/osteoporosis/symptoms-causes/syc-20351968.

Osteoporosis Canada n.d., *Hip fracture*, viewed 10 March 2020, https://osteoporosis.ca/bone-health-osteoporosis/living-with-the-disease/after-the-fracture/what-to-expect-from-some-specific-types-of-fracture/hip-fractures/.

Published 22 June 2020,
for implementation 01 July 2020.

Ref No: Q3471 | Published On: 22-Jun-2020 | Status: Current

Occlusion or stenosis of (pre)cerebral arteries and cerebral infarction

Q:

Does a causal relationship need to be documented between occlusion or stenosis of (pre)cerebral arteries and cerebral infarction?

A:

Cerebral infarction, also known as ischaemic stroke, is the end result of decreased blood supply to an area of the brain that occurs over a period of time (Healthdirect 2019; Saver 2008). Cerebral infarction occurs due to narrowed (stenosed) or blocked (occluded) blood vessels (Saver 2008).

Stenosis may occur as a result of atherosclerosis or other diseases, and occlusion may be caused by thrombi or emboli.

Where documentation indicates (pre)cerebral occlusion alone, and it meets the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*, assign an appropriate code from categories I65 *Occlusion and stenosis of precerebral arteries, not resulting in cerebral infarction* or I66 *Occlusion and stenosis of cerebral arteries, not resulting in cerebral infarction*.

Where documentation indicates (pre)cerebral artery occlusion resulting in or causing infarction, and it meets the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*, assign an appropriate code from category I63 *Cerebral infarction* by following the *Excludes* note at categories I65 and I66 that state:

> **Excludes:** *when causing cerebral infarction (I63.-)*

References:

Healthdirect 2019, *Stroke*, Healthdirect, viewed 6 April 2020, https://www.healthdirect.gov.au/stroke.

Saver, J.L. 2008, 'Proposal for a universal definition of cerebral infarction', *Stroke*, vol. 39, no. 11, pp. 3110–3115, https://www.ahajournals.org/doi/full/10.1161/strokeaha.108.518415.

Published 22 June 2020,
for implementation 01 July 2020.

Ref No: Q3543 | Published On: 22-Jun-2020 | Status: Current

Pharmacological agent for termination of pregnancy following spontaneous fetal demise

Q:

What code is assigned for medical management (eg administration of misoprostol) for missed abortion or incomplete spontaneous abortion (without documentation of induction of labour)?

A:

Misoprostol is a medication that is used as part of the treatment for miscarriage (early pregnancy loss) and for termination of a pregnancy (Royal Australian and New Zealand College of Obstetricians and Gynaecologists 2016).

Where a pharmacological agent (eg misoprostol) is administered to induce expulsion of a fetus and/or products of conception following spontaneous fetal demise (ie missed abortion or incomplete spontaneous abortion), assign 90462-01 **[1330]** *Termination of pregnancy [abortion procedure], not elsewhere classified*.

Follow the ACHI Alphabetic Index:

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

- indication

- - termination of pregnancy (abortion) NEC 90462-01 **[1330]**

- type of agent

- - misoprostol

- - - for termination of pregnancy (abortion) 90462-01 **[1330]**

OR

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

References:

Royal Australian and New Zealand College of Obstetricians and Gynaecologists 2016, *The use of misoprostol in obstetrics and gynaecology*, viewed 8 April 2020, https://ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical-Obstetrics/The-use-of-misoprostol-in-obstetrics-(C-Obs-12)-Review-March-2016.pdf?ext=.pdf.

Published 22 June 2020,
for implementation 01 July 2020.

Ref No: Q3545 | Published On: 22-Jun-2020 | Status: Current

Reflux associated with digestive system

Q:

What code is assigned for reflux associated with the digestive system?

A:

Reflux in adults and paediatrics

The term reflux may refer to gastro-oesophageal reflux (GOR) or gastro-oesophageal reflux disease (GORD) when associated with the digestive system (Rosen et al. 2018).

ICD-10-AM does not differentiate GOR and GORD. Oesophageal reflux NOS is an *Inclusion* term at K21.9 *Gastro-oesophageal reflux disease without oesophagitis*.

Therefore, in the context of the digestive system, where reflux is documented without further qualification, assign K21.9 *Gastro-oesophageal reflux disease without oesophagitis*.

Follow the ICD-10-AM Alphabetic Index:

Reflux

- gastro-oesophageal K21.9

OR

Reflux

- oesophageal K21.9

Reflux may be used to describe the attribute of conditions or symptom such as ‘reflux-type chest pain’ or ‘reflux heartburn’. In these scenarios, assign the appropriate code for the condition or symptom. For example, for ‘reflux heartburn’ assign R12 *Heartburn*.

Reflux in neonates

Reflux in neonates generally refers to GOR, which is defined as the passage of gastric contents into the oesophagus (National Collaborating Centre for Women’s and Children’s Health 2015). In contrast, regurgitation is the voluntary or involuntary movement of part or all of the stomach contents up the oesophagus at least as far as the mouth, and often emerging from the mouth (National Collaborating Centre for Women’s and Children’s Health 2015). Regurgitation is a specific symptom of GOR but it can also be caused by other conditions such as achalasia and regurgitation rumination (Royal Children’s Hospital 2018).

ICD-10-AM classifies neonatal GOR and regurgitation separately.

When reflux not otherwise specified (NOS) is documented in a neonate, assign P78.8 *Other specified perinatal digestive system disorders*.

Follow the ICD-10-AM Alphabetic Index:

Reflux

- gastro-oesophageal K21.9

- - in newborn P78.8

When regurgitation NOS is documented in a neonate, assign P92.1 *Regurgitation and rumination in newborn*.

Follow the ICD-10-AM Alphabetic Index:

Regurgitation

- food

- - newborn P92.1

Where reflux and regurgitation are both documented in a neonate, assign P78.8 for the neonatal reflux alone.

Assign and sequence codes as per the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*.

References:

National Collaborating Centre for Women's and Children's Health 2015, *Gastro-oesophageal reflux disease in children and young people*, National Institute for Health and Care Excellence, viewed 4 May 2020, https://www.spg.pt/wp-content/uploads/2015/11/2015-GERD-in-young-people.pdf

Rosen, R., Vandenplas, Y., Singendonk, M., Cabana, M., Di Lorenzo, C., Gottrand, F., Gupta, S., Langendam, M., Staiano, A., Thapar, N., Tipnis, N. & Tabbers, M. 2018, 'Pediatric gastroesophageal reflux clinical practice guidelines: joint recommendations of the North American Society for Pediatric Gastroenterology, Hepatology, and Nutrition (NASPGHAN) and the European Society for Pediatric Gastroenterology, Hepatology, and Nutrition (ESPGHAN)'. *Journal of Pediatric Gastroenterology and Nutrition*, vol. 66, no. 3, pp. 516–554, viewed 13 May 2020, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5958910/

Royal Children's Hospital 2018, *Reflux (GOR) and GORD*, Royal Children's Hospital, Melbourne, viewed 7 May 2020. http://www.rch.org.au/kidsinfo/fact_sheets/Reflux_GOR_and_GORD/.

Published 22 June 2020,
for implementation 01 July 2020.

Ref No: Q3448 | Published On: 22-Jun-2020 | Status: Current

Rhabdomyolysis due to prolonged immobilisation following a fall

Q:

What code is assigned for rhabdomyolysis due to prolonged immobilisation following a fall?

A:

Rhabdomyolysis is a complex medical condition involving the rapid dissolution of damaged or injured muscle (Torres et al. 2015).

A study by Wongrakpanich et al. (2018) identified falls (with or without immobilisation) as the most frequent cause of rhabdomyolysis in the elderly.

Traumatic rhabdomyolysis may be caused by a crush injury, such as from a fall or motor vehicle accident, or from long-lasting muscle compression, such as that caused by prolonged immobilisation after a fall (Robinson 2019).

Causes of nontraumatic rhabdomyolysis include alcohol abuse, seizures, muscle enzyme deficiencies, electrolyte abnormalities, infections, drugs and toxins, or endocrinopathy (Strong & Pryor 2010).

Assign T79.6 *Traumatic ischaemia of muscle* where rhabdomyolysis is documented as due to prolonged immobilisation (ie 'long lie') after a fall.

Follow the ICD-10-AM Alphabetic Index:

Rhabdomyolysis

- traumatic T79.6

Also assign applicable external cause, place of occurrence and activity codes.

References:

Strong, M.L. & Pryor, J.P. 2010, 'What are the critical implications of muscle and long bone trauma?', in C.S. Deutschman & P.J. Neligan (eds), *Evidence Based Practice of Critical Care*, 3rd edn, pp. 599–606, viewed 6 February 2020, https://www.sciencedirect.com/science/article/pii/B9781416054764000857.

Torres, P.A., Helmstetter, J.A., Kaye, A.M. & Kaye, A.D. 2015, 'Rhabdomyolysis: pathogenesis, diagnosis, and treatment', *Ochsner Journal*, vol. 15, no. 1, pp. 58–69, viewed 16 April 2020, https://www.ncbi.nlm.nih.gov/pubmed/25829882.

Wongrakpanich, S., Kallis, C., Prasad, P., Rangaswami, J. & Rosenzweig, A. 2018, 'The study of rhabdomyolysis in the elderly: an epidemiological study and single center experience', *Aging and Disease*, vol. 9, no. 1, pp. 1–7, viewed 5 February 2020, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5772847/#__ffn_sectitle.

Published 22 June 2020,
for implementation 01 July 2020.

Ref No: Q3472 | Published On: 22-Jun-2020 | Status: Current

Targeted muscle reinnervation

Q:

What code is assigned for targeted muscle reinnervation (TMR)?

A:

Targeted muscle reinnervation (TMR) is a surgical technique that allows individuals with amputated limbs to have better control of their prostheses (Cheesborough et al. 2016). TMR also treats and prevents chronic localised symptomatic neuromas and phantom limb pain (Bowen et al. 2019).

The procedure involves transfer of severed nerves from the amputated limb to reinnervate the new muscle targets of the amputated nerve motor signals (Kuiken et al. 2017).

Assign 39321-00 **[83]** *Transposition of nerve* where targeted muscle reinnervation is documented.

Follow the ACHI Alphabetic Index:

Transposition (of)

- nerve 39321-00 **[83]**

Amendments will be considered for a future edition.

References:

Bowen, J.B., Ruter, D., Wee, C., West, J. & Valerio, I.L. 2019, 'Targeted muscle reinnervation technique in below-knee amputation', *Plastic and Reconstructive Surgery*, vol. 143, no. 1, pp. 309–312, viewed 16 March 2020, https://www.ncbi.nlm.nih.gov/pubmed/30589808.

Cheesborough, J., Smith, L., Kuiken, T. & Dumanian, G. 2016, 'Targeted muscle reinnervation and advanced prosthetic arms', *Seminars in Plastic Surgery*, vol. 29, no. 1, pp. 62–72, viewed 16 March 2020, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4317279/.

Kuiken, T.A., Barlow, A.K., Hargrove, L. & Dumanian, G.A. 2017, 'Targeted muscle reinnervation for the upper and lower extremity', *Techniques in Orthopaedics*, vol. 32, no. 2, pp. 109–116, viewed 16 March 2020, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5448419.

Published 22 June 2020,
for implementation 01 July 2020.

Ref No: Q3533 | Published On: 22-Jun-2020 | Status: Current

Bandage contact lens (BCL)

Q:

What codes are assigned for insertion, replacement and removal of bandage contact lens?

A:

Bandage contact lenses (BCLs) are predominantly used in the treatment of ocular surface diseases (Solomon 2013). However, they may also be used in other circumstances. BCLs mechanically protect the eye by shielding the epithelial surface from the external environment and sources of infection, promote re-epithelialisation and reduce discomfort and pain during blinking (Rachel et al. 2019). BCLs can be applied alone or in conjunction with other eye operations such as corneal glueing.

For application of BCL alone, assign 96092-00 **[1870]** *Application, fitting, adjustment or replacement of other assistive or adaptive device, aid or equipment*.

Follow the ACHI Alphabetic Index:

Fitting

- contact lenses 96092-00 **[1870]**

For removal of BCL alone, assign 90061-00 **[165]** *Other procedures on eyeball*.

Follow the ACHI Alphabetic Index:

Removal

- contact lens

- - as operative procedure 90061-00 **[165]**

For replacement of BCL not in conjunction with other eye procedures, assign:

90061-00 **[165]** *Other procedures on eyeball*

and

96092-00 **[1870]** *Application, fitting, adjustment or replacement of other assistive or adaptive device, aid or equipment*

When insertion, removal or replacement of BCL is performed in conjunction with other eye procedures such as corneal glueing, it is regarded as a procedure component. Therefore, as per the guidelines in ACS 0016 *General procedure guidelines/Procedure components*, do not assign a separate code for insertion, removal or replacement of BCL.

Amendments will be considered for a future edition.

References:

Solomon, A. 2013, 'Corneal epithelial adhesion disorders', in E.J. Holland, M.J. Mannis, W.B. Lee (eds), *Ocular surface disease: cornea, conjunctiva and tear film*, W.B. Saunders, pp. 195–203, viewed 7 April 2020, https://doi.org/10.1016/B978-1-4557-2876-3.00026-2.

Williams, R.L., Levis, H.J., Lace, R., Doherty, K.G., Kennedy, S.M. & Kearns, V.R. 2019, 'Biomaterials in ophthalmology', in R. Narayan (ed.), *Encyclopedia of biomedical engineering*, Elsevier, pp. 289–300, viewed 7 April 2020, doi.org/10.1016/B978-0-12-801238-3.11034-7.

Published 22 June 2020,
for implementation 01 July 2020.

Ref No: Q3510 | Published On: 22-Jun-2020 | Status: Current

Carpometacarpal (CMC) joint washout

Q:

What code is assigned for carpometacarpal joint washout?

A:

The Australian Classification of Health Interventions (ACHI) Alphabetic Index *Introduction* states:

> *Both the ACHI Tabular List and Alphabetic Index are meant to be used together. It is not recommended that the ACHI Tabular List or ACHI Alphabetic Index be used in isolation of each other. After locating a code in the index, refer to that code in the Tabular List for important instructions, such as Includes and Excludes notes.*

In ACHI Chapter 15 *Procedures on musculoskeletal system* the hierarchical structure follows a first level (principal) axis of anatomical site. Under the first level axis for *Hand, Wrist* the *Instructional* note states:

> ***HAND, WRIST***
>
> **Includes**: *carpometacarpal joint*
> *carpus NOS*
> *finger*
> *wrist NOS*

This *Includes* note applies to all codes classified to the site of *Hand, Wrist* (ie blocks **[1439]** to **[1474]**).

Therefore, for washout of a carpometacarpal joint (CMC) assign 49212 00 **[1443]** *Arthrotomy of wrist*.

Follow the ACHI Alphabetic Index:

Washing(s) — *see also Lavage AND Irrigation*

Lavage

- joint (open)

- - wrist 49212-00 **[1443]**

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for implementation 01 July 2020.

Coding Rules

Published 20 March 2020

Ref No: Q3443 | Published On: 20-Mar-2020 | Status: Current

Hypothenar fat pad and nerve wrap performed with a revision procedure for carpal tunnel syndrome

Q:

What codes are assigned for revision decompression surgery for carpal tunnel syndrome involving a hypothenar fat pad flap or isolated nerve wrap?

A:

Surgical treatment for recurrent or persistent carpal tunnel syndrome may use a number of techniques, including revision decompression, collagen nerve wrap and adipofascial flap (Konopka et al. 2017). Isolated (collagen) nerve wraps are used in revision surgery to prevent scars from recurring (Konopka et al. 2017).

The hypothenar fat pad flap (HTFPF) uses fat tissue from the hypothenar eminence as a pedicle flap to cover the median nerve (Kanchanathepsak et al. 2017). The flap provides protection to the median nerve by stopping structures within the carpal tunnel from adhering to it and allowing the nerve to glide freely (Kanchanathepsak et al. 2017).

When an isolated (collagen) nerve wrap is performed during the revision decompression surgery for carpal tunnel syndrome, it is not necessary to assign a separate code as it is inherent in the decompression procedure.

HTFPF is not inherent in revision decompression surgery. Assign:

39331-01 **[76]** *Release of carpal tunnel*

45563-00 **[1673]** *Island flap with vascular pedicle*

Follow the ACHI Alphabetic Index:

Release

- carpal tunnel (open) 39331-01 **[76]**

Flap (repair)

- island

- - with

- - - vascular pedicle (noninnervated) 45563-00 **[1673]**

References:

Kanchanathepsak, T., Wairojanakul, W., Phakdepiboon, T., Suppaphol, S., Watcharananan, I. & Tawonsawatruk, T. 2017, 'Hypothenar fat pad flap vs conventional open release in primary carpal tunnel syndrome: a randomized controlled trial', *World Journal of Orthopedics*, vol. 8, no. 11, pp. 846–852, viewed 23 January 2020, https://www.wjgnet.com/2218-5836/full/v8/i11/846.htm.

Konopka, G., Mundra, L.S., Perez, E.N. & Panthaki, Z.J. 2017, 'Revision decompression, collagen nerve wrap, and adipofascial flap for recurrent and persistent carpal tunnel syndrome', *Plastic and Reconstructive Surgery*, vol. 5, issue 9S, pp. 208–209, viewed 23 January 2020, https://journals.lww.com/prsgo/FullText/2017/09001/Abstract___Revision_Decompression,_Collagen_Nerve.310.Aspx.

Published 20 March 2020,
for implementation 01 April 2020.

Ref No: Q3461 | Published On: 20-Mar-2020 | Status: Updated | Updated On: 15-Jun-2022

Autoimmune lymphoproliferative syndrome (ALPS)

Q:

What codes are assigned for autoimmune lymphoproliferative syndrome?

A:

Autoimmune lymphoproliferative syndrome (ALPS) is a primary lymphoproliferative disorder. Lymphoproliferative disorders originate when the mechanisms that control lymphocytes break down, resulting in the uncontrolled increase of immune cells leading to lymphocytosis and lymphadenopathy, often involving extranodal sites (Justiz Vaillant & Stang 2019).

ALPS can manifest as lymphadenopathy, hepatomegaly or splenomegaly (van der Werff ten Bosch cited in Teachey et al. 2009). Other manifestations of ALPS include peripheral lymphocytosis, hypergammaglobulinemia, autoimmune cytopenias and rarely autoimmune glomerulonephritis and hepatitis (Lim & Elenitoba-Johnson 2004).

As per the guidelines in ACS 0005 *Syndromes*, in the absence of a single ICD-10-AM code to classify all the elements of ALPS, assign:

- code(s) 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.

Where no manifestation is documented or meets the criteria in ACS 0001 or ACS 0002, assign D89.89 *Other specified disorders involving the immune mechanism, not elsewhere classified* as a default, with U91.

Follow the ICD-10-AM Alphabetic Index:

Disorder (of)

- immune mechanism (immunity)

- - specified type NEC D89.89

Syndrome NEC *(see also Disease)* U91

Note that ALPS is not neoplastic; therefore, do not assign a neoplasm code by following the ICD-10-AM Alphabetic Index at *Disease, diseased/immunoproliferative.*

Amendments will be considered for a future edition.

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

References:

Justiz Vaillant, A.A. & Stang, C.M. 2019, 'Lymphoproliferative disorders', *StatPearls*, viewed 29 October 2019, https://www.ncbi.nlm.nih.gov/books/NBK537162/.

Lim, M.S. & Elenitoba-Johnson, K.S.J. 2004, 'The molecular pathology of primary immunodeficiencies', *The Journal of Molecular Diagnostics*, vol. 6, no. 2, pp. 59–83, viewed 9 October 2019, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1867474/.

Teachey, D.T., Seif, A.E. & Grupp, S.A. 2009, 'Advances in the management and understanding of autoimmune lymphoproliferative syndrome (ALPS)', *British Journal of Haematology*, vol. 148, no. 2, pp. 205–216, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2929682/.

Published 20 March 2020,
for implementation 01 April 2020.

Ref No: Q3440 | Published On: 20-Mar-2020 | Status: Current

Fine needle aspiration (FNA) without documentation of biopsy

Q:

Is fine needle aspiration, without documentation of biopsy, classified in ACHI as a biopsy?

A:

Biopsy is a diagnostic intervention performed to extract a sample of tissue, fluid or cells for laboratory analysis. Fine needle aspiration (FNA) is a type of biopsy that involves a long, thin needle inserted into the target site with a syringe used to draw out tissue, fluid or cells.

A fine needle aspiration is usually performed via a percutaneous approach, and may be performed in a radiological department using image guidance.

The terms *percutaneous and needle* are inconsistently listed under the lead term *Biopsy*, and in the ACHI Tabular List. Where FNA of a particular site is not specifically indexed, follow the lead term *Biopsy* and assign a code for closed (percutaneous) needle biopsy. For example:

30094-05 **[977]** *Percutaneous needle biopsy of pancreas* for FNA of the pancreas

and

30094-10 **[112]** *Percutaneous [needle] biopsy of thyroid gland* for FNA of the thyroid.

Follow the ACHI Alphabetic Index:

Biopsy (brush) (with brushing(s)) (with washing(s) for specimen collection)

- pancreas (open) 30075-16 **[977]**
- - percutaneous (closed) 30094-05 **[977]**
- thyroid gland (closed) (needle) (percutaneous) 30094-10 **[112]**

As aspiration may also be performed as a therapeutic intervention (ie drainage), documentation of aspiration without mention of biopsy or fine needle cannot be assumed to be a biopsy.

Where it is not clear in the documentation if an aspiration has been performed for diagnostic or therapeutic purposes, seek clarification from the clinician.

Amendments will be considered for a future edition.

References:

Mayo Clinic Staff 2019, *Biopsy: types of biopsy procedures used to diagnose cancer*, viewed 27 September 2019, https://www.mayoclinic.org/diseases conditions/cancer/in depth/biopsy/art 20043922.

Published 20 March 2020,
for implementation 01 April 2020.

Ref No: Q3466 | Published On: 20-Mar-2020 | Status: Current

Ligament Augmentation and Reconstruction System (LARS)™

Q:

What code is assigned for gluteal tendon reconstruction using the Ligament Augmentation and Reconstruction System™?

A:

The Ligament Augmentation and Reconstruction System (LARS)™ uses tightly woven synthetic material designed to repair soft tissue injury or weakness, provide joint stability and promote healing after surgery (Bucher et al. 2014; Ebert et al. 2018).

During surgical repair of gluteal tendon tears, a tunnel is created through the greater trochanter. One end of the LARS™ is sutured onto the under surface of the gluteus medius muscle. The free end of the LARS™ is drawn through the tunnel bringing the gluteal tendon in to where it normally inserts. Then, an interference screw is placed into the bone tunnel to secure the tension in the ligament–bone interface (Australian New Zealand Clinical Trials Registry 2016; Corin Group 2013).

Assign 47954-00 **[1572]** *Repair of tendon, not elsewhere classified*.

Follow the ACHI Alphabetic Index:

Repair

- tendon 47954-00 **[1572]**

Amendments will be considered for a future edition.

References:

Australian New Zealand Clinical Trials Registry 2016, *Surgical reconstruction of gluteal tendon tears*, ANZCTR, viewed 12 February 2020, https://www.anzctr.org.au/Trial/Registration/TrialReview.aspx?id=371934.

Bucher, T.A., Darcy, P., Ebert, J.R., Smith, A. & Janes, G. 2014, 'Gluteal tendon repair augmented with a synthetic ligament: surgical technique and a case series', *Hip International*, vol. 24, no. 2, pp. 187–193, viewed 12 February 2020, https://www.ncbi.nlm.nih.gov/pubmed/24186680.

Corin Group 2013, *LARS™ gluteal tendon repair and reinforcement surgical technique*, viewed 18 December 2019, https://www.coringroup.com/assets/product-resources/LARS/Resources-Product-Literature-LARS-Gluteal-Tendon-Repair-and-Reinforcement-Surgical-Technique.pdf.

Ebert, J.R., Bucher, T.A., Mullan, C.J. & Janes, G.C. 2018, 'Clinical and functional outcomes after augmented hip abductor tendon repair', *Hip International*, vol. 28, no. 1, pp. 74–83, viewed 12 February 2020, https://www.ncbi.nlm.nih.gov/pubmed/28967055.

Published 20 March 2020,
for implementation 01 April 2020.

Ref No: Q3434 | Published On: 20-Mar-2020 | Status: Current

Petersen's defect with or without hernia

Q:

What codes are assigned for Petersen's defect with and without hernia?

A:

Petersen's defect is defined as the potential space between the small bowel limbs and the transverse mesocolon after any type of gastrojejunostomy, especially the Roux-en-Y anastomosis (Hirahara et al. 2015). The internal herniation of the small intestine through this potential space is called a Petersen's hernia, which is a type of internal trans-mesenteric hernia (Hirahara et al. 2015; Crispin-Trebejo et al. 2014).

In adults, the predisposing factors for the differing types of internal trans-mesenteric hernias include previous gastrointestinal surgery, abdominal trauma, intraperitoneal inflammation and congenital abnormalities (Crispin-Trebejo et al. 2014).

Clinical advice confirms that Petersen's defect, by definition, is a procedural complication, which means it meets the ACS 1904 *Procedural complications* criteria below:

> *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:*

…

- *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)*

…

As per the guidelines in ACS 1904:

- Where Petersen's defect without hernia is documented, assign:

  K91.89 *Other intraoperative and postprocedural disorders of digestive system, not elsewhere classified*

  K66.8 *Other specified disorders of peritoneum*

  Appropriate external cause and place of occurrence codes.

- Where Petersen's defect with hernia is documented, assign:

  K91.89 *Other intraoperative and postprocedural disorders of digestive system, not elsewhere classified*

  K45.8 *Other specified abdominal hernia without obstruction or gangrene*

  Appropriate external cause and place of occurrence codes.

Follow the ICD-10-AM Alphabetic Index:

Complication(s) (from) (of)

- gastrointestinal

- - intraoperative or postprocedural

- - - specified NEC K91.89

Disease, diseased

- peritoneum

- - specified NEC K66.8

Hernia, hernial (acquired) (recurrent)

- abdomen, abdominal

- - specified site NEC K45.8

Note that where clinical documentation specifies that the cause of Petersen's defect or hernia is not a procedural complication (ie it is due to another specified cause such as congenital malformation), do not apply the guidelines in ACS 1904.

For closure of Petersen's defect, assign 90329-03 **[1000]** *Other repair of mesentery*. Also assign 90307-00 **[903]** *Other procedure on small intestine* where Petersen's hernia is reduced prior to closure of the defect.

Follow the ACHI Alphabetic Index:

Repair

- mesentery 90329-03 **[1000]**

Procedure

- intestine

- - small NEC 90307-00 **[903]**

Amendments may be considered for a future edition.

References:

Crispin-Trebejo, B., Robles-Cuadros, M.C., Orendo-Velasquez, E. & Andrade, F.P. 2014, 'Internal abdominal herniA: intestinal obstruction due to trans-mesenteric hernia containing transverse colon', *International Journal of Surgery Case Reports*, vol. 5, no. 7, pp. 396–398, viewed 2 September 2019, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4064401/.

Hirahara, N., Matsubara, I., Hayashi, H., Takai, K., Fujii, Y. & Tajima, Y. 2015, 'Easy and secure closure of Petersen's defect after laparoscopic distal gastrectomy with Roux-en-Y reconstruction', *Journal of Laparoendoscopic & Advanced Surgical Techniques*, vol. 25, no. 1, pp. 55–59, viewed 2 September 2019, https://www.ncbi.nlm.nih.gov/pubmed/25531205.

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Multiple heart valve diseases

Q:

Can codes from categories I34–I38 be assigned with codes from category I08 *Multiple valve diseases* in the same episode of care?

A:

Follow the classification convention for the prepositional term 'with' in the ICD-10-AM Alphabetic Index, which is based on ICD-10. Before assigning a code, users of ICD-10-AM must also apply the *Instructional* notes in the ICD-10-AM Tabular List and the Australian Coding Standards (ACS) (eg ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*).

The *Instructional* notes at category I08 *Multiple valve diseases* states:

> ***Includes:*** *whether specified as rheumatic or of unspecified origin*
>
> ***Excludes:*** *…*
>
> *multiple valve diseases of specified origin other than rheumatic heart diseases (use appropriate codes in I34–I38, Q22–Q23 and Q24.87)*

Scenario 1

Patient admitted with aortic stenosis. There is documented history of mitral valve regurgitation. The cause of the aortic stenosis or mitral valve regurgitation is not specified.

Assign I08.0 *Disorders of both mitral and aortic valves*.

Follow the ICD-10-AM Alphabetic Index:

Stenosis (cicatricial)
- aortic (valve) I35.0

Follow the *Excludes* note at category I35 *Nonrheumatic aortic valve disorders*:

> ***Excludes:*** unspecified *cause but with mention of diseases of mitral valve (I08.0)*

Scenario 2

Patient admitted with aortic stenosis due to previous endocarditis. There is documented history of mitral valve insufficiency.

Assign I35.0 *Aortic (valve) stenosis*.

Follow the ICD-10-AM Alphabetic Index:

Stenosis (cicatricial)
- aortic (valve) I35.0

The *Excludes* note at category I35 does not apply to scenario 2 because the aortic stenosis is documented as due to a specified cause (ie endocarditis). A code for mitral valve regurgitation is not assigned because it does not meet the criteria in ACS 0002 *Additional diagnoses*.

Scenario 3

Patient admitted for treatment of mitral and aortic valve insufficiency due to calcium deposits.

Assign I34.0 *Mitral (valve) insufficiency* and I35.1 *Aortic (valve) insufficiency*.

Follow the ICD-10-AM Alphabetic Index:

Insufficiency, insufficient

- mitral

- - with

- - - aortic valve disease (unspecified origin) I08.0

The mitral and aortic valve insufficiencies are due to a specified origin (ie calcium deposits). Therefore, follow the *Excludes* note at category I08 and assign appropriate codes from the range I34–I38 (specifically I34.0 and I35.1).

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Surgically assisted maxillary expansion (SAME) or surgically assisted rapid maxillary expansion (SARME)

Q:

What ACHI code is assigned for a surgically assisted maxillary expansion (SAME) or surgically assisted rapid maxillary expansion (SARME)?

A:

Surgically assisted maxillary expansion (SAME) and surgically assisted palatal expansion (SAPE) combine surgical and orthodontic techniques for management of transverse maxillary discrepancies in mature patients (Robiony et al. 2007). SAME and SAPE can also be undertaken in 'rapid' form (ie SARME and SARPE). The procedures allow surgeons to achieve effective maxillary expansion in a skeletally mature patient and decrease unwanted effects of orthopaedic or orthodontic expansion (Suri & Taneja 2008).

The procedure consists of various components including multiple osteotomies combined with application of a fixed orthodontic appliance. An ostectomy can also be performed to assist expansion (Suri & Taneja 2008).

Assign an appropriate code from blocks **[1705]** *Osteotomy or ostectomy of mandible or maxilla* or **[1707]** *Osteotomy or ostectomy of mandible or maxilla, procedures in combination*, where SAME procedure is documented.

Follow the ACHI Alphabetic Index:

Osteotomy

- maxilla

- - bilateral 45726-01 **[1705]**

…

- - multiple procedures (multiple ostectomies or osteotomies of maxilla, in combination) — *see block* **[1707]**

…

- - unilateral 45720-01 **[1705]**

Also assign 97843-01 **[480]** *Insertion of fixed maxillary or mandibular expansion appliance* for the application of the maxillary expansion device.

Follow the ACHI Alphabetic Index:

Application

- orthodontic appliance

- - fixed (expansion)

- - - maxillary 97843-01 **[480]**

References:

Robiony, M., Polini, F., Costa, F., Zerman, N. & Politi, M. 2007, 'Ultrasound bone cutting for surgically assisted rapid maxillary expansion under local anesthesia. Preliminary results.', *Minerva Stomatologica*, vol. 56, no. 6, pp. 359–368, viewed 7 January 2020, https://www.ncbi.nlm.nih.gov/pubmed/17625493.

Suri, L. & Taneja, P. 2008, 'Surgically assisted rapid palatal expansion: a literature review', *American Journal of Orthodontics and Dentofacial Orthopedics*, vol. 133, no. 2, pp. 290–302, viewed 17 December 2019, https://bbo.org.br/bbo/files/bibliografia/artigos/12_Suri_Surgically_assisted_rapid_palatal_expansion.pdf.

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Supplementary U code for obesity

Q:

Can a supplementary U code for obesity be assigned when body mass index (BMI) is documented on a malnutrition screening tool document?

A:

Malnutrition screening tools such as the Malnutrition Universal Screening Tool (MUST) categorise the risk of malnutrition for individual patients by calculating a numerical score. Patients with a high nutritional risk score are then referred for a formal clinical assessment.

ACS 0010 *Clinical documentation and general abstraction guidelines* states:

> *Accurate clinical documentation is the responsibility of the treating clinician.*
>
> …
>
> *Before classifying any documented clinical concept, the clinical coder must verify the presence and consistency of information on the front sheet and/or the discharge summary (or equivalent) with the relevant documentation within the body of the current episode of care.*
>
> …
>
> *Do not use test result values, descriptions, health risk screening (assessment) tools, medication charts, symbols and abbreviations from clinical documentation* ***in isolation*** *to assign diagnosis codes.*
>
> …

Diagnoses and procedures must be documented by a clinician before assigning a code. This principle also applies to the assignment of supplementary codes for chronic conditions.

Documented components of a malnutrition screening tool, including body mass index (BMI), are not considered diagnoses for classification purposes. Therefore, in the absence of supporting clinical documentation, a supplementary U code is not assigned based on a BMI value alone from a nutritional screening tool.

See also Coding Rule *BMI from calculated EMR fields*.

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

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Coding Rules

Published 16 December 2019

Ref No: Q3411 | Published On: 16-Dec-2019 | Status: Updated | Updated On: 15-Jun-2022

Application, replacement and removal of endoluminal sponge for negative pressure wound treatment (NPWT)

Q:

What codes are assigned for application, replacement and removal of a sponge, as part of endoluminal NPWT, for anastomotic leakage in the rectum or presacral space?

A:

Endo-SPONGE® is a proprietary name for a type of sponge used in endoluminal negative pressure wound treatment (NPWT) (B Braun n.d.).

Endoluminal NPWT is a minimally invasive method used in the management or prevention of septic complications of surgery such as anastomotic leakage. In endoluminal NPWT, a sponge is introduced via endoscopy and connected to a drainage system. The wound is drained through the use of suction to create a vacuum effect.

Endoluminal NPWT is similar in technique to sponges used in endoscopic vacuum-assisted closure (EVAC).

Endo-SPONGE® and EVAC are placed either within a cavity or intraluminally, which differentiates them from other vacuum-assisted closure (VAC) dressings that are applied topically on the surface of a wound (Gestring 2019).

Where a sponge (eg Endo-SPONGE®) is inserted into the rectum or presacral space, as part of endoluminal NPWT, assign 90314-00 **[942]** *Other procedures on rectum*.

Follow the ACHI Alphabetic Index:

Procedure

- rectum NEC 90314-00 **[942]**

Where a sponge is removed from the rectum or presacral space, as part of endoluminal NPWT, assign 92086-00 **[1896]** *Removal of other device from gastrointestinal tract*.

Follow the ACHI Alphabetic Index:

Removal

- device

- - gastrointestinal tract NEC 92086-00 **[1896]**

Where the procedure is performed using a minimally invasive technique, also follow the guidelines in ACS 0023 *Minimally invasive interventions.*

See also Coding Rule *Endoscopic vacuum-assisted closure (EVAC) of gastrointestinal defect*.

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

References:

Braun, n.d., Endo-SPONGE® Endoluminal vacuum therapy, viewed 19 September 2019, https://www.bbraun.com/en/products-and-therapies/wound-closure/endoluminal-vacuum-therapy.html

Gestring, M. 2019, Negative pressure wound therapy, viewed 22 November 2019, https://www.uptodate.com/contents/negative-pressure-wound-therapy

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Removal or replacement of a failed (meaning ineffective) implanted device

Q:

What ICD-10-AM code is assigned when a failed (meaning ineffective) implanted device is removed or replaced?

A:

An implanted device may be considered ‘failed’, or ineffective, if it did not achieve the expected outcome.

A device may be documented as ‘failed’, meaning it was ineffective, as the indication for elective removal or replacement. In these scenarios, the failed device is not a complication and therefore, a postprocedural complication code is not assigned.

Example 1 – Removal of a failed (ineffective) device:

Patient admitted for a gastric band removal due to ‘failed lap band’. Documentation stated that there was no failure of the device, but the patient did not experience any significant weight loss and remained morbidly obese more than two years following insertion of the gastric band.

Assign Z45.89 *Adjustment and management of other implanted devices*. Follow the ICD-10-AM Alphabetic Index:

Management (of)

- implanted device NEC

- - specified NEC Z45.89

Example 2 – Replacement of a failed (ineffective) device:

Patient with chronic pain admitted for neurostimulator and lead exchange due to ‘initial device being ineffective’. Documentation stated that there was no mechanical failure of the device, but the patient did not experience any pain relief following the insertion of the initial neurostimulator. Patient reported effective pain management post replacement of the device.

Assign R52.2 *Chronic pain*. Follow the ICD-10-AM Alphabetic Index:

Pain(s)

- chronic (intractable) R52.2

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Cardiorenal syndrome

Q:

What code is assigned for cardiorenal syndrome?

A:

Cardiorenal syndrome (CRS) is a general term used to describe clinical conditions in which cardiac and renal dysfunctions coexist.

CRS is classified to category I13 *Hypertensive heart and kidney disease* in ICD-10-AM, as per ICD-10 WHO, which assumes a causal relationship between hypertension and heart and/or kidney disease.

For classification purposes, assign I13.9 *Hypertensive heart and kidney disease, unspecified* for CRS not otherwise specified (NOS) by following the ICD-10-AM Alphabetic Index:

Syndrome — *see also Disease*

- cardiorenal (*see also Hypertensive/cardiorenal*) I13.9

Where CRS is documented with chronic kidney disease and heart failure, follow the above Alphabetic Index cross reference:

Hypertension, hypertensive (accelerated) (benign) (essential) (idiopathic) (malignant) (primary) (systemic) I10

- cardiorenal (disease) I13.9

- - with

- - - CKD stage 5 (kidney failure) I13.1

- - - - and heart failure (congestive) I13.2

Amendments may be considered for a future edition.

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COF values for suspected conditions in neonates

Q:

What COF value is assigned for observation codes in neonates?

A:

ACS 0048 *Condition onset flag*, defines a condition with an onset flag of 1 (COF 1) as:

> *A condition which arises during the episode of admitted patient care and would not have been present or suspected on admission.*

Codes from category Z03.7 *Observation and evaluation of newborn for suspected condition not found* are assigned for newborns who are suspected of having an abnormal condition that is ruled out or not confirmed after examination and observation.

As these neonatal conditions are suspected but not confirmed, assignment of COF 1 is inappropriate. Therefore, assign COF 2 *Condition not noted as arising during the episode of admitted patient care* to codes from category Z03.7 *Observation and evaluation of newborn for suspected condition not found*.

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Assignment of R79.83 and D68.3 in the same episode of care

Q:

Can R79.83 and D68.3 be assigned in the same episode of care?

A:

R79.83 *Abnormal coagulation profile* and D68.3 *Haemorrhagic disorder due to circulating anticoagulants* are mutually exclusive and cannot be assigned in the same episode of care. This is supported by the *Excludes* note in the ICD-10-AM Tabular List for both codes.

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Dexamethasone intravitreal implant (Ozurdex®)

Q:

What ACHI code is assigned for a dexamethasone intravitreal implant?

A:

Ozurdex® is the brand name for a dexamethasone intravitreal implant that is injected into the vitreous body in the posterior segment of the eye. The dissolving implant is a slow-release rod-shaped drug delivery system used to treat conditions such as diabetic macular oedema or retinal vein occlusion and posterior segment uveitis (Rx List 2018).

Assign 90078-00 **[208]** *Other procedures on vitreous* for insertion of Ozurdex® implantation. Follow the ACHI Alphabetic Index:

Procedure

- vitreous (eye) NEC 90078-00 **[208]**

References:

Rx List 2018, Ozurdex®, viewed 4 October 2019, https://www.rxlist.com/ozurdex-drug.htm

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Coding Rules

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ACS 1904 *Procedural complications*

Q:

When are procedural complications classified to an injury code rather than a body system code?

A:

ICD-10-AM classifies procedural complications to either the body system chapters or block T80–T88 *Complications of surgical and medical care, not elsewhere classified*.

ACS 1904 *Procedural complications/classification of procedural complications (diagnosis codes)* instructs:

> *Where a complication is related to a prosthetic device, implant or graft, assign T82–T85 Complications of prosthetic devices, implants and grafts,* ***except*** *where directed by an Includes note or the Alphabetic Index…*
>
> *…*
>
> *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 listed above*
>
> *• the complication is not related to a body system, assign an appropriate code from T80–T81 or T86–T88.*

Complications related to prosthetic devices, implants or grafts

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 national coding advice or ACS that indicates otherwise (eg complications related to coronary artery bypass graft).

For a medical condition occurring during or following insertion of prosthetic devices but not classified to T82–T85, see *ACS 1904 Procedural complications/Intraoperative/postoperative medical conditions.*

Example 1: Endoleaks following endovascular repair (EVAR).

Assign T82.3 *Mechanical complication of other vascular grafts.*

Follow the ICD-10-AM Alphabetic Index:

Leak, leakage

- device, implant or graft

- - arterial graft NEC T82.3

Also assign external cause and place of occurrence codes.

Rationale:

T82.3 is assigned in accordance with the Alphabetic Index, to identify that the endoleaks are a mechanical complication of the EVAR.

Example 2: Ureteral stricture following insertion of a prosthetic device, implant or graft.

Assign T83.84 *Stenosis following insertion of genitourinary prosthetic devices, implants and grafts.*

Follow the ICD-10-AM Alphabetic Index:

Complication(s) (from) (of)

- genitourinary NEC (see also Complication(s)/by site and type)

- - device, implant or graft

- - - stricture (stenosis) T83.84

Also assign external cause, place of occurrence and activity codes.

Rationale:

T83.84 is assigned in accordance with the Alphabetic Index, to identify that the ureteral stricture is a complication of the prosthetic device, implant or graft.

Example 3: Wound dehiscence following ACL reconstruction with graft, for ruptured anterior cruciate ligament (ACL).

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

Follow the ICD-10-AM Alphabetic Index:

Complication(s) (from) (of)

- postprocedural

- - dehiscence (of wound) NEC T81.3

Also assign external cause and place of occurrence codes.

Rationale:

T81.3 is assigned to identify that wound dehiscence rather than a code from T82–T85, following the Alphabetic Index in accordance with the exception specified above. This supported by the *Excludes* note at category T84 *Complications of internal orthopaedic prosthetic devices, implants and grafts.*

Complications assigned to body system chapters

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 (E89, G97, H59, H95, I97, J95, K91, M96, N99).

Categories found at the end of body system chapters within ICD-10-AM classify specific intraoperative and postoperative complications associated with the body system. Many of these specific conditions have been identified as well-known complications for that body system that are frequently related to medical or surgical interventions.

Where the classification links the condition and the specific intervention via the Alphabetic Index the causal relationship can be assumed. Conditions classified to the end of body system chapters that commonly occur following an intervention are generally found with the condition being the lead term in the Alphabetic Index, followed by an essential modifier which specifies the intervention. For example:

Lymphoedema

- postmastectomy I97.2

Scoliosis (acquired) (postural) M41.9-

- postradiation therapy M96.5

In some instances, the Alphabetic Index does not link a condition with a specific intervention for an end of chapter code. In these instances, a causal relationship between the condition and the intervention must be documented within the episode of care for the condition to be considered a procedural complication. For example:

Adhesions, adhesive (postinfective)

- postprocedural

- - peritoneal

- - - pelvic N99.4

Example 1: Ureteral stricture due to a procedure, with no involvement of a prosthetic device, implant or graft.

Assign:

N99.89 *Other intraoperative and postprocedural disorder of genitourinary system*

N13.5 *Kinking and stricture of ureter without hydronephrosis*

Follow the ICD-10-AM Alphabetic Index:

Complication(s) (from) (of)

- genitourinary

- - intraoperative or postprocedural

- - - specified NEC N99.89

Stricture

- ureter (postprocedural) N13.5

Also assign external cause, place of occurrence and activity codes.

Rationale:

N99.89 is assigned to identify ureteral stricture due to a procedure without involvement of a prosthetic device, implant or graft.

N13.5 is assigned as an additional diagnosis to provide further specificity of the condition.

Example 2: Lymphoedema of the right arm 2 years after radical mastectomy requiring examination and ultrasound to confirm the diagnosis, and physiotherapy and compression garment.

Assign I97.2 *Postmastectomy lymphoedema syndrome*

Follow the ICD-10-AM Alphabetic Index:

Lymphoedema

- postmastectomy I97.2

Also assign external cause, place of occurrence and activity codes.

Rationale:

I97.2 is assigned to identify lymphoedema due to mastectomy. As the classification links the condition and the specific intervention via the Alphabetic Index, the causal relationship can be assumed.

Example 3: Lymphocele due to prostatectomy

Assign I97.83 *Postprocedural lymphocele, lymphoedema and chylothorax*

Follow the Alphabetic Index:

Lymphocele

- postprocedural I97.83

Also assign external cause, place of occurrence and activity codes.

Rationale:

I97.83 is assigned to identify lymphocele due to prostatectomy. In this instance the Alphabetic Index does not link the condition with a specific intervention for an end of chapter code. The causal relationship between the condition and the intervention must be documented for the condition to be considered an intraoperative or postoperative complication.

Complications classified to T80–T81 or T86–T88

Where a condition is not related to a prosthetic device, implant or graft and the complication is not related to a body system, assign an appropriate code from T80–T81 or T86–T88.

Example 1: Infection at saphenous vein donor site following coronary bypass graft (CAGB), requiring skin graft to the donor site.

Assign:

T81.4 *Wound infection following a procedure, not elsewhere classified*

Y83.2 *Surgical operation with anastomosis, bypass or graft.*

Follow the ICD-10-AM Alphabetic Index:

Complication(s) (from) (of)

- postprocedural

- - wound infection T81.4

Also assign a place of occurrence code.

Rationale:

Wound infections that develop at the vein donor site post CABG are post procedural skin infections, not complications of the CABG.

T81.4 is assigned to identify the infection at the saphenous vein donor site.

Y83.2 is assigned to identify the type of procedure causing the complication.

Example 2: Cellulitis of an 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*

Z89.5 *Acquired absence of leg at or below knee*

Follow the ICD-10-AM Alphabetic Index Section I *Alphabetic index of diseases and nature of injury*:

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

- - specified Y84.8

Also assign a place of occurrence code.

Rationale:

Although the cellulitis is due to a prosthetic device, the Alphabetic Index directs code assignment to T88.8, to identify that the cellulitis is a complication of the ill-fitting prosthetic limb.

L03.13 is assigned to provide further specificity of the condition.

Y84.8 is assigned to identify that the prosthesis is a medical procedure (device).

Z89.5 is assigned to identify that the amputation is of the leg, and was acquired (ie is not congenital).

This classification advice has been amended for clarity without a change to code assignment

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Procedural complications – additional code to add specificity

Q:

When should you use an additional code to add specificity for procedural complications?

A:

When classifying procedural complications, apply the *Conventions used in the ICD-10-AM Tabular List/Multiple condition coding* which 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).*

Also following the guidelines in ACS 1904 *Procedural complications*:

> *Assign an additional diagnosis code from Chapters 1 to 18 where it provides further specificity regarding the condition/complication.* ***Do not*** *assign an additional code from Chapters 1 to 18 to provide specificity for the anatomical site alone.*

Example 1: Postoperative knee pain specified as due to meniscal debridement, requiring review by the pain management team and an increase in the prescribed and administered pain medication dosage.
Assign:
T81.83 *Pain following a procedure, not elsewhere classifi*ed
Follow the ICD-10-AM Alphabetic Index:
Complication(s) (from) (of)
- postprocedural
- - pain NEC T81.83

Also assign external cause and place of occurrence codes.

Rationale:

T81.83 is assigned to identify pain due to the meniscal debridement, with no involvement of a prosthetic device, implant of graft. Do not assign M25.56 *Pain in joint, lower leg* to capture the site of the pain.

Example 2: Patient admitted for joint manipulation, due to stiffness of right total knee replacement (TKR**)**
Assign:
T84.89 *Other specified complications following insertion of internal orthopaedic prosthetic devices, implants and grafts*
M25.66 *Stiffness of joint, not elsewhere classified, lower leg*

Follow the ICD-10-AM Alphabetic Index:
Complication(s) (from) (of)
- prosthetic device, implant or graft (*see also Complication(s)/by site and type*)
- - joint prosthesis T84.89
Stiffness, joint
- knee M25.66

Also assign external cause and place of occurrence codes.

Rationale:

The additional code M25.66 is assigned to provide further specificity of the condition not the site (ie stiffness of the joint).

See also Coding Rule *ACS 1904 Procedural complications.*

This classification advice has been amended for clarity without a change to code assignment

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Urethral injury due to displacement of indwelling catheter

Q:

What codes are assigned for urethral injury due to displacement of an indwelling catheter (IDC)?

A:

Where the urethral injury is the result of a complication of the device (catheter), follow the guidelines in ACS 1904 *Procedural complications* to assign T83.0 *Mechanical complication of urinary (indwelling) catheter.*

Follow the ICD-10-AM Alphabetic Index:

Displacement, displaced

- device, implant or graft

- - catheter NEC

- - - urinary (indwelling) T83.0

Also assign external cause and place of occurrence codes.

See also Coding Rules *ACS 1904 Procedural complications* and *Procedural complications – additional code to add specificity*

Where a urethral injury occurs when a patient accidentally or intentionally removes their IDC, ACS 1904 *Procedural complications* is not applicable as the trauma/injury is not a complication of the device (catheter).

Assign the following codes if the urethral injury meets the criteria in ACS 0002 *Additional diagnoses*:

S37.3- *Injury of urethra*

X58 *Exposure to other specified factors*

Follow the ICD-10-AM Alphabetic Index Section I *Alphabetic index of diseases and nature of injury*:

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

Also assign place of occurrence code.

Amendments may be considered for a future edition.

This classification advice has been amended for clarity without a change to code assignment

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Coding Rules

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Multiple administrations of chemotherapy with anaesthesia

Q:

What ACHI codes are assigned when intrathecal chemotherapy is assigned with general anaesthesia multiple times during an episode of care?

A:

In accordance with the guidelines in ACS 0206 *Pharmacotherapy for neoplasms/Other classification guidelines:*

> *Do not assign the same ACHI code for pharmacotherapy more than once in an episode of care.*

Therefore, where pharmacotherapy is administered for a neoplasm with anaesthesia multiple times during an episode of care, assign:

- a code from block **[1920]** *Administration of pharmacotherapy* with extension -00 *Antineoplastic agent* **once**
- **multiple** anaesthesia codes to indicate the number of visits to theatre (ie as many times as anaesthesia is administered), as per the guidelines in ACS 0031 *Anaesthesia/Classification*:

> 2. *If the same anaesthetic is administered more than once during different 'visits to theatre', within the total episode of care (eg two general anaesthetics), it should be coded as many times as performed.*
>
> …
>
> 6. *Sequence the anaesthetic code(s) immediately following the procedure code to which it relates*.

Example:

Patient admitted for bone marrow aspiration and trephine (BMAT) and intrathecal (IT) chemotherapy. BMAT and IT chemotherapy performed with general anaesthesia (GA) on first visit to theatre. Two further sessions of IT chemotherapy performed with GA during the episode of care.

Assign:

30084-00 **[800]** *Percutaneous biopsy of bone marrow*
96198-00 **[1920]** *Intrathecal administration of pharmacological agent, antineoplastic agent*
92514-99 **[1910]** *General anaesthesia, ASA 99*
92514-99 **[1910]** *General anaesthesia, ASA 99*
92514-99 **[1910]** *General anaesthesia, ASA 99*

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

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Revision of peritoneovenous shunt

Q:

What code(s) are assigned for a revision of a peritoneovenous shunt?

A:

A peritoneovenous shunt is inserted to enable continuous draining of ascitic fluid from the peritoneal cavity into the venous system, including the Hyde shunt, LaVeen shunt and Dever shunt (Encyclopaedia of Surgery 2019).

ACHI currently does not have a single code for revision of peritoneovenous shunt (where a shunt is removed and a new shunt is inserted), therefore, assign as best fit:

92082-00 **[1896]** *Removal of peritoneal drainage device*, and

30408-00 **[983]** *Insertion of peritoneovenous shunt*

Follow the ACHI Alphabetic Index:

Removal

- drain

- - peritoneal 92082-00 **[1896]**

Shunt

- peritoneovenous 30408-00 **[983]**

For 'revision' of a peritoneovenous shunt where there is removal of a peritoneovenous shunt without reinsertion, only assign 92082-00 **[1896]** *Removal of peritoneal drainage device.*

Amendments may be considered for a future edition.

References:

Encyclopaedia of Surgery 2019, *Peritoneovenous shunt,* viewed 12 February 2019 https://www.surgeryencyclopedia.com/Pa-St/Peritoneovenous-Shunt.html

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Ref No: Q3332 | Published On: 15-Mar-2019 | Status: Updated | Updated On: 15-Jun-2022

E. coli UTI and *E.coli* bacteraemia

Q:

What codes are assigned for *E. coli* urinary tract infection (UTI) and bacteraemia?

A:

The urinary tract is the most common site of *Escherichia coli (E. coli)* infection, and more than 90% of all uncomplicated urinary tract infections (UTI) are caused by *E. coli* infection. Cases of *E. coli* bacteraemia are usually associated with UTIs, especially in cases of urinary tract obstruction of any cause (Madappa 2017).

E. coli bacteraemia is a separate clinical concept entity to *E. coli* UTI, although the two conditions can be present within the same episode of care.

Assign codes for both conditions and sequence as per the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*.

Assign the following codes for *E. coli* UTI:

N39.0 *Urinary tract infection, site not specified*

B96.2 *Escherichia coli [E. coli] as the cause of diseases classified to other chapters*

Follow the ICD-10-AM Alphabetical Index:

Infection, infected

- Escherichia (E.) coli
- - as cause of disease classified to other chapters B96.2
- urinary (tract) NEC N39.0

Where *E. coli* bacteraemia is also documented, assign:

A49.84 *Escherichia coli [E. coli] infection, unspecified site*

Follow the Alphabetical Index:

Bacteraemia *(see also Infection/bacterial)*

Infection, infected

- bacterial
- - agent (unspecified site) NEC — *see also Infection/by type of agent*
- Escherichia (E.) coli NEC A49.84

Note: The *Excludes* note at A49 regarding B95–B96 does not apply as the *E. Coli* infection in this scenario relates to two different clinical concepts (ie UTI and bacteraemia).

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

Reference:

Madappa, T 2017, *Escherichia coli (E coli) infections,* Medscape, viewed 15 August 2018, https://emedicine.medscape.com/article/217485-overview

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Insertion of anal seton

Q:

What code is assigned when insertion of anal seton is performed for any documented condition (with or without documentation of anal fistula)?

A:

Setons, made from various material, are commonly used in the treatment of anal fistulas. An anal fistula, also known as fistula-in-ano or perianal sinus tract, is an abnormal hollow tract or cavity lined with granulation tissue and may arise from inflamed or infected glands and ulcers of the rectum and anal canal in conditions such as Crohn's disease, tuberculosis or diverticulitis. The seton is threaded through the fistula tract to drain, promote fibrosis and cut through the fistula (Poggio 2018; Subhas et al 2012). Setons also act as a marker of the fistula tract for sphincter-sparing procedures such as fistula plug, fibrin glue and ligation of the intersphincteric fistula tract (LIFT). Further operations may be required to replace or adjust the seton.

Where insertion of anal seton is performed for any documented condition (with or without documentation of anal fistula), assign as a best fit:

32166-00 **[929]** *Insertion of anal seton*

Or

32159-01 **[937]** *Insertion of seton for anal fistula involving lower half of anal sphincter mechanism*

Or

32162-01 **[937]** *Insertion of seton for anal fistula involving upper half of anal sphincter mechanism*

Follow the Alphabetic Index:

Insertion

- seton
- - for
- - - anal fistula *(see also Fistulectomy/anus/with/insertion seton)* 32166-00 **[929]**
- - - - involving
- - - - - lower half of anal sphincter 32159-01 **[937]**
- - - - - upper half of anal sphincter 32162-01 **[937]**

Amendments may be considered for a future edition.

References:

Poggio, JL 2018, Fistula-in-Ano, Medscape, viewed 21 August 2018, https://emedicine.medscape.com/article/190234-overview

Subhas, G, Bhullar, JS, Al-Omari, A, Unawane, A, Mittal, VJ Pearlman, R 2012, Setons in the treatment of anal fistulA: review of variations in materials and tchniques, Digestive surgery, vol 29, pp 292-300, viewed 30 November 2018, https://pdfs.semanticscholar.org/1973/4a957201a20711d1f78f0b3ce2b5d154a3b7.pdf?_ga=2.78978198.389091853.1545027033-108336841.1545027033

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Cervical radiculopathy due to spinal stenosis

Q:

What codes are assigned for cervical radiculopathy due to spinal stenosis?

A:

Cervical radiculopathy is usually due to compression of or an injury to a cervical nerve root by a herniated intervertebral disc or degenerative changes of the spinal canal (RACGP 2019).

For classification purposes, in the absence of another documented cause of radiculopathy, assign a code for nerve root compression.

For example, cervical radiculopathy due to spinal stenosis NOS assign:

M48.02† *Spinal stenosis, cervical region*

G55.3* *Nerve root and plexus compressions in other dorsopathies (M45–M46†, M48.-†, M53–M54†)*

Follow the ICD-10-AM Alphabetic Index:

Compression

- nerve

- - root or plexus (in) NEC

- - - with spinal (vertebra) stenosis M48.0-† G55.3*

Assign and sequence codes as per the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*.

Where there is documentation of an intervention for decompression of cervical radiculopathy assign 40330-00 **[49]** *Decompression/spinal/nerve roots* (rhizolysis).

Follow the ACHI Alphabetic Index:

Decompression

- spinal

- - nerve

- - - roots (rhizolysis) 40330-00 **[49]**

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

References:

The Royal Australian College of General Practitioners 2019, *Cervical radiculopathy*, RACGP, viewed 18 February 2019,

https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/clinical-guidance-for-mri-referral/mri-of-the-cervical-spine/cervical-radiculopathy

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Intraoperative oroantral fistula resulting from tooth removal

Q:

What code is assigned for an intraoperative oroantral fistula resulting from removal of a tooth?

A:

Oroantral fistula (OAF) is a persistent open communication between the oral cavity and the maxillary sinus. It most commonly occurs as a result of extraction of upper molar and premolar teeth due to the anatomical proximity or projection of the tooth roots in the maxillary sinus. Other causes of OAF include tuberosity fracture, dentoalveolar/periapical infections of molars, trauma, implant dislodgement into maxillary sinus, presence of maxillary cysts or tumours, and osteoradionecrosis. The defect after tooth extraction can contaminate the sinus with food and saliva from the oral cavity leading to infection, impaired healing and chronic sinusitis (Khandelwal Hajira 2017).

ACS 1904 *Procedural complications* states:

> *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')*

Therefore, an intraoperative OAF resulting from removal of a tooth, without documentation of a causal inference, is not classified as a procedural complication. Assign:

J32.0 *Chronic maxillary sinusitis*

Follow the Alphabetic Index:

Fistula

- oroantral J32.0

The indexing and classification of OAF to J32.0 *Chronic maxillary sinusitis* in ICD-10-AM is consistent with ICD-10, where OAF is classified by its manifestation.

Amendments may be considered for a future edition.

Reference:

Khandelwal, P Hajira, N 2017, Management of oro-antral communication and fistulA: various surgical options, World Journal of Plastic Surgery, vol. 6, no. 1, pp. 3-8, viewed 7 November 2018, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5339603/

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Restenosis of previous vascular bypass, graft or stent

Q:

What code(s) should be assigned for restenosis of a previous vascular graft/stent?

A:

Restenosis of previous angioplasty, arterial bypass and stent sites may occur as a result of recurrent atherosclerosis or tissue growth, in response to the vascular injury caused by the initial treatment (Fogoros 2017).

ACS 0941 *Arterial disease/9. Stenosis* states:

> *Stenosis is a quantitative anatomical term and often refers to atherosclerosis.*
>
> *…stenosis of other arteries that is not documented as due to another cause is to be assigned the appropriate atherosclerosis code*

Therefore, where documentation specifies that restenosis of a peripheral (vascular) bypass graft/in-stent stenosis is due to recurrent atherosclerosis or the cause is unspecified, assign a code from category I70.2- *Atherosclerosis of arteries of extremities.*

Also assign Z95.8 *Presence of other cardiac and vascular implants and grafts* to indicate the stent status.

Where documentation specifies that restenosis of a coronary in-stent stenosis is due to recurrent atherosclerosis or the cause is unspecified, assign I25.11 *Atherosclerotic heart disease of native coronary artery.*

Also assign Z95.5 *Presence of coronary angioplasty implant and graft* to indicate the stent status.

ACS 0934 *Cardiac and vascular revision/reoperation procedures/Reoperation (Redo) CABGS/Disease classification* states:

> *Assign I25.12* Atherosclerotic heart disease of autologous bypass graft *or I25.13* Atherosclerotic heart disease of nonautologous bypass graft *when it is a repeat CABG on the previous bypass grafts. In this instance, it is not necessary to assign Z95.1* Presence of aortocoronary bypass graft *as an additional diagnosis.*

Therefore, where documentation specifies that restenosis of a coronary bypass graft/in-stent stenosis is due to recurrent atherosclerosis or the cause is unspecified, assign either I25.12 *Atherosclerotic heart disease of autologous bypass graft* or I25.13 *Atherosclerotic heart disease of nonautologous bypass graft*.

Where documentation specifies that restenosis of a vascular bypass graft/in-stent stenosis is caused by a complication of the initial treatment, assign T82.84 *Stenosis following insertion of cardiac and vascular prosthetic device, implants and grafts*. Follow the Alphabetic Index:

Stenosis

- due to presence of device, implant or graft NEC

- - arterial graft NEC T82.84

Also assign external case and place of occurrence codes, as appropriate.

The material used for the bypass graft (vein, artery, synthetic, etc.) does not have any bearing on the classification of the stenosis.

Amendments may be considered for a future edition.

References:

Fogoros, RN 2017, *Restenosis after angioplasty and stenting,* Very Well Health, viewed 8 May 2018, https://www.verywell.com/restenosis-after-angioplasty-and-stenting-1745217

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Ref No: Q3371 | Published On: 15-Mar-2019 | Status: Current

Gastropexy or cardiopexy performed without fundoplasty

Q:

What codes are assigned for gastropexy or cardiopexy, performed without fundoplasty?

A:

Gastropexy is surgical fixation of the stomach to the abdominal wall and is performed for conditions such as gastro-oesophageal reflux disease, gastric volvulus in high risk patients, paraoesophageal hiatal hernia and in conjunction with percutaneous endoscopic gastrostomy in children for gastric feeding (Atlanta Reflux Group 2018; Merriam-Webster 2018; Yates et al. 2015).

Where gastropexy is documented, assign 30530-00 **[886]** *Fundoplasty with cardiopexy* by following the Alphabetic Index:

Gastropexy 30530-00 **[886]**

Cardiopexy is fixation of the cardia of the stomach to the diaphragm with the ligamentum terres of the liver and is generally performed with fundoplasty (fundoplication) for gastro-oesophageal reflux disease and closure of hiatal hernia (Flamant et al, 1991). Cardiopexy may be performed with or without fundoplasty, however, ACHI does not include a code for cardiopexy alone. Therefore, where cardiopexy is performed, assign 30530-00 **[886]** *Fundoplasty with cardiopexy* regardless of whether fundoplasty has been performed.

Follow the Alphabetic Index:

Cardiopexy

- with fundoplasty 30530-00 **[886]**

Amendments may be considered for a future edition.

References:

Atlanta Reflux Group 2018, *Fundoplication and Gastropexy surgeries for GERD*, Atlanta Reflux group, Georgia, viewed 8 November 2018, http://www.atlantareflux.com/?p=141

Flamant, JB, Plet, H, Palot, JP, Delattre, JF, Cazabat, A Thiefin, G 1991, Cardiopexy using the hepatic ligament in the treatment of gastroesophageal reflux, *Chirurgie*, vol. 117, no. 3, pp. 214-223, viewed 8 November 2018, https://www.ncbi.nlm.nih.gov/pubmed/1797473

Merriam-Webster 2018, Gastropexy, Merriam-Webster dictionary, viewed 8 November 2018, https://www.merriam-webster.com/medical/gastropexy

Yates, RB, Hinojosa, MW, Wright, AS, Pellegrini, CA Oelschlager, BK 2015, Laparoscopic gastropexy relieves symptoms of obstructed gastric volvulus in high operative risk patients, *The American Journal of Surgery*, vol. 209, no. 5, pp. 875-880, viewed 8 November 2018, https://www-clinicalkey-com-au.ezproxy1.library.usyd.edu.au/#!/content/journal/1-s2.0-S0002961015000707

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Allergic reaction to venom immunotherapy

Q:

What codes are assigned for an allergic reaction to venom immunotherapy?

A:

Venom immunotherapy (VIT) is the specialised form of allergen immunotherapy for patients allergic to Hymenoptera venom. VIT may be associated with local side effects (ie swelling, reddening of skin and itch) and systemic side effects (ie hypotension, fever, nausea and anaphylaxis). Depending on the type of allergy, specific and standardised allergenic extracts of venom (eg bee or wasp) are used (ARTG 2018, Kolaczek et al. 2017).

Where there is documentation of an allergic reaction to bee venom immunotherapy, assign codes as per the classification guidelines in ACS 1902 *Adverse Effects.*

Therefore, where the manifestation of the allergic reaction (adverse effect) to VIT is specified in the clinical record, assign:

- A code(s) for the adverse effect/manifestation (eg rash, anaphylaxis – see ICD-10-AM Alphabetic Index Section I *Alphabetic index of diseases and nature of injury*)
- Y59.8 *Other specified vaccines and biological substances causing adverse effects in therapeutic use.*

  Follow the ICD-10-AM Alphabetic Index Section III *Table of Drugs and Chemicals*:

  Immunological agent

  - specified NEC (Adverse effect in therapeutic use) Y59.8
- Y92.23 *Place of occurrence, health service area, not specified as this facility*

  or

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

Where the manifestation of the allergic reaction (adverse effect) to VIT is unspecified, assign T88.7 *Unspecified adverse effect of drug or medicament*.

Follow the ICD-10-AM Alphabetic Index Section I *Alphabetic index of diseases and nature of injury*:

Allergy, allergic (reaction)

- drug, medicament and biological (any) (correct medicinal substance properly administered) (external) (internal) NEC T88.7

Also assign external cause and place of occurrence codes as listed above.

Amendments may be considered for a future edition.

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

References:

Australian Register of Therapeutic Goods 2018, ARTG, viewed 14 November 2018, https://search.tga.gov.au/s/search.html?collection=tga-websites-webquery=venom

Kołaczek A, Skorupa D, Antczak-Marczak M, Kuna P, Kupczyk M 2017, *Safety and efficacy of venom immunotherapy: a real life study*. Postepy Dermatol Alergol, viewed 24 October 2018, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5420609/

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Follow-up for *H. pylori* after eradication therapy

Q:

What codes are assigned for follow-up of *H. pylori* after eradication therapy, where no associated conditions are present?

A:

The effect of *Helicobacter pylori* (*H.* pylori) eradication treatment can be assessed by a variety of methods, of which urea breath testing is the easiest and most reliable method. Further endoscopic follow-up is needed in patients with uninvestigated dyspepsia who do not respond to *H. pylori* eradication. Patients with complicated peptic ulcer need thorough confirmation of successful *H. pylori* eradication. Given the importance of adequate assessment and the fact that the use of acid suppressants interferes with urea breath testing, *H. pylori* status is usually checked by repeat endoscopy (Kuipers 2015)

The *Instructional* note at B96.81 *Helicobacter pylori [H. pylori] as the cause of diseases classified to other chapters* states:

> *Code first, if applicable:*
> • *any documented condition stated as due to Helicobacter pylori*
> • *chronic gastritis — see Alphabetic Index: Gastritis/chronic*
> • *duodenal ulcer (K26.-)*
> • *gastric ulcer (K25.-)*
> • *gastrojejunal ulcer (K28.-)*
> • *MALT (mucosa associated lymphoid tissue) lymphoma — see Alphabetic Index: Lymphoma/MALT*

Assign B96.81 when *H. pylori* is found in the presence of the above conditions or there is documentation associating it with another condition.

Do not assign B96.81 when there is no documented association between the *H. pylori* infection and another condition.

Where the presence of *H. pylori* is documented at follow-up, but no associated condition(s) is documented, clinical consultation should be sought to determine if there is a *H. pylori* associated condition present.

If, after clinical consultation, the presence of *H. pylori* was not associated with another condition (or if consultation is not possible), assign:

Z09.2 *Follow-up examination after pharmacotherapy for other conditions*

Z87.18 *Personal history of other digestive system disease*.

Follow the ICD-10-AM Alphabetic Index:

Examination (for) (general) (of) (routine)

- follow-up (following) (routine)

- - pharmacotherapy NEC Z09.2

History (of) (personal)

- disease or disorder (of)

- - digestive system

- - - specified disease or disorder NEC Z87.18

Amendments may be considered for a future edition.

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

References:

Kuipers, A 2015, 'When is endoscopic follow-up appropriate after Helicobacter pylori eradication therapy', *Gastroenterology Clinics of North America*, vol 44, issue 3, pp. 597-608, viewed 11 February 2019, https://www.ncbi.nlm.nih.gov/pubmed/26314670

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BMI from calculated EMR fields

Q:

Can clinical coders use BMI values from calculated fields in EMR systems to assign codes from category E66 Obesity and overweight?

A:

Body mass index (BMI) is an index for relating weight to height. BMI provides an estimate of total body fat and related risk of developing weight related diseases.

BMI is less accurate for assessing healthy weight in some groups because it does not distinguish between the proportion of weight due to fat or muscle. BMI is therefore less accurate in:

- certain ethnic groups, such as Pacific Islander populations (including Torres Strait Islander peoples and Maori), Aboriginal peoples, South Asian, Chinese and Japanese population
- body builders or weight lifters
- some high-performance athletes
- pregnant women
- the elderly
- people with a physical disability
- people with eating disorders
- people under 18 years
- those with extreme obesity

(Healthdirect 2019)

To determine if a BMI result is a health risk, a healthcare provider would need to perform further assessments such as measurements of skinfold thickness, waist circumference, evaluations of diet, physical activity, family history and other health screenings (CDC 2019).

Obesity or overweight (whether specifically documented or documented as a BMI value) must meet the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*, to assign a code from category E66 *Obesity and overweight.*

References:

Centres for disease control and prevention 2019, *Body Mass Index,* CDC, viewed 12 February 2019, https://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html

Healthdirect 2019, *Body mass index (BMI) and waist circumference,* Healthdirect, viewed 12 February 2019, https://www.healthdirect.gov.au/body-mass-index-bmi-and-waist-circumference

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Endoscopic vacuum-assisted closure (EVAC) of gastrointestinal defect

Q:

What codes are assigned for insertion, replacement and removal of EVAC for leaking anastomosis following sleeve gastrectomy?

A:

Endoscopic vacuum-assisted closure (EVAC) is a treatment option for repair of gastrointestinal defects (eg perforation/leakage at anastomosis site following oesophagectomy or bariatric surgery). The EVAC applies continuous, controlled negative pressure at the defect site via a (nasal) drainage tube, using a polyurethane sponge connected to an electronic vacuum device. The sponge is replaced every 3–5 days until the defect is healed (Bludau et al 2018; Watson Zuchelli 2018).

- Assign 90305-00 **[890]** *Other procedures on stomach* for insertion of an EVAC device into the stomach. Follow the ACHI Alphabetic Index:

  Procedure

  - stomach NEC 90305-00 **[890]**

  Note: For insertion of an EVAC device into another gastrointestinal site (eg oesophagus or rectum), follow the Alphabetic Index at Procedure/by site.
- Assign 92086-00 **[1896]** *Removal of other device from gastrointestinal tract* for removal of an EVAC device. Follow the ACHI Alphabetic Index:

  Removal

  - device — see also Removal/by type of device

  - - gastrointestinal tract NEC 92086-00 **[1896]**
- Assign both of the above codes (sequencing 92086-00 **[1896]** before 90305-00 **[890]**) for replacement of an EVAC device.

Also assign 30473-00 **[1005]** *Panendoscopy to duodenum* when oesophagogastroduodenoscopy is performed, as per the guidelines in ACS 0023 *Minimally invasive interventions.*

Amendments may be considered for a future edition.

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

References:

Bludau, M, Fuchs, HF, Herbold, T, Maus, MKH, Alakus, H, Popp, F, Leers, JM, Bruns, CJ, Hölscher, AH, Schröder, W, Chon, SH 2018, 'Results of endoscopic vacuum-assisted closure device for treatment of upper GI leaks', *Surgical endoscopy* 2018 Apr;32(4):1906-1914, viewed 6 December 2018, https://www.ncbi.nlm.nih.gov/pubmed/29218673

Watson, A Zuchelli, T 2018, 'Repair of upper gastrointestinal fistulas and anastomotic leakage utilizing endoluminal vacuum-assisted closure', *Gastrointestinal endoscopy* June 2018Volume 87, Issue 6, Supplement, Page AB123, viewed 6 December 2018, https://www.giejournal.org/article/S0016-5107(18)31593-1/fulltext

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ICD-10-AM classification of adverse effect of drugs in therapeutic use

ICD-10 and hence ICD-10-AM, generally classifies drugs by class, not by therapeutic indication. A drug may have multiple indications, or the indication may change over time, but the class remains stable. Therefore, for data consistency, it serves no purpose to change the classification of a drug for every possible therapeutic indication.

As per the guidelines in ACS 1902 *Adverse effects,* where an adverse effect of a drug in therapeutic use is documented, assign:

- a code for the nature of the adverse effect (ie the manifestation)
- an external cause code for the causative agent as listed in the ICD-10-AM Alphabetic Index Section III Table of drugs and chemicals (Adverse effect in therapeutic use) regardless of the clinical indication
- an appropriate place of occurrence code

For example, assign Y47.1 *Benzodiazepines* as the adverse effect of *clozapine* by following the Alphabetic Index Section III Table of drugs and chemicals:

Clozapine (Adverse effect in therapeutic use) Y47.1

Note that the indexing for *Antipsychotic drug* is a NEC option. The ICD-10-AM Conventions used in the Alphabetic Index of Diseases state that NEC (not elsewhere classified) is:

> *…added after terms classified to residual or unspecific categories and to terms in themselves ill-defined as a warning that specified forms of the conditions are classified differently. If the clinical record includes more precise information the coding should be modified according.*

Category Y49 *Psychotropic drugs, not elsewhere classified* also *Excludes* benzodiazepines (Y47.1).

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Cricopharyngeal dilation

Q:

What code is assigned for endoscopic dilation of the cricopharyngeus muscle (upper/superior oesophageal sphincter)?

A:

Treatment options for cricopharyngeal dysfunction (cricopharyngeus muscle dysfunction (CPMD)) include systemic medical therapy, mechanical dilation (dilatation), botulinum toxin injection or cricopharyngeal myotomy. Endoscopic balloon dilation of the cricopharyngeus muscle (upper/superior oesophageal sphincter) is performed to effect relaxation of the muscle (Chandrasekhara et al 2017; Huoh et al 2013; Kocdor et al 2015).

Assign as a best fit 41832-00 **[862]** *Endoscopic balloon dilation of oesophagus* for cricopharyngeal (upper oesophageal sphincter) dilation. Follow the ACHI Alphabetic Index:

Dilation

- oesophagus

- - endoscopic (by) (for stricture)

- - - balloon (using interventional imaging techniques) 41832-00 **[862]**

Amendments may be considered for a future edition.

References:

Chandrasekhara, V, Koh, J, Lattimer, L, Dunbar, K, Ravich, W, Clarke, J 2017, 'Endoscopic balloon catheter dilatation via retrograde or static technique is safe and effective for cricopharyngeal dysfunction' *World Journal of Gastrointestinal Endoscopy,* Apr 16, 2017; 9(4): 183-188, viewed 10 December 2018, https://www.wjgnet.com/1948-5190/full/v9/i4/183.htm

Huoh, K, Messner, A 2013 'Cricopharyngeal achalasia in children: indications for treatment and management options', *Current Opinion in Otolaryngology Head and Neck Surgery,* December 2013 - Volume 21 - Issue 6 - p 576–580, viewed 6 December 2018, https://journals.lww.com/co-otolaryngology/Fulltext/2013/12000/Cricopharyngeal_achalasia_in_children__.12.aspx

Kocdor, P, Siegel, E, Tulunay-Ugur, O 2015, 'Cricopharyngeal dysfunction: a systematic review comparing outcomes of dilatation, botulinum toxin injection, and myotomy', *Laryngoscope* 126:135–141, 2016, viewed 6 December 2018, https://www.metroatlantaotolaryngology.org/journal/apr16/Cricopharyngeal%20dysfunction.pdf

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Ref No: Q3404 | Published On: 15-Mar-2019 | Status: Current

Incision of ureterocele

Q:

What code is assigned for incision of ureterocele?

A:

A ureterocele is a cystic outpouching of the distal ureter into the urinary bladder. Surgical therapy for ureteroceles may include incision by endoscopic puncture or transurethral unroofing, upper pole heminephrectomy, excision of ureterocele and ureteral reimplantation, and nephroureterectomy (Cooper C, 2017).

For incision of ureterocele, assign 36848-00 **[1077]** *Endoscopic resection of ureterocele,* as a best fit.

Follow the ACHI Alphabetic Index:

Resection

- ureterocele

- - endoscopic 36848-00 **[1077]**

Amendments may be considered for a future edition.

Reference:

Cooper C, 2017, *Ureterocele Treatment Management,* Medscape, viewed 21st November 2018, https://emedicine.medscape.com/article/451105-treatment#d10

Published 15 March 2019,
for implementation 01 April 2019.

Ref No: Q3408 | Published On: 15-Mar-2019 | Status: Updated | Updated On: 15-Jun-2022

Triangular fibrocartilage complex (TFCC) injury repair

A:

What codes are assigned for triangular fibrocartilage complex (TFCC) injury and repair?

Q:

The triangular fibrocartilage complex (TFCC) is a bundle of ligaments that connects the radius and ulna with the carpal bones of the wrist. The TFCC is often subject to traumatic injuries and ligament degeneration compromising the movement of the wrist (Lex Medicus, 2018).

ICD-10-AM classification of a triangular fibrocartilage complex (TFCC) injury of wrist is dependent on the cause of the condition. A patient may present with a TFCC condition due to a current trauma, a previously healed trauma or a nontraumatic (degenerative) tear.

Tear of a ligament is classified as a sprain in ICD-10-AM. For a current (traumatic) injury assign S63.58 *Sprain and strain of other parts of wrist.*

Follow the ICD-10-AM Alphabetic Index:

Sprain, strain

- wrist (cuneiform) (scaphoid) (semilunar)

- - specified part NEC S63.58

Also assign external cause, place of occurrence and activity codes.

For a nontraumatic injury, assign M24.23 *Disorder of ligament, forearm.*

Follow the ICD-10-AM Alphabetic Index and Tabular List *Site of musculoskeletal involvement*:

Disorder

- Ligament, forearm M24.23

Assign 49215-00 **[1470]** *Reconstruction of wrist* for repair of a triangular fibrocartilage complex tear.

Follow the ACHI Alphabetic Index:

Repair

- ligament NEC

- - wrist, with reconstruction 49215-00 **[1470]**

Also assign a code for arthroscopy as per the guidelines in ACS 0023 *Minimally invasive interventions*, if applicable.

Amendments may be considered for a future edition.

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

References:

Lex Medicus, 2018, *'Triangular Fibrocartilage Complex Injury'*, viewed 4 December 2018, http://pathologies.lexmedicus.com.au/pathologies/triangular-fibrocartilage-complex-injury

Published 15 March 2019,
for implementation 01 April 2019.

Coding Rules

Published 15 December 2018

Ref No: Q3336 | Published On: 15-Dec-2018 | Status: Updated | Updated On: 15-Jun-2022

Assignment of additional diagnosis codes for prematurity

Q:

Does prematurity need to meet the criteria in ACS 0002 *Additional diagnoses*?

A:

Prematurity is a significant indicator of neonatal morbidity and mortality.

The *Includes* note at category P07 reflects the criteria and guidelines in ACS 0002:

> P07 *Disorders related to short gestation and low birth weight, not elsewhere classified*
>
> **Includes***: the listed conditions, without further specification, as the cause of mortality, morbidity or additional care, in newborn*
>
> ACS 0002 *Additional diagnoses*
>
> *Additional diagnoses are conditions that significantly affect patient management in an episode of care in terms of requiring any of the following:*
>
> - *commencement, alteration or adjustment of therapeutic treatment*
> - *diagnostic interventions*
> - *increased clinical care*
>
> ***PROBLEMS AND UNDERLYING CONDITIONS***
>
> *If a condition (problem) with a known underlying cause is treated in an episode of care, then assign codes for both conditions (see also* ACS 0001 *Principal diagnosis/Problems and underlying conditions).*

Therefore, assign a code from subcategories P07.4 *Extreme prematurity* or P07.5 *Other and unspecified preterm infants* for:

- all neonates with a gestational age of less than 37 completed weeks in the **birth episode of care**
- episodes of care **subsequent to the birth episode of care**, when immaturity/prematurity meets the criteria in ACS 0002 *Additional diagnoses*.

ACS 1605 *Conditions originating in the perinatal period* Example 2 reflects the logic in the second dot point above, where a code for prematurity (P07.47) is assigned as it meets the criteria in ACS 0002 (ie it is the underlying cause of the jaundice):

> A premature infant (born at 27 weeks; birth weight 700g), was transferred from another hospital at 30 days of age, for ongoing care of jaundice of prematurity and low birth weight. During this admission the infant received 24 hours of phototherapy and supplementary feeds.

Codes:

P59.0 *Neonatal jaundice associated with preterm delivery*

P07.47 *Extreme prematurity, gestational age 27 completed weeks*

P07.02 *Extremely low birth weight 500–749g*

90677-00 **[1611]** *Other phototherapy, skin*

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

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Periosteal flap

Q:

What code is assigned for a periosteal flap?

A:

A periosteal flap is a vascularised pedicle from the periosteum and the outer layer of bone and plays an important role in bone healing. The rich blood supply of periosteal flaps means they are often used in the reconstruction of complex, large bone defects due to trauma, to assist in bone growth and repair. Properties of the periosteal flap include its ease of harvesting and its great elasticity, which allows adaptation of the flap over the reconstruction including both bone junctions. However, the main attribute of the periosteal flap is the rich content of stem cells located at the cambium layer, which provide excellent osteogenic and angiogenic properties that biologically support bone healing and revascularization (Christoph et al. 2017; Sierra et al. 2016).

Periosteal flaps are not classified in ACHI. In ACHI, flaps are classified based on the anatomical location of the flap, type of tissue used eg skin, myocutaneous, muscle flap or bone, and the complexity of the flap eg local, distant, island, free, noninnervated or innervated.

When documentation is not available or is unclear, clinical coders must seek clinical advice regarding periosteal flap, to determine the appropriate code to assign from Chapter 16 *Dermatological and plastic procedures*.

For example, periosteal flap performed during repair of a ruptured extensor carpi ulnaris (ECU) tendon; assign 45206-05 **[1651]** *Local skin flap of hand* as a best fit by following the ACHI Alphabetic Index:

Flap (repair)

- wrist (local) (single stage) 45206-05 **[1651]**

Amendments may be considered for a future edition.

See also Coding Rule: *Perforator flap*.

References:

Christoph, N, Henrich, D, Seebach, C, Schröder, Barker, JH, Marzi, I & Frank, J 2017, 'Tissue engineered vascularized periosteal flap enriched with MSC/EPCs for the treatment of large bone defects in rats', *International Journal of Molecular Medicine*, vol. Apr; 39, no. 4, pp. 907-917, viewed 07 June 2018, PMC database, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5360440/

Sierra N, Gallardo P, Knorr J, Mascarenhas V, García-Diez E, Munill-Ferrer M, Bescós-Atín M, Soldado F, 2016, *Bone Allograft Segment Covered with a Vascularized Fibular Periosteal Flap: A New Technique for Pediatric MandibularReconstruction, Journal of Craniomaxillofacial Trauma & Reconstruction,* viewed 16th October 2018,https://www.thieme-connect.de/products/ejournals/html/10.1055/s-0036-1593992#JR160569cr-3

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Ref No: Q3288 | Published On: 15-Dec-2018 | Status: Current

Sling procedures for unspecified urinary incontinence

Q:

What code is assigned for sling procedure performed for urinary incontinence not specified as stress incontinence?

A:

There are two main types of urinary incontinence, stress incontinence and urge incontinence. Sling procedures are generally performed for stress incontinence, while urge incontinence is treated with medication, Botox injection or sacral nerve stimulation (Chung et al 2017; MedlinePlus 2017).

When a sling procedure is performed with no documentation on the type of urinary incontinence and clinical clarification is not possible, assign:

37044-00 **[1109]** *Retropubic procedure for stress incontinence, male*

or

35599-00 **[1110]** *Sling procedure for stress incontinence, female*.

Follow the Alphabetic Index:

Sling procedure

- for

- - stress incontinence

- - - female 35599-00 **[1110]**

- - - male 37044-00 **[1109]**

Amendments will be considered for a future edition.

References:

Chung E, Katz DJ Love C 2017, Adult male stress and urge urinary incontinence – A review of pathophysiology and treatment strategies for voiding dysfunction in men, Australian Family Physician Urology, Royal Australian College of General Practice, vol. 46, No. 9, pp. 661-666, viewed 27 July 2018, https://www.racgp.org.au/afp/2017/september/adult-male-stress-and-urge-urinary-incontinence/

MedlinePlus 2017, Urinary incontinence – vaginal sling procedures, NIH U.S. National Library of Medicine, viewed 27 July 2018, https://medlineplus.gov/ency/article/007376.htm

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Ref No: Q3259 | Published On: 15-Dec-2018 | Status: Updated | Updated On: 15-Jun-2022

Neonatal sepsis/risk of sepsis

Q:

What code is assigned for suspected neonatal sepsis?

A:

ACS 0012 *Suspected conditions* provides the following guidelines in regard to suspected diseases and conditions in neonates:

> *Z03.7-* Observation and evaluation of newborn for suspected condition not found *is assigned following the criteria in ACS 1611* Observation and evaluation of newborn and *infants for suspected condition not found and ACS 1617* Neonatal sepsis/risk of sepsis.

The *Note* at category Z03.7 *Observation and evaluation of newborn for suspected condition not found* and the risk of sepsis classification instructions within ACS 1617 *Neonatal sepsis/risk of sepsis* are ambiguous, as neonates with risk of/suspected sepsis may be symptomatic and have other conditions. However, clinical coders should apply the guidelines in ACS 1617 regardless of whether the neonate has signs or symptoms, or coexisting conditions documented.

Therefore:

- when there is documentation of "suspected neonatal sepsis" but there is conflicting, unclear or no supporting documentation in the body of the clinical record, seek clinician clarification prior to code assignment
- where a diagnosis of 'neonatal sepsis' is confirmed, assign a code for sepsis, as per the guidelines ACS 1617 *Neonatal sepsis/risk of sepsis*
- for classification purposes, a diagnosis of 'risk of sepsis' or 'suspected sepsis' (ie probable, possible, likely, queried sepsis) are synonymous in neonates. Assign Z03.71 *Observation of newborn for suspected infectious condition* regardless of whether the neonate has signs or symptoms, or coexisting conditions documented.

Amendments may be considered for a future edition.

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

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Ref No: Q3281 | Published On: 15-Dec-2018 | Status: Current

Perforator flap

Q:

What code is assigned for a perforator flap?

A:

A perforator flap is a flap consisting of skin and/or subcutaneous fat with its blood supplied by a small isolated vessel. Other types of perforator flaps may also penetrate muscle (muscle perforator) and/or muscle septae (septal perforator), to supply the overlying skin.

The name of a perforator flap is derived from the (perforator) vessel that supplies the blood, and the structures they cross before reaching the skin. For example, anterior intercostal artery perforator (AICAP) flaps, commonly used in breast reconstruction, obtain their blood supply from the intercostal arteries. Some may be named by their anatomical region (eg adipofascial flap, which consists of adipose and fascia layers). Some perforator flaps may also include nerves (eg anterolateral thigh (ALT) flaps) (Blondeel et al. 2003; Kim & Kim 2015).

Perforator flaps are not classified in ACHI. Depending on the location of the flap being performed, a perforator flap may be a free flap or an island flap. Therefore, seek clinical advice on the flap undertaken to determine the appropriate code from Chapter 16 *Dermatological and plastic procedures* when clinical documentation is unclear or unavailable.

When a perforator flap is used in breast reconstruction, assign 45530-02 **[1756]** *Reconstruction of breast using flap.* Follow the ACHI Alphabetic Index:

Flap (repair)

- for

- - reconstruction of breast 45530-02 **[1756]**

Amendments may be considered for a future edition.

See also Coding Rule: *Periosteal flap*.

References:

Blondeel, PN, Van Landuyt, KH, Monstrey, SJ, Hamdi, M, Matton, GE, Allen, RJ, Dupin, C, Feller, A-M, Koshlina, I, Kostakoglu, N Wei, F-C 2003, *The "Gent" Consensus on Perforator Flap Terminology: Preliminary Definitions*, Robert J. Allen, MD: The Center for Microsurgical Breast Reconstruction, New York, viewed 02 April 2018, https://www.diepflap.com/articles/the-gent-consensus-on-perforator-flap-terminology-preliminary-definitions

Kim, JT Kim, SW 2015, *Perforator Flap versus Conventional Flap,* Journal of Korean Medical Science, vol. 30, no. 5, pp. 514-522, viewed 02 April 2018, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4414633/

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Ref No: Q3291 | Published On: 15-Dec-2018 | Status: Updated | Updated On: 15-Jun-2022

Insertion of cardiac contractility modulation (CCM) device

Q:

What code is assigned for the insertion of a cardiac contractility modulation (CCM) device?

A:

Cardiac contractility modulation (CCM) is used for treatment of patients with moderate to severe chronic heart failure who have not responded to medical therapy. The CCM signals are electrical pulses that are delivered by a CCM system, which consists of a small, implantable pulse generator unit (device) and electrodes (leads) similar to a pacemaker. These signals are delivered via the two electrodes during the absolute refractory period (ie the period just after the heart contracts). It comes with a rechargeable battery to minimise the need for replacement.

The CCM device is typically implanted under the skin in the right pectoral region and connected to two electrodes that are transvenously placed in the right ventricle of the heart to sense ventricular activity. An optional electrode may also be inserted to sense atrial activity. Unlike the cardiac pacemaker or the defibrillator, the CCM device is designed to modulate the strength of contraction of the heart muscle rather than its rhythm (Impulse Dynamics 2018).

ACHI does not currently have a specific code for insertion of a cardiac contractility modulation (CCM) device.

Assign:

38353-00 **[650]** *Insertion of subcutaneous cardiac pacemaker generator*

38350-00 **[648]** *Insertion of permanent transvenous electrode into other heart chamber(s) for subcutaneous cardiac pacemaker*.

Follow the ACHI Alphabetic Index:

Insertion
- electrode(s) lead(s)
- - cardiac (for)
- - - pacemaker
- - - - permanent
- - - - - transvenous (atrium) (right ventricle) 38350-00 **[648]**

…
- pacemaker
- - cardiac
- - - electrode — *see Insertion/electrode(s) lead(s)/cardiac*
- - - generator (biventricular) (cardiac resynchronisation therapy) (dual chamber) (single chamber) (subcutaneous) (triple chamber) 38353-00 **[650]**

Amendments may be considered for a future edition.

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

References:

Impulse Dynamics n.d., *Understanding heart failure treatment options*, Impulse Dynamics, viewed 10 November 2020, <https://impulse-dynamics.com/heart-failure-treatment/>.

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for implementation 01 January 2019.

Ref No: Q3295 | Published On: 15-Dec-2018 | Status: Current

Z72.2 Drug use

Q:

When is it appropriate to assign Z72.2 *Drug use*?

A:

As per *Note* (b) at the beginning of Chapter 21 *Factors influencing health status and contact with health services* which states:

> *Categories Z00–Z99 are provided for occasions when circumstances other than a disease, injury or external cause ... are recorded as 'diagnoses' or 'problems'. This can arise in two main ways:*
>
> *…*
>
> *(b) When some circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury…*

The *Note* at category Z72 *Problems related to lifestyle* states:

> *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, assign Z72.2 *Drug use* where there is documentation that a patient is a current user of a drug(s) of addiction and the drug use status is relevant to the current episode of care, however there is insufficient information to assign a code from categories F11–F16, F18 or F19 (ie for acute intoxication, harmful use or dependence).

See also ACS 0503 *Drug, alcohol and tobacco use disorders*.

Amendments may be considered for a future edition.

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Ref No: Q3296 | Published On: 15-Dec-2018 | Status: Current

Endoscopic septoplasty for Zenker's diverticulum

Q:

What code is assigned for endoscopic septoplasty for Zenker's diverticulum?

A:

Zenker's diverticulum occurs when the pharyngeal lining herniates through the muscles of the pharyngeal wall of the hypopharynx. It is also known as pharyngo-oesophageal diverticulum, hypopharyngeal diverticulum or pharyngeal pouch. Symptoms include dysphagia, regurgitation of undigested food, halitosis, hoarseness, chronic cough and aspiration of the pouch's content into the lungs.

Endoscopic septoplasty for Zenker's diverticulum is performed via a flexible endoscope with an overtube, hood or cap. The procedure involves division of the septum (containing the cricopharyngeus muscle) to reconnect the pouch lumen with the normal pharyngo-oesophageal pathway (National Institute for Health and Excellence 2015; Vandergriendt 2018). An endoscopic stapling technique consisting of simultaneously stapling the mucosa edges and cutting the partition may also be performed (Ernster 2018).

For endoscopic septoplasty of Zenker's diverticulum assign, 41773-00 **[421]** *Endoscopic resection of pharyngeal pouch* as best fit.

Follow the Alphabetic Index:

Removal — *see also Excision*

- pharyngeal

- - pouch (open)

- - - endoscopic 41773-00 **[421]**

Amendments may be considered for a future edition.

References:

Ernster, J A 2018, Zenker Diveticulum, *Medscape*, viewed 1 November 2018, https://emedicine.medscape.com/article/836858-overview#a11

National Institute for Health and Care Excellence 2015, *Flexible endoscopic treatment of a pharyngeal pouch*, National Institute for Health and Care Excellence Interventional procedures guidance [IPG513], viewed 14 August 2018, https://www.nice.org.uk/guidance/ipg513/chapter/2-Indications-and-current-treatments

Vandergriendt, C 2018, *What is Zenker's diverticulum?* Healthline, viewed 22 October 2018, https://www.healthline.com/health/zenkers-diverticulum

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Ref No: Q3299 | Published On: 15-Dec-2018 | Status: Current

Bone marrow aspirate for bone marrow concentrate graft

Q:

What ACHI codes are assigned when bone marrow aspiration is performed for a bone marrow concentrate graft?

A:

Bone marrow aspirate concentrate consists of fluid taken from bone marrow, which is spun down in a centrifuge to separate the cells. The resulting liquid contains a high concentration of stem cells, which are then injected directly into the surgical site to help the healing of bone and joint conditions such as cartilage defects and arthritis (American Orthopaedic Foot & Ankle Society 2018; Chahla et al. 2017).

Where bone marrow aspiration is performed for bone marrow concentrate grafts, assign:

13700-00 **[801]** *Procurement of bone marrow for transplantation* (as best fit), for aspiration of the bone marrow, and

14203-01 **[1906]** *Direct living tissue implantation* for the bone marrow concentrate graft.

Follow the Alphabetic Index:

Procurement

- bone

- - marrow, for transplantation 13700-00 **[801]**

Implant, implantation

- living tissue

- - by

- - - direct implantation 14203-01 **[1906]**

Amendments may be considered for a future edition.

References:

American Orthopaedic Foot Ankle Society 2018, Bone marrow aspiration, viewed 5 September 2018, http://www.aofas.org/footcaremd/treatments/Pages/Bone-Marrow-Aspirate-Concentrate.aspx

Chahla, J, Mannava, S, Cinque, M, Geeslin, A, Codina, D, LaPrade, R 2017, 'Bone marrow aspirate concentrate harvesting and processing technique', *Arthroscopy Techniques*, vol 6.2, pp 441-445, viewed 5 September 2018, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5443590/

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Ref No: Q3342 | Published On: 15-Dec-2018 | Status: Current

Nontraumatic rotator cuff tear in Type 2 diabetes mellitus

Q:

What code is assigned for type 2 diabetes mellitus with nontraumatic rotator cuff tear/rotator cuff syndrome?

A:

ICD-10-AM classifies nontraumatic rotator cuff tear and rotator cuff syndrome to M75.1 *Rotator cuff syndrome*. Therefore, these terms are considered synonymous for classification purposes.

ACS 0401 *Diabetes Mellitus and Intermediate Hyperglycaemia/ General classification rules for DM and IH*/Rule 2 states:

> *The terms 'diabetic', 'due to' or 'secondary to' infer a causal relationship between the DM and other conditions. Where such terms are used check the Alphabetic Index for appropriate codes indexed directly under* Diabetes, diabetic *or appropriate codes indexed under the lead term for the condition with a subterm diabetic.*

- Where rotator cuff tear/syndrome meets the criteria for classification in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses* and is documented as having a causal relationship (ie diabetic, due to or secondary to) to diabetes mellitus, assign*:*

  E11.61 *Type 2 diabetes mellitus with specified diabetic musculoskeletal and connective tissue complication*, and

  M75.1 *Rotator cuff syndrome*.

  Follow the ICD-10-AM Alphabetic Index:

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

  - rotator cuff syndrome E1-.61

  Tear, torn (traumatic)

  - rotator cuff (complete) (incomplete) (nontraumatic) M75.1

- Where there is no documented causal relationship between rotator cuff tear/syndrome and diabetes mellitus, assign a code for the DM as per ACS 0401 *Diabetes Mellitus and Intermediate Hyperglycaemia/General classification rules for DM and intermediate hyperglycaemia.*

  Assign M75.1 *Rotator cuff syndrome* as per the criteria in ACS 0001 and ACS 0002.

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Decompression of sigmoid volvulus

Q:

What code is assigned for endoscopic decompression of sigmoid (colonic) volvulus?

A:

Treatment for colonic (including sigmoid) volvulus may involve endoscopic decompression, detorsion and reduction (EDDR) which is performed via sigmoidoscopy or colonoscopy prior to more complicated surgical interventions such as colonic resection (Tang & Wu 2013: Lianos, et al. 2012).

For classification purposes, reduction and decompression are synonymous as interventions for treatment of colonic volvulus.

Where endoscopic decompression of colonic (sigmoid) volvulus is performed, assign 30375-17 **[916]** *Reduction of volvulus of large intestine*.

Follow the ACHI Alphabetic Index:

Reduction

- volvulus

- - intestine

- - - large 30375-17 **[916]**

Assign a code for the endoscopy (ie sigmoidoscopy or colonoscopy), as per the guidelines in ACS 0023 *Minimally invasive interventions*.

Amendments may be considered for a future edition.

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

References:

Lianos G, Ignatiadou E, Lianou E, Anastasiadi Z, Fatouros M, 2012, *Sigmoid and Cecal Volvulus,* viewed 16th October 2018 https://emedicine.medscape.com/article/2048554

Tang, S & Wu, R 2014, Endoscopic decompression, detorsion and reduction of sigmoid volvulus, *Video Journal and Encyclopedia of GI Endoscopy*, vol.2, nn.1, pp.20-25, viewed 16 October 2018, https://www.sciencedirect.com/science/article/pii/S2212097114000260

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Complications of medical abortion

Q:

What codes are assigned for complications of medical abortion before fetal viability, documented as 'labour and delivery', or 'postpartum' complications (eg retained placenta or postpartum haemorrhage (PPH)?

A:

The following codes/categories in Chapter 15 *Pregnancy, childbirth and the puerperium* exclude pregnancy with abortive outcome/abortion (ie they are mutually exclusive):

- O20 *Haemorrhage in early pregnancy* excludes pregnancy with abortive outcome (O00-O08)
- O22 *Venous conditions and haemorrhoids in pregnancy* excludes venous complications of abortion or ectopic or molar pregnancy (O00-O07, O08.7)
- O26.2 *Pregnancy care of habitual aborter* excludes current abortion (O03-O06)
- O88 *Obstetric embolism* excludes embolism complicating abortion or ectopic or molar pregnancy (O00-O07, O08.2)

Complications of abortion classified to categories O00-O02, are assigned an additional code from category O08 *Complications following abortion and ectopic and molar pregnancy.*

Complications of a medical abortion that occur during the same episode of care in which the abortion was performed, are classified by the assignment of a relevant fourth character with O04 *Medical abortion.* Note that retained products of conception (including retained placenta) is classified as an incomplete abortion.

Medical abortion before fetal viability (less than 20 completed weeks (140 days) gestation and/or fetal weight less than 400g) is not classified as a delivery episode of care (ie codes from categories O80-O84 *Delivery* are not assigned, as per the guidelines in ACS 1511 *Termination of pregnancy (abortion)*).

Therefore, for classification purposes, codes for complications of childbirth and the puerperium (ie codes from categories O60-O75 *Complications of labour and delivery* and O85-O92 *Complications predominantly related to the puerperium*) are generally not assigned before fetal viability.

However, in some rare scenarios, codes for complications of childbirth or the puerperium may be assigned with codes from category O04, where supported by documentation in the clinical record, if the complication does not exclude abortion (see list above).

See also ACS 1544 *Complications following pregnancy with abortive outcomes* and ACS 1511 *Termination of pregnancy (abortion).*

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

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Noninvasive ventilation (NIV) provided for less than 1 hour

Q:

Is a code assigned when noninvasive ventilation (NIV) is provided for less than 1 hour?

A:

ACS 1006 *Ventilatory support* states:

> ***CLASSIFICATION***
>
> ***1. Code first the ventilatory support***
>
> ***…***
>
> *c. For the purpose of calculating the duration of ventilatory support:*
>
> - *hours of ventilatory support should be interpreted as **completed cumulative hours.** If a patient is intubated and ventilated for less than 1 hour the intubation and ventilation are not coded. This includes patients who die or are discharged or transferred.*

Although the above highlighted text relates specifically to continuous ventilatory support, the same logic is applicable to noninvasive ventilatory (NIV) support.

Therefore, if a patient receives NIV for less than one hour, do not assign
92209-00 **[570]** *Management of noninvasive ventilatory support, 24 hours or less.*

Amendments may be considered for a future edition.

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

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Coding Rules

Published 15 September 2018

Ref No: Q3274 | Published On: 15-Sep-2018 | Status: Updated | Updated On: 16-Dec-2019

Skin tear during hand manipulation procedure for Dupuytren's contracture

Q:

What codes are assigned for a skin tear that occurs during the treatment of Dupuytren's contracture?

A:

Dupuytren's disease is the contracture of the hand where tight cords develop in the palm and gradually cause the fingers to curl inwards resulting in the inability to straighten the fingers.

One of the treatment options for Dupuytren's contracture is collagenase injections (eg Xiaflex). These are used to break down the collagen in the Dupuytren's cords, which can then be broken by manipulating the finger. Skin tears are known to often occur during this manipulation of the fingers following collagenase injections (Atroshi et al. 2015; Henderson 2016; Melbourne Institute of Plastic Surgery 2018).

For skin tears occurring during the manipulation of the hand for the treatment for Dupuytren's contracture, assign as a best fit:

T81.2 *Accidental puncture and laceration during a procedure, not elsewhere classified*

Y60.8 *Unintentional cut, puncture, perforation or haemorrhage during other surgical and medical care*

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

Follow the Alphabetic Index Section I, *Alphabetic Index of Diseases*:

Complication(s) (from) (of)

- accidental puncture or laceration during procedure NEC T81.2

Follow the Alphabetic Index Section II, *External causes of injury:*

Unintentional event(s)

- cut, cutting, haemorrhage, perforation or puncture (accidental) (during) (inadvertent)
- - specified procedure NEC Y60.8

and

Place of occurrence of external cause

- health service area (not specified as this facility)
- - this facility Y92.24

Amendments will be considered for a future edition.

References:

Atroshi, I, Nordenskjold, J, Lauritzson, A, Ahlgren, E, Waldau, J & Walden, M 2015, 'Collagenase treatment of Dupuytren's contracture using a modified injection method: A prospective cohort study of skin tears in 164 hands, including short-term outcome', Acta Orthopaedica, vol. 86, no. 3, pp. 310-315, viewed 10 May 2018, https://www.tandfonline.com/doi/full/10.3109/17453674.2015.1019782

James Henderson 2016, Dupuytren's Contracture, James Henderson, Bristol, viewed 10 May 2018, https://jameshenderson.net/wp-content/uploads/Dupuytrens-Contracture-Information-JHenderson.pdf

Melbourne Institute of Plastic Surgery, Dupuytren's Disease 2018, The Melbourne Institute of Plastic Surgery, Malvern, viewed 10 May 2018, http://www.melbplastsurg.com/hands/dupuytrens-disease/

Published 15 September 2018,
for implementation 01 January 2020.

Ref No: Q3276 | Published On: 15-Sep-2018 | Status: Updated | Updated On: 15-Jun-2022

Clot retention following transurethral resection of the prostate

Q:

What codes are assigned for urinary retention secondary to clot retention (ie blood clots) following transurethral resection of the prostate (TURP)?

A:

Clot retention following a TURP indicates bleeding from the surgical wound.

The guidelines in ACS 1904 *Procedural complications* state a condition is classified as a procedural complication:

> • *… 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)*

Therefore, follow the guidelines in ACS 1904 for clot retention following a TURP.

ACS 1904 *Procedural complications* also states:

> *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*
>
> *Assign an additional diagnosis code from Chapters 1 to 18 where it provides further specificity regarding the condition/complication. Do not assign an additional code from Chapters 1 to 18 to provide specificity for the anatomical site alone.*

Therefore, for urinary retention due to blood clots following a TURP, assign:

N99.89 *Other intraoperative and postprocedural disorder of genitourinary system*

R33 *Retention of urine*

Follow the ICD-10-AM Alphabetic Index:

Complication(s) (from) (of)

- postprocedural

- - urinary

- - - specified NEC N99.89

Retention, retained

- urine R33

Also assign external cause and place of occurrence codes.

Note: N32.8 *Other specified disorders of bladder* is not assigned as an additional diagnosis code, as it does not provide further specificity.

This classification advice has been amended for clarity without a change to code assignment.
Published 15 September 2018,
for implementation 01 October 2018.

Ref No: Q3238 | Published On: 15-Sep-2018 | Status: Current

Same injury code with different condition onset flags

Q:

What condition onset flag (COF) values are assigned when the same injury code meets the criteria in both ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnosis*? For example, a patient admitted with a left subcapital femoral fracture, fractures the right subcapital section of their femur during the episode of care.

A:

ACS 0025 *Double coding* instructs that clinical coders should not assign multiple codes for the same condition.

ACS 0048 *Condition onset flag/Guide for use/point 7* states:

> *Where multiple conditions/sites are classifiable to a single ICD-10-AM code that meets the criteria for different condition onset flag values, assign COF 1 …. The exception to this is when the condition is sequenced as the principal diagnosis and must be assigned COF 2….*

When an injury occurring during the episode of care meets the criteria in ACS 0002 *Additional diagnoses* and is classified to the same code as the principal diagnosis, assign only the principal diagnosis code and its related external cause codes with COF value 2.

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for implementation 01 October 2018.

Ref No: Q3240 | Published On: 15-Sep-2018 | Status: Current

Control of bleeding during ERCP

Q:

What ACHI code is assigned for the administration of adrenaline to control bleeding during endoscopic retrograde cholangiopancreatography (ERCP)?

A:

Bleeding is a serious adverse event with endoscopic retrograde cholangiopancreatography (ERCP) and is most commonly the result of endoscopic sphincterotomy of the sphincter of Oddi located at the major duodenal papilla. An injection of epinephrine (adrenaline) to control bleeding is often used during endoscopic procedures such as ERCP. The targeted injection of epinephrine (adrenaline) achieves haemostasis through a combination of compression, vasoconstriction, and platelet activation (ASGE 2017; Jacques et al 2014; JHMICall 2018).

There are no specific Alphabetic Index entries or codes in ACHI for the control of bleeding during an ERCP.

Where there is injection of epinephrine (adrenaline) for control of sphincterotomy bleeding during ERCP assign 30478-07 **[870]** *Endoscopic administration of agent into lesion of stomach or duodenum* as best fit.

Follow the Alphabetical Index:

Administration

- indication

- - lesion

- - - duodenal (bleeding) (endoscopic) 30478-07 **[870]**

Amendments to the ACHI will be considered for a future edition.

References:

ASGE Standards of Practice Committee, American Society for Gastrointestinal Endoscopy, 2017, “Adverse events associated with ERCP”, *Gastrointestinal Endoscopy* Volume 85, No. 1, pp. 32-47, viewed 10 May 2018, https://www.asge.org/docs/defaultsource/education/practice_guidelines/adverse_events_ercp.pdf?sfvrsn=4

Jacques, J, Legros, R, Chaussade, S & Sautereau, D 2014, Digestive and Liver Disease Vol 46(9): 766-776 *Endoscopic haemostasis: An overview of procedures and clinical scenarios,* viewed 25 October 2017, http://www.sciencedirect.com/science/article/pii/S1590865814003661

JHMICall, Johns Hopkins Gastroenterology and Hepatology 2018, *Sphincter of Oddi Dysfunction: Anatomy*, viewed 10 May 2018, https://www.jhmicall.org/GDL_Disease.aspx?CurrentUDV=31&GDL_Cat_ID=BB532D8A-43CB-416C-9FD2-A07AC6426961&GDL_Disease_ID=7AB086B0-AB01-446E-B011-2E67CAFEF96D

Published 15 September 2018,
for implementation 01 October 2018.

Ref No: Q3277 | Published On: 15-Sep-2018 | Status: Current

Cosmetic upper lip lift

Q:

What code is assigned for a cosmetic upper lip lift?

A:

Lip lift, also known as upper lip shortening, is a minor cosmetic surgical procedure to permanently enhance the appearance and shape of the lips to restore a more youthful look.

Lip lift is performed under local anaesthetic with intravenous sedation. Excess skin is removed from the tissue above the upper lip, and a slight lift in the upper lip is created when the cut skin edges are pulled together and sutured. A corner lip lift may also be performed in combination with the lip lift.

This is a separate procedure to specifically lift the corners of the lip to create a more uniform lip line (International Centre of Cosmetic Medicine 2018; John Hilinski Facial Plastic Surgery 2018; Plastic Surgery Portal 2018).

Assign 90676-00 **[1660]** *Other procedures of skin and subcutaneous tissue* as a best fit for lip lift procedures by following the Alphabetic Index:

Procedure

- skin (subcutaneous tissue) NEC 90676-00 **[1660]**

Amendments will be considered for a future edition.

References:

International Centre of Cosmetic Medicine, Lip Lift 2018, ICCM, Sydney, viewed, 28 June 2018, https://www.iccm.com.au/procedures/face/lip-lift/

John Hilinski Facial Plastic Surgery, Upper Lip Lift 2018, JH, San Diego, viewed, 28 June 2018, https://www.drhilinski.com/procedures/upper-lip-lift/

Plastic Surgery Portal, More About Lip Lifts 2018, SignatureSpecialists, Inc., Evanston, viewed 28 June 2018, http://www.plasticsurgeryportal.com/articles/lip-filler-vs-lip-lift

Published 15 September 2018,
for implementation 01 October 2018.

Ref No: Q3289 | Published On: 15-Sep-2018 | Status: Current

ATOMS® sling procedure

Q:

What code is assigned for adjustable transobturator male system (ATOMS®) sling procedure?

A:

Adjustable transobturator male system (ATOMS®) insertion also known as suburethral male sling procedure, is performed for the treatment of male urinary stress incontinence. ATOMS® is a hydraulic system where an implant (cushion) substituting a suburethral sphincter is inserted and anchored with a mesh around the obturator foramen of the inferior pubic ramus. It is connected to a scrotal port by a catheter through which the implant is filled with saline. Adjustment of the saline volume is made during the procedure to ensure an even distribution of pressure on the urethra.

If required, further adjustments are performed postoperatively by instilling or removing saline through a percutaneous puncture via the scrotal port, until continence is achieved (Bauer & Brossner 2011; Parrillo & Wein 2016).

Assign 37044-00 **[1109]** *Retropubic procedure for stress incontinence, male* for ATOMS.

Follow the Alphabetic Index:

Procedure

- for

- - stress incontinence

- - - retropubic approach

- - - - male 37044-00 **[1109]**

Adjustment of the saline volume during the initial insertion is a component of the procedure. See also ACS 0016 *General procedure guidelines/Procedure components*.

Where adjustment of the saline volume for ATOMS is performed through the catheter via percutaneous puncture as a standalone procedure (ie after the initial surgery), assign 92195-00 **[1908]** *Irrigation of catheter, not elsewhere classified* as a best fit.

Follow the Alphabetic Index:

Irrigation

- catheter 92195-00 **[1908]**

Amendments will be considered for a future edition.

References:

Bauer W, Brossner, C 2011, Adjustable transobturator male system – ATOMS – for the treatment of post-prostatectomy urinary incontinence: the surgical technique, *Pelviperineology*, vol.30, pp.10-16, viewed 17 July 2018, http://www.pelviperineology.org/march_2011/pdf/adjustable_transobturator_male_system.pdf

Parrillo L, Wein, A 2016, *Postradical prostatectomy incontinence*, Prostate Cancer (Second Edition), Science and Clinical Practice, Chapter 32, Academic Press, Cambridge, Massachusetts, viewed 17 July 2018, https://www.sciencedirect.com/science/article/pii/B9780128000779000323

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for implementation 01 October 2018.

Ref No: Q3271 | Published On: 15-Sep-2018 | Status: Current

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:

Cardiac catheterisation may be performed:

- alone, as a diagnostic procedure, where the catheter is inserted into the heart chambers and valves to perform various tests
- with insertion of dye into the coronary arteries to evaluate coronary artery disease (ie coronary angiography)
- with a catheter based intervention, where the cardiac catheterisation serves as a guiding catheter (eg percutaneous coronary angioplasty with stenting).

For post procedural groin haematoma following cardiac catheterisation performed as a diagnostic procedure or with coronary angiography, assign:

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

Y84.0 *Cardiac catheterisation (as the cause of abnormal reaction, or of later complication, without mention of unintentional events at the time of the procedure)*

Y92.24 *Health service area, this facility*

For post procedural groin haematoma following cardiac catheterisation performed with a catheter based cardiac intervention (eg insertion of cardiac stent), assign:

T82.81 *Haemorrhage and haematoma following insertion of cardiac and vascular prosthetic devices, implants and grafts*

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

Y92.24 *Health service area, this facility*

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Coding Rules

Published 15 June 2018

Ref No: Q3206 | Published On: 15-Jun-2018 | Status: Updated | Updated On: 15-Jun-2022

TNM stage documentation

Q:

Can a code for metastatic (secondary) lymph node neoplasm be assigned based on documentation of TNM staging?

A:

The TNM (**T**umour, **N**ode, **M**etastasis) staging system is a classification system used to describe cancer severity based on the size of the primary neoplasm and the extent of its spread in the body. Numbers are assigned after each letter (ie T, N and M) based on standardised criteria (eg T1N0MX or T3N1M0).

Primary tumour (**T**) – refers to the depth of the tumour invasion.

- TX: Primary tumour cannot be evaluated.
- T0: Noevidence of primary tumour.
- T1, T2, T3, T4: Refers to the size and/or extent of the main tumour.

A higher number after the T indicates a larger tumour, or invasion into adjacent tissue.

T's may be further divided to provide more detail, such as T3a and T3b.

Regional lymph nodes (**N**) – refers to lymph node involvement.

- NX: Regional lymph nodes cannot be evaluated.
- N0: No regional lymph node involvement (no cancer found in the lymph nodes).
- N1, N2, N3: Involvement of regional lymph nodes (number and/or extent of spread).

The higher the number after the N, the more lymph nodes that contain cancer.

Distant metastasis (**M**) – refers to whether the cancer has spread to other parts of the body.

- MX: Metastasis cannot be evaluated.
- M0: No distant metastasis (cancer has not spread to other parts of the body).
- M1: Distant metastasis (cancer has spread to distant parts of the body)
  (American Joint Committee on Cancer 2017).

ACS 0010 *Clinical documentation and general abstraction guidelines/Test results and medication charts* states:

> *Test results and medication charts can inform code assignment where they clearly add specificity to an already documented condition/diagnosis. However, all information from test results and medication charts should be qualified with clinical documentation within the current episode of care.*

Therefore, do not assume a neoplasm diagnosis or a spread by interpreting the TNM staging system. Use the TNM to add specificity to a neoplastic condition documented elsewhere in the clinical record. Where documentation is unclear, seek clinical clarification to ascertain the severity of the neoplasm. Do not assign neoplasm codes based on the TNM staging alone.

Note: For classification purposes, terms such as “lymph node involvement”/”positive lymph nodes” are regarded as documented evidence of a secondary (metastatic) lymph node neoplasm.

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

References:

American Joint Committee on Cancer, CancerStaging System 2017, AJCC, Chicago, viewed 17 July 2017, https://cancerstaging.org/references-tools/Pages/What-is-Cancer-Staging.aspx

Published 15 June 2018,
for implementation 01 January 2020.

Ref No: Q3228 | Published On: 15-Jun-2018 | Status: Current

Spinal Fenestration

Q:

What code is assigned for spinal fenestration (technique)?

A:

Spinal fenestration is an approach used to access the spinal nerve roots during spinal surgery (Wankhade et al. 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, a code for spinal fenestration is not required. Assign ACHI codes for the procedure(s) performed, such as rhizolysis.

Amendments will be considered for a future edition.

References:

Wankhade, UG, Umashankar, MK Reddy, BSJ 2016, 'Functional Outcome of Lumbar Discectomy by Fenestration Technique in Lumbar Disc Prolapse – Return to Work and Relief of Pain', *Journal of Clinical Diagnostic Research*, vol. 1, no. 3, RC09-RC13, viewed 17 February 2018, PubMed Central database, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4843341/

Published 15 June 2018,
for implementation 01 July 2018.

Ref No: Q3232 | Published On: 15-Jun-2018 | Status: Current

Gastric heterotopia of duodenum

Q:

What code is assigned for gastric heterotopia of duodenum?

A:

Duodenal gastric heterotopia is an incidental finding of ectopic gastric foveolar type mucosa in the duodenum at endoscopy. While it is generally assumed to be congenital in origin, there has been evidence of possible association with the presence of gastric fundal gland polyps (Conlon et al. 2013).

Assign Q43.82 *Congenital transposition of intestine* as a default for duodenal gastric heterotopia.

Follow the Alphabetic Index:

Heterotopia, heterotopic — *see also Malposition/congenital*

Malposition

- congenital

- - intestine (large) (small) Q43.82

If documentation indicates that the condition is **not** congenital, assign K31.88 *Other specified diseases of stomach and duodenum*.

Follow the Alphabetic Index:

Disease, diseased

- duodenum

- - specified NEC K31.88

Amendments will be considered for a future edition.

References:

Conlon, N, Logan, E, Veerappan, S, McKiernan, S O'Briain, S 2013, 'Duodenal gastric heterotopia: further evidence of an association with fundic gland polyps', *Human Pathology*, vol 44, no. 4, pp. 636-642, viewed 14 February 2018, https://www.sciencedirect.com/science/article/pii/S0046817712002717

Published 15 June 2018,
for implementation 01 July 2018.

Ref No: Q3234 | Published On: 15-Jun-2018 | Status: Current

Creation of testicular thigh pockets for Fournier's gangrene

Q:

What procedure codes are assigned for creation of bilateral testicular thigh pockets in a patient with Fournier's gangrene?

A:

Fournier's gangrene is an acute, sometimes life threatening necrotic infection that affects the scrotum, penis or perineum regions of the body. It is characterised by scrotal pain and redness, with rapid progression to gangrene and tissue shedding (Nall 2018; NORD 2017).

Treatment may involve debridement of extensive areas of necrotic tissue, the administration of antibiotics, and surgical options such as creation of testicular pockets, flaps and skin grafts (Chan 2013; NORD 2017). Where there is significant loss of scrotal tissue, temporary subcutaneous thigh pockets may be created to allow implantation of the exposed testicle to aid and improve any future scrotal reconstruction (Chenam et al. 2015).

Assign 90401-01 **[1189]** *Other procedures on testis* and 90661-00 **[1608]** *Other incision of skin and subcutaneous tissue* (assign both codes twice if bilateral) by following the Alphabetic Index:

Procedure

- testis NEC 90401-01 **[1189]**

and

Incision

- skin (subcutaneous tissue) 90661-00 **[1608]**

Amendments will be considered for a future edition.

References:

Chan, C, Shahrour, K, Collier, R, Welch, M, Chang, S, Williams, M 2013, 'Abdominal implantation of testicles in the management of intractable testicular pain in fournier gangrene', *Journal of Internal Surgery,* vol. 98, pp 367-371, viewed 19 March 2018, National Centre for Biotechnology Information (NCBI) database.

Chenam, A, Khourdaji, I, Burks, F, Killinger, K 2015, 'Contemporary diagnosis and management of fournier's gangrene', *Therapeutic Advances in Urology*, May 2015, viewed 17 April 2018, ResearchGate database.

Nall, R 2018, *What causes fournier's gangrene?,* Medical News Today, viewed 19 March 2018, https://www.medicalnewstoday.com/articles/320692.php

National Organization for Rare Disorders (NORD) 2017, *Fournier gangrene*, NORD, viewed 19 March 2018, https://rarediseases.org/rare-diseases/fournier-gangrene/

Published 15 June 2018,
for implementation 01 July 2018.

Ref No: Q3249 | Published On: 15-Jun-2018 | Status: Current

Neuroendocrine cell hyperplasia of infancy (NEHI)

Q:

What code is assigned for neuroendocrine cell hyperplasia of infancy (NEHI)?

A:

Neuroendocrine cell hyperplasia of infancy (NEHI) is an interstitial lung disease that occurs in children, most commonly under two years of age. Symptoms include chronic tachypnoea, crackles, hypoxemia and failure to thrive. Children may be initially diagnosed with asthma, or a chronic respiratory infection, however they do not respond to asthma treatments and corticosteroids (Caimmi et al. 2006; Children's Interstitial Lung Disease Foundation 2017; Popler et al. 2010).

For neuroendocrine cell hyperplasia of infancy (NEHI), assign J84.8 *Other specified interstitial pulmonary diseases* as a best fit. Follow the Alphabetic Index:

Disease, diseased

- lung

- - interstitial

- - - specified NEC J84.8

Amendments will be considered for a future edition.

References:

Caimmi, S, Licari, A, Caimmi, D, Rispoli, A, Baraldi, E, Calabrese, F, Marseglia, G L 2016, 'Neuroendocrine cell hyperplasia of infancy: an unusual cause of hypoxemia in children', Italian Journal of Paediatrics, vol 42, p. 84, viewed 14 February 2018, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5024443/

Children's Interstitial Lung Disease Foundation 2017, *Neuroendocrine cell hyperplasia of infancy*, viewed 16 February 2018, http://child-foundation.org/what-is-child/child-disorders/neuroendocrine-hyperplasia-of-infancy-nehi/

Popler, J, Gower, W A, Mogayzel Jr, P J, Nogee, L M, Langston, C, Wilson, A C, Hay, T C, Deterding, R R 2010, 'Familial Neuroendocrine Cell Hyperplasia of Infancy', *Journal of Pediatric Pneumonology*, vol 45, pp. 749– 755, viewed 14 February 2018, http://child-foundation.org/wp-content/uploads/2016/07/Familial-NEHI-Popler-et-al-2010.pdf

Published 15 June 2018,
for implementation 01 July 2018.

Ref No: Q3297 | Published On: 15-Jun-2018 | Status: Current

Percutaneous electrical nerve stimulation (PENS)

Q:

What ACHI code is assigned for percutaneous electrical nerve stimulation (PENS)?

A:

Percutaneous electrical nerve stimulation (PENS) is an intervention that is used to alter the nerve and reduce its sensitivity to pain. A specially designed needle delivers low voltage electrical currents into the fatty layer just below the surface of the skin. PENS is similar to transcutaneous electrical nerve stimulation (TENS), however unlike TENS, the needle probes are inserted through the skin and placed as close as possible to the pain-causing nerve (Living with Peripheral Neuropathy 2014; Pain Matrix n.d).

For percutaneous electrical nerve stimulation (PENS) assign 96155-00 **[1880]** *Stimulation therapy, not elsewhere classified***.**

Follow the Alphabetic Index:

Therapy

- stimulation (using electrophysical agent) NEC 96155-00 **[1880]**

Amendments will be considered for a future edition.

References:

Living with Peripheral Neuropathy 2014, *TENS and PENS*, Living with Peripheral Neuropathy, viewed 29 January 2018, http://livingwithperipheralneuropathy.com/tens-and-pens/

Pain Matrix n.d., *PENS therapy*, Pain Matrix, viewed 15 January 2018, http://painmatrix.com.au/procedures/pens-therapy

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for implementation 01 July 2018.

Coding Rules

Published 15 March 2018

Ref No: Q3209 | Published On: 15-Mar-2018 | Status: Updated | Updated On: 15-Jun-2022

Acute urinary retention due to clot obstruction in urinary catheters

Q:

Is acute urinary retention due to clot obstruction in urinary catheters classified as a mechanical complication of the catheter?

A:

ACS 1904 *Procedural complications/Classification of procedural complications (Diagnosis codes)* states:

> *Where a complication is related to a prosthetic device, implant or graft, assign T82–T85 Complications of prosthetic devices, implants and grafts, except where directed by an Includes note or the Alphabetic Index…*
>
> *Assign an additional diagnosis code from Chapters 1 to 18 where it provides further specificity regarding the condition/complication.* ***Do not*** *assign an additional code from Chapters 1 to 18 to provide specificity for the anatomical site alone.*

ICD-10-AM classifies obstruction of an indwelling urinary catheter (IDC) as a mechanical complication.

For urinary retention due to clot obstruction of an IDC, assign:

T83.0 *Mechanical complication of urinary (indwelling) catheter*

R33 *Retention of urine*

Y84.6 *Urinary catheterisation*

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

Follow the ICD-10-AM Alphabetic Index Section I *Alphabetic index of diseases and nature of injury*:

Obstruction, obstructed, obstructive

- device, implant or graft

- - catheter

- - - urinary (indwelling) T83.0

Retention, retained

- urine R33

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

Complication(s) (delayed) (medical or surgical procedure) (of or following)

- catheterisation

- - urinary Y84.6

Place of occurrence of external cause

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

- - this facility Y92.24

Note: N32.8 *Other specified disorders of bladder* is not assigned as an additional diagnosis as it does not provide further specificity of the condition.

This advice has modifications 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: Q3160 | Published On: 15-Mar-2018 | Status: Updated | Updated On: 15-Jun-2019

Pre-op Workup

Q:

What principal diagnosis is assigned for pre-op workup?

A:

The aim of a preoperative workup is to identify and optimise conditions that increase perioperative morbidity and mortality (Feely et al. 2013), and decrease the perioperative risk.

The following are common examples of documentation pertaining to pre-op workup scenarios.

Note: ACHI codes are not included in examples.

Example 1:

Patient planned for gastric bypass for obesity. Routine screening endoscopy to check the state of the oesophagus and to screen for the presence of *H. pylori*. No conditions found.

Follow the guidelines in ACS 0052 *Same-day endoscopy – surveillance* which states:

> *This standard applies to patients who are admitted for endoscopic surveillance of any body system...*
>
> *For classification purposes endoscopic surveillance refers to:*
>
> *…*
>
> - *screening of other diseases and pre-cursors (risk factors) …*
> - *screening due to other factors…*
>
> ***CLASSIFICATION***
>
> *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*

Assign:

Z13.83 *Special screening examination for digestive tract disorder*

ACHI codes as appropriate.

Example 2:

Patient planned for liver transplant for liver cirrhosis. Coronary angiography performed prior to transplant to screen for coronary artery disease due to the risk factors of hyperlipidaemia and family history of CAD. No coronary artery disease found.

The coronary angiography was performed because of the hyperlipidaemia (current condition) and family history of CAD (risk factor). Follow the guidelines and criteria in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses.*

Assign:

E78.5 *Hyperlipidaemia, unspecified*

Z82.4 *Family history of ischaemic heart disease and other diseases of the circulatory system*

ACHI codes as appropriate.

Example 3:

Patient planned for liver transplant for liver cirrhosis. Coronary angiography performed prior to transplant due to symptoms of shortness of breath and chest pain. No coronary artery disease found.

Follow the guidelines and criteria in ACS 0001 *Principal diagnosis.*

Assign:

R06.0 *Dyspnoea*

R07.4 *Chest pain, unspecified*

ACHI codes as appropriate.

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

Reference:

Feely, MA, Collins, CS, Daniels, PR, Kebede, EB, Jatoi, A, Mauck, KF 2013, 'Preoperative Testing Before Noncardiac Surgery: Guidelines and Recommendations', *American Family Physician*, vol. 87, no. 6, viewed 1 May 2017, http://www.aafp.org/afp/2013/0315/p414.pdf

Published 15 March 2018,
for implementation 01 April 2018.

Ref No: Q3215 | Published On: 15-Mar-2018 | Status: Updated | Updated On: 15-Jun-2019

Mollaret meningitis

Q:

What code is assigned for Mollaret meningitis?

A:

Mollaret (Mollaret's) meningitis, is also known as benign recurrent aseptic meningitis, recurrent benign lymphocytic meningitis, benign recurrent endothelial meningitis and benign recurrent endothelial-leukocytic meningitis (RBLM). It is a rare and painful, recurrent form of aseptic meningitis which is characterised by episodes of fever, stiff neck and myalgia lasting 2–5 days followed by spontaneous recovery. The time between these episodes and their frequency vary from person to person.

The exact cause of this disease is unknown. However, research suggests that the herpes simplex virus (HSV-2) may cause some, if not most cases (Mollaret's Meningitis Association, 2017; Genetic and Rare Diseases Information Center, 2017; Shalabi & Whitley, 2006).

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 and assign codes for both the condition and the underlying cause.*

Assign G03.2 *Benign recurrent meningitis [Mollaret]* for Mollaret meningitis NOS.

Note that G03.2 is listed in category G03 *Meningitis due to other and unspecified causes.*

Therefore, for Mollaret meningitis documented as due to HSV-2, assign G03.2 *Benign recurrent meningitis [Mollaret]* with B00.3 *Herpesviral meningitis* to classify the underlying cause.

Follow the Alphabetic Index:

Meningitis (basal) (cerebral) (spinal)

- Mollaret (benign recurrent) G03.2

- in (due to)

- - herpes (simplex) virus B00.3

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

References:

Genetic and Rare Diseases Information Center, Mollaret meningitis 2017, GARD, Gaithersburg, viewed 11 October 2017, https://rarediseases.info.nih.gov/diseases/10868/mollaret-meningitis

Mollaret's Meningitis Association, Mollaret's Meningitis Information 2017, MMA, Hayden, viewed 11 October 2017, https://www.mollarets.org/mollarets-meningitis-info.html

Shalabi, M & Whitley, RJ 2006, 'Recurrent Benign Lymphocytic Meningitis' *Clinical Infectious Diseases Journal*, vol. 43 (9), pp.1194-1197, https://academic.oup.com/cid/article/43/9/1194/425988/Recurrent-Benign-Lymphocytic-Meningitis

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Initiation of PCA in recovery or theatre after general anaesthesia

Q:

Is patient controlled analgesia (PCA) initiated in theatre or recovery after general anaesthesia routinely coded?

A:

The guidelines for coding patient controlled analgesia (PCA) initiated in theatre or recovery after general anaesthesia (GA) in ACS 0031 *Anaesthesia* states:

> *The term 'postprocedural analgesia' in ACHI encompasses only those procedures which provide ongoing postprocedural analgesia via continuous infusion **AND** were initiated in the operating suite (theatre or recovery).*

The *Note* in block **[1912]** *Postprocedural analgesia* states:

> *Codes within this block are to be used only when the procedure described is initiated in the labour ward and/or operating suite (theatre or recovery) and there is documentation of continuing infusion/bolus injection/top up occurring postprocedurally.*

The above *Note* applies to the continuing infusion of neuraxial and regional blocks initiated in the labour ward and/or operating suite (theatre or recovery) only. **Do not assign** the following postprocedural infusion codes when initiated in theatre or recovery after a GA, or on the ward:

90030-00 **[1912]** *Subcutaneous postprocedural analgesic infusion*

92518-00 **[1912]** *Intravenous postprocedural infusion, patient controlled analgesic*

92518-01 **[1912]** *Intravenous postprocedural analgesic infusion*.

Amendments will be considered for a future edition.

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

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COPD with aspiration pneumonia/Mendelson's syndrome

Q:

What code(s) are assigned for COPD with aspiration pneumonia or Mendelson's syndrome?

A:

Aspiration pneumonitis and pneumonia are caused by inhaling toxic substances, usually gastric contents, into the lungs (Sethi 2007).

Aspiration pneumonia occurs when oropharyngeal contents, for example bacteria, food, liquids, are aspirated leading to infection of the lungs. It is commonly seen in in stroke or motor neurone disease patients with difficulties in swallowing. In Mendelson's syndrome, aspiration of gastric acid or contents in patients under anaesthesia results in rapid development of inflammation in the lungs causing chemical pneumonitis (Swaminathan 2017).

In ICD-10-AM, the terms 'pneumonitis' and 'pneumonia' are used interchangeably. Aspiration pneumonia is classified to category J69 *Pneumonitis due to solids and liquids*.

ACS1008 *Chronic obstructive pulmonary disease (COPD)* states:

> ***Infective exacerbation of COPD*** *does not require an additional code to reflect the infective description unless the infective condition is a condition in its own right, such as pneumonia (see COPD with pneumonia).*

For documentation of COPD with aspiration pneumonia assign:

J44.0 *Chronic obstructive pulmonary disease with acute lower respiratory infection*

J69.- *Pneumonitis due to solids and liquids*

with appropriate external cause codes

Where aspiration pneumonia is documented and there is no indication of what was aspirated, do not assign an external cause code, as it will not provide any additional information (see also Coding Rule: *Aspiration pneumonia*.)

For documentation of COPD with Mendelson's syndrome assign:

J44.0 *Chronic obstructive pulmonary disease with acute lower respiratory infection*

J95.4 *Mendelson's syndrome*

W78 *Inhalation of gastric contents*

Y48.- *Anaesthetics and therapeutic gases causing adverse effects in therapeutic use*

with appropriate activity and place of occurrence codes

Apply the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses* to determine sequencing of the above codes.

Amendments will be considered for a future edition.

References:

Sethi, S 2017, Aspiration pneumonitis and pneumonia, Merck, Sharp Dohme Manuals, viewed 9 October 2017, http://www.msdmanuals.com/en-au/professional/pulmonary-disorders/pneumonia/aspiration-pneumonitis-and-pneumonia

Swaminathan, A 2017, Aspiration pneumonitis and pneumonia, Medscape, viewed 9 October, http://emedicine.medscape.com/article/296198-overview

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Transferred patients with an ongoing neuraxial/regional block infusion

Q:

Are codes for management of neuraxial/regional blocks (in block **[1912]** *Postprocedural analgesia*) assigned for transferred patients with ongoing neuraxial/regional block infusions, when the procedure was initiated in the operating suite/labour room of another health care facility?

A:

ACS 0031 *Anaesthesia/Classification Point 5* states:

> *The neuraxial and regional block codes in block **[1912]*** Postprocedural analgesia *should be assigned only for management (continuing infusion/bolus injection/top up) of blocks that were previously administered for pain relief/anaesthesia in the labour ward and/or operating suite (theatre or recovery). The initial insertion of the neuraxial/regional block is not inherent in these codes, and should be represented by the appropriate code from block **[1909]*** Conduction anaesthesia *or **[1333]*** Analgesia and anaesthesia during labour and delivery procedure.

The *Code first* instruction at management of neuraxial and regional block codes in block **[1912]** states that the codes must never be assigned alone, and must be sequenced after the neuraxial and regional block codes from blocks **[1333]** and **[1909]**.

When patients are transferred to a health facility with ongoing neuraxial/regional block infusions that were initiated in the operating suite/labour room of another health care facility, do not assign management of neuraxial and regional block codes from block **[1912]**.

Amendments will be considered for a future edition.

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Pain buster infusion devices

Q:

What codes are assigned for pain buster infusion devices that are inserted at the end of a procedure under anaesthesia with infusion initiated while in recovery?

A:

Pain busters inserted at the end of procedures in operating theatre, are devices loaded with local anaesthetic (LA) to provide continuous infusion through a catheter placed under the surgical incision, to relieve pain at the incision site. It is also used for continuous infusion perineurally after upper limb or lower limb surgery, where blocking a peripheral nerve's conduction is likely to reduce postoperative pain. The catheters are attached to an elastomeric infusion pump that delivers LA at a constant and preset rate (The Royal Children's Hospital Melbourne n.d.).

Where subcutaneous rectus sheath catheter pain busters are inserted in theatre at the end of a procedure without documentation of a nerve block, do not assign 90030-00 **[1912]** *Subcutaneous postprocedural analgesic infusion*.

Where pain buster catheters are inserted as a nerve block (ie alongside a peripheral nerve), assign one of the following codes:

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*

Also assign the corresponding codes for management of regional blocks from **[1912]**. See also ACS 0031 *Anaesthesia/Classification/Point 5*.

Follow the Alphabetic Index:

Anaesthesia

- conduction

- - regional block

- - - nerve of

- - - - head or neck 92509 **[1909]**

- - - - lower limb 92512 **[1909]**

- - - - trunk (transversus abdominis plane (TAP)) 92510 **[1909]**

- - - - upper limb 92511 **[1909]**

and

Management (of)

- block

- - postprocedural

- - - regional

- - - - nerve of

- - - - - head or neck 92517-00 **[1912]**

- - - - - lower limb 92517-03 **[1912]**

- - - - - trunk (transversus abdominis plane (TAP)) 92517-01 **[1912]**

- - - - - upper limb 92517-02 **[1912]**

Amendments will be considered for a future edition.

References

The Royal Children's Hospital, Melbourne, n.d., *Clinical guidelines nursing, Wound catheter management,* viewed 20 October 2017, https://www.rch.org.au/rchcpg/hospital_clinical_guideline_index/Wound_Catheter_Management/

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TAP block performed at the end of surgical procedure

Q:

What is the correct code to assign for TAP Block performed at the end of a surgical procedure just before closure of the operative site without continuing infusion as post procedural analgesia?

A:

A transversus abdominis plane (TAP) block is a regional block of the abdominal wall that is primarily administered as an operative anaesthesia in surgeries involving the lower abdominal wall, such as bowel surgery, appendicectomy, hernia repair and gynaecological surgery. TAP blocks are also used for postprocedural analgesia as it allows a significantly prolonged duration of analgesia during the early postoperative stage.

TAP blocks that are initiated in the operation theatre at the end of surgical procedure but without continuing infusion should be clarified with the clinician on whether it was performed for operative anaesthesia or postprocedural analgesia. Where clarification is not possible, assign 92510-xx **[1909]** *Regional block, nerve of trunk*.

Follow the Alphabetic index:

Anaesthesia

- conduction

- - regional block

- - - nerve of

- - - - trunk (transversus abdominis plane (TAP)) 92510 **[1909]**

Amendments will be considered for a future edition.

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COF assignment for hyperglycaemia due to adverse drug reaction in a patient with uncomplicated diabetes mellitus

Q:

What codes and condition onset flags (COF) are assigned for uncomplicated diabetes mellitus with a hyperglycaemic episode secondary to an adverse drug effect during the episode of care?

A:

Hyperglycaemia is a symptom of diabetes mellitus. Where diabetes mellitus is exacerbated by an adverse drug reaction, assign an appropriate code from E10-E14 **diabetes mellitus,* with an external cause code to indicate the drug that caused the adverse effect, and a place of occurrence code.

As per ACS 0048 *Condition onset flag,* condition onset flag (COF) 2 is assigned with:

- uncomplicated diabetes mellitus code; a previously existing condition that is exacerbated during the current episode of admitted patient care
- external cause and place of occurrence codes; the COF value assigned to external cause, place of occurrence and activity codes should match that of the corresponding injury or disease code

For example, a patient with **uncomplicated** type 2 diabetes mellitus has a hyperglycaemic episode secondary to an adverse effect of Prednisolone during the episode of care. Assign:

COF

2 E11.9 *Type 2 diabetes mellitus without complication*

2 Y42.0 *Glucocorticoids and synthetic analogues, causing adverse effects in therapeutic use*

2 Y92.24 *Health service area, this facility*

Follow the Alphabetic Index Section I:

Hyperglycaemia, hyperglycaemic
- with diabetes (mellitus) — *see Diabetes, diabetic*

Diabetes, diabetic (controlled) (mellitus) (without complication) E1-.9

Note: The three character subdivision for diabetes mellitus is:

1 Type 2 (NIDDM)

Alphabetic Index/Section III Table of drugs and chemicals:

Prednisolone (oral) .....*(Adverse effect in therapeutic use)* Y42.0

Alphabetic Index/Section II External causes of injury:

Place of occurrence of external cause

- health service area

- - this facility Y92.24

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Ref No: Q3254 | Published On: 15-Mar-2018 | Status: Current

Caesarean section for fetal distress before onset of labour

Q:

What code is assigned for fetal distress as the indication for a caesarean section, where labour has not commenced?

A:

Category O36 *Maternal care for other known of suspected fetal problems* lists an *Includes* note:

> **Includes**: *the listed conditions in the fetus as a reason for observation, hospitalisation or other obstetric care of the mother, or for termination of pregnancy*

Therefore, where fetal distress is the *reason for the obstetric care* (ie caesarean section) **before onset of labour**, assign O36.3 *Maternal care for signs of fetal hypoxia.* Follow the Alphabetic Index:

Distress

- fetal (syndrome)

- - affecting

- - - management of pregnancy (unrelated to labour or delivery) O36.3

Amendments will be considered for a future edition.

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Removal of placenta NOS

Q:

What code is assigned for removal of (partial) (whole) placenta following vaginal delivery?

A:

Removal of the placenta is classified in ACHI to block **[1345]** *Postpartum evacuation of uterus*:

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

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

16564-01 **[1345]** *Postpartum evacuation of uterus by suction curettage*

Follow the ACHI Alphabetic Index:

Removal
- placenta
- - by
- - - aspiration 16564-01 **[1345]**
- - - dilation and curettage (DC) 16564-00 **[1345]**
- - - manual (part) (whole) 90482-00 **[1345]**
- - - - following caesarean section — *omit code*

ACHI does not list a default code for 'removal of (partial) (whole) placenta' NOS (not otherwise specified). Therefore, clinical coders must seek advice from the clinician if the type of intervention is not specified in the documentation, to determine which code is applicable.

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

References:

College of Nursing, University of Utah n.d., Psychomotor skills for intrapartum management, Tutorial 2: Birth of the Placenta: Birth of the Problem Placenta During Childbirth: 5. Procedures for Manual Removal of the Placenta and Membranes, Tutorial, viewed 26 October 2017, https://library.med.utah.edu/nmw/mod2/Tutorial2/manual_removal.html

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Ref No: Q3311 | Published On: 15-Mar-2018 | Status: Current

SLE with intestinal involvement

Q:

What codes are assigned for systemic lupus erythematosus (SLE) with intestinal involvement?

A:

The ICD-10-AM Alphabetic Index *Introduction/General arrangement of the Alphabetic Index/Code numbers* states*:*

> *Where an index term is one of the diagnostic statements for which there is a dual classification according to the aetiology and manifestation convention (dagger and asterisk):*
>
> - *assign code combinations as specified in the Alphabetic Index, or as per the discrete code ranges listed in the Tabular List*

The Alphabetic Index and Tabular List do not list a code combination for M32.- *Systemic lupus erythematosus* with intestinal involvement/disorder.

Therefore, assign M32.8 *Other forms of systemic lupus erythematosus* by following the Alphabetic Index:

Lupus

- erythematosus (discoid) (local)

- - systemic

- - - specified NEC M32.8

Also, assign a code for the intestinal disorder from ICD-10-AM Chapter 11 *Diseases of the digestive system*.

Sequence the codes as per the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses.*

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Coding Rules

Published 15 December 2017

Ref No: Q3204 | Published On: 15-Dec-2017 | Status: Updated | Updated On: 15-Jun-2022

Nicotine dependence tests

Q:

Is F17.2 *Tobacco dependence syndrome* assigned if a Fagerström Test for Nicotine Dependence has been completed in the clinical record, as the score provides a level of nicotine dependence?

A:

The Fagerström Test for Nicotine Dependence is a questionnaire commonly used to measure a smoker's level of dependence on nicotine, and uses a scoring mechanism to allocate a 'level of dependence'.

As per ACS 0010 *Clinical documentation and General abstraction guidelines/Test results and medication charts:*

> *Test results and medication charts can inform code assignment where they clearly* ***add specificity to an already documented condition/diagnosis****. However, all information from test results and medication charts should be qualified with clinical documentation within the current episode of care.*

The Fagerström Test for Nicotine Dependence is considered a diagnostic test, and therefore the results cannot be used exclusively to assign F17.2 *Tobacco dependence syndrome.*

Where there is no documentation of nicotine dependence in the clinical record to support the Fagerström Test, assign Z72.0 *Tobacco use, current.*

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 2018.

Ref No: Q3214 | Published On: 15-Dec-2017 | Status: Updated | Updated On: 15-Jun-2022

Endoscopic cystogastrostomy

Q:

What code is assigned for an endoscopic cystogastrostomy?

A:

Endoscopic cystogastrostomy is performed for pancreatic pseudocysts that often develop as a result of acute or chronic pancreatitis. Endoscopic cystogastrostomy is performed using endoscopic ultrasound (EUS) imaging to visualise the pancreatic pseudocyst. The pseudocyst is punctured, and a stent deployed to facilitate drainage into the stomach (Nelson et al. 2015).

Assign the following codes for an endoscopic cystogastrostomy:

30375-14 **[976]** *Incision and drainage of pancreas*

30473-00 **[1005]** *Panendoscopy to duodenum*

30688-00 **[1949]** *Endoscopic ultrasound*

Follow the ACHI Alphabetical Index:

Drainage

- pancreas, pancreatic (by catheter) 30375-14 **[976]**

Panendoscopy (to duodenum) 30473-00 **[1005]**

Ultrasound

- endoscopic 30688-00 **[1949]**

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:

Nelson E, Johnson E, Walker A, Pfau P & Gopal D 2015, *Endoscopic ultrasound-guided pancreatic pseudocyst cystogastrostomy using a novel self-expandable metal stent with antimigration system: a case series*, Endosc Ultrasound Journal, 2015 Jul-Sep; 4(3): 229–234, viewed 11 July 2017, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4568636/

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Ref No: Q3188 | Published On: 15-Dec-2017 | Status: Updated | Updated On: 15-Jun-2022

Rectus sheath haematoma secondary to overwarfarinisation

Q:

What codes are assigned for a rectus sheath haematoma secondary to anticoagulation?

A:

A rectus sheath haematoma is an accumulation of blood in the sheath of the rectus abdominis muscle. When no precipitating event has caused the haematoma, it is referred to as spontaneous rectus sheath haematoma (SRSH). An increased use of antiplatelet and anticoagulant therapies has possibly led to an increase in SRSH (Galyfos et al. 2014; Venkata 2010).

ACS 0303 *Anticoagulant use and abnormal coagulation profile/Classification Point 3* states:

> *If bleeding occurs as the result of anticoagulant use, assign D68.3 Haemorrhagic disorder due to circulating anticoagulants. The causal relationship between the bleeding and the use of anticoagulant must be documented in the clinical record before D68.3 is assigned.*

When a patient is admitted with a haematoma of the rectus sheath secondary to anticoagulation use, assign:

M79.88 *Other specified soft tissue disorders, other site*

D68.3 *Haemorrhagic disorder due to circulating anticoagulants*

Y44.2 *Anticoagulants causing adverse effects in therapeutic use*

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

or

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

Follow the ICD-10-AM Alphabetic Index Section I *Alphabetic index of diseases and nature of injury*:

Haematoma (skin surface intact) (traumatic)

- muscle

- - nontraumatic M79.8-

- nontraumatic, due to circulating anticoagulants (heparin) (warfarin) D68.3

Follow the ICD-10-AM Alphabetic Index Section III *Table of drugs and chemicals*:

Anticoagulant…(Adverse effect in therapeutic use) Y44.2

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

Place of occurrence of external cause

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

- - this facility Y92.24

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

References:

Galyfos, G, Karantzikos G, Palogos K, Sianou, A, Filis K & Kavouras N 2014, 'Spontaneous Rectus Sheath Hematoma in the Elderly: An Unusual Case and Update on Proper Management', *Case Reports in Emergency Medicine*, pp. 1-4, viewed 10 April 2017, https://www.ncbi.nlm.nih.gov/pubmed/24839570f

Venkata MA, Karnam SM, Kaushik M & Porter J, 2010, 'Spontaneous Rectus Sheath Haematoma', *West J Emergency Medicine*, vol. 11, no. 1, pp. 76-79, viewed 13 April 2017, PMC https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2850860/

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Ref No: Q3142 | Published On: 15-Dec-2017 | Status: Current

Sleep disordered breathing

Q:

What code is assigned for sleep-disordered breathing not otherwise specified (NOS), or where no other diagnosis has been documented?

A:

Sleep-disordered breathing (SDB) is a general term for breathing difficulties that occur during sleep and range from snoring to obstructive sleep apnoea (OSA) (Academy of Otolaryngology 2017).

SDB may cause detrimental health consequences such as a rise in blood pressure associated with the reduced oxygen level in the blood. Other symptoms include daytime sleepiness, insomnia, attention problems, morning headaches, irritability and mood changes. Obesity is a strong causal factor for sleep-disordered breathing. (MedicineNet 2017; Peppard et al. 2017).

As SDB encompasses a wide spectrum of sleep-related breathing abnormalities, seek clinical clarification to ascertain the particular breathing disorder prior to code assignment.

If no specific disorder is identified or no further clarification is available, and SDB meets the criteria for code assignment, assign R06.8 *Other and unspecified abnormalities of breathing* by following the Alphabetic Index:

Abnormal, abnormality, abnormalities

- breathing NEC R06.8

Amendments will be considered for a future edition.

References:

Academy of Otolaryngology – Head and Neck Surgery, Pediatric Sleep Disordered Breathing/Obstructive Sleep Apnea, 2017, AAO-HNS, viewed 10 April 2017, http://www.entnet.org/content/pediatric-sleep-disordered-breathingobstructive-sleep-apnea

MedicineNet, Medical Definition of Sleep-disordered breathing 2016, WebMD, New York, viewed 10 April 2017, http://www.medicinenet.com/script/main/art.asp?articlekey=13152

Peppard PE, Young T, Barnet JH, Palta M, Hagen EW Hla KM 2013, 'Increased Prevalence of Sleep-Disordered Breathing in Adults', *American Journal of Epidemiology*, vol. 177, no. 9, pp. 1006-1014, viewed 10 April 2017, Oxford Academic. https://academic.oup.com/aje/article/177/9/1006/145450/Increased-Prevalence-of-Sleep-Disordered-Breathing

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Ref No: Q3092 | Published On: 15-Dec-2017 | Status: Current

Neonatal acidosis

Q:

What code is assigned for neonatal acidosis NOS (not otherwise specified)?

A:

Acidosis is an acid-base imbalance causing an accumulation of acid in the blood (decreased pH), that usually occurs as a result of an underlying disease process. There are two major types of acidosis: metabolic and respiratory. Mixed metabolic and respiratory acidosis may also occur and is most common in premature infants.

Neonatal acidosis is acute or chronic, caused by maternal, fetal or placental factors, and arises antenatally, intrapartum (during labour) or at delivery (Bobrow & Soothill 1999; Victoria State Government 2015; Royal Prince Alfred Hospital n.d).

ICD-10-AM classifies both metabolic and respiratory acidosis in non-neonatal patients to E87.2 *Acidosis*.

Whilst P74.0 *Metabolic acidosis of newborn* classifies neonatal metabolic acidosis, there is no code for respiratory acidosis or acidosis NOS in the neonate.

Clinical advice indicates that the causes of the two types of acidosis are quite different with distinctive treatment and prognosis. Seek clinical clarification for the type of acidosis the patient has.

Where clinical consultation is not possible, assign P74.8 *Other transitory metabolic disturbances of newborn* for mixed metabolic and respiratory acidosis, respiratory acidosis or neonatal acidosis NOS by following the Alphabetic Index:

Disturbance — *see also Disease*

- metabolism

- - neonatal, transitory

- - - specified NEC P74.8

It is not appropriate to assign E87.2 *Acidosis* as per the *Excludes* note at the beginning of Chapter 4 *Endocrine, nutritional and metabolic diseases (E00–E89)* which states:

> **Excludes:** *transitory endocrine and metabolic disorders specific to fetus and newborn (P70–P74)*

Amendments will be considered for a future edition.

References:

Bobrow, CS Soothill, PW 1999, 'Causes and consequences of fetal acidosis', BMJ Journals: ADC Fetal Neonatal edition, vol. 80, no. 3, pp. 246-249, viewed 17 March 2017, BMJ Journals database. http://fn.bmj.com/content/fetalneonatal/80/3/F246.full.pdf

Royal Prince Alfred Hospital, n.d., *RPA Newborn Care Guidelines*: *Acidosis*, RPA, Sydney, viewed 23 January 2017, http://www.slhd.nsw.gov.au/rpa/neonatal/html/docs/acidosis.pdf

Victoria State Government 2015, Metabolic disease in neonates, Health.Vic, Victoria, viewed 23 January 2017, https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/perinatal-reproductive/neonatal-ehandbook/conditions/metabolic-disease

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for implementation 01 January 2018.

Ref No: Q3157 | Published On: 15-Dec-2017 | Status: Current

Acroangiodermatitis

Q:

What code is assigned for acroangiodermatitis?

A:

Acroangiodermatitis, also known as Pseudo-Kaposi sarcoma is a benign angioproliferative disorder often seen in association with venous insufficiency or with certain vascular anomalies.

Acroangiodermatitis may be caused by a number of vascular conditions, such as Klippel-Trenaunay syndrome, intravenous drug abuse, arteriovenous malformation of the legs, arteriovenous fistula, chronic renal failure treated with dialysis, paralysis of legs and amputation stump dermatosis. It presents as macules, indurated plaques or nodules, usually bilaterally on the extensor surfaces of lower extremities.

Although the precise aetiology is unknown, it is thought that severe chronic venous stasis with insufficiency of the calf muscle pump, elevates the capillary pressure to induce neovascularisation and fibroblast proliferation (Mehta et al. 2010; Singh Manchanda 2014).

In the absence of a specific code or index entries for *acroangiodermatitis*, assign I87.8 *Other specified disorders of veins* as a best fit.

Follow the Alphabetic Index:

Stasis

- venous I87.8

Amendments will be considered for a future edition.

References:

Mehta, AA, Pereira, RR, Nayak, CS Dhurat RS 2010, Acroangiodermatitis of mali: a rare vascular phenomenon, *Indian Journal of dermatology, Venereology and Leprology*, vol.76, no.5, pp. 553-556, viewed 26 June 2017, http://www.ijdvl.com/article.asp?issn=0378-323;year=2010;volume=76;issue=5;spage=553;epage=556;aulast=Mehta

Singh, SK Manchanda, K 2014, Acroangiodermatitis (Pseudo-Kaposi sarcoma), *Indian dermatology online journal*, vol.5, no.3, pp.323–325, viewed 26 June 2017, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4144224/

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Anti-neutrophil cytoplasmic antibody (ANCA) associated vasculitis (AAV) with lung disease

Q:

What codes are assigned for ANCA associated vasculitis (AAV) with lung disease?

A:

Anti-neutrophil cytoplasmic antibody (ANCA) associated vasculitis (AAV) is an immune related condition characterised by necrotising vasculitis predominantly affecting small vessels. The major clinical varieties of AAV are:

- granulomatosis with polyangiitis
- microscopic polyangiitis (MPA)
- eosinophilic granulomatosis with polyangiitis (Churg-Strauss syndrome).

Pulmonary manifestations such as interstitial lung disease and pulmonary fibrosis are characteristic features of AAV (Alba et al. 2015; Katsumata et al. 2017).

When documentation states specific AAV conditions such as:

- granulomatosis with polyangiitis with lung involvement assign:

  M31.3 *Granulomatosis with polyangiitis*
  J99.1 *Respiratory disorders in other diffuse connective tissue disorders*
  an appropriate code from J84 for the lung involvement

- MPA with lung involvement assign:

  M31.7 *Microscopic polyangiitis*
  an appropriate code from J84 for the lung involvement

- eosinophilic granulomatosis with polyangiitis (Churg-Strauss syndrome) with lung involvement assign:

  M30.1 *Polyarteritis with lung involvement [Churg-Strauss]*
  an appropriate code from J84 for the lung involvement

Where documentation states ‘ANCA vasculitis with lung involvement’ without further specification of a specific vasculitis, seek clinical clarification on the type of vasculitis and the associated lung condition. Where clarification is not possible, assign:

I77.6 *Arteritis, unspecified*

and

J84.9 *Interstitial pulmonary disease, unspecified*

Follow the Alphabetic Index:

Vasculitis I77.6

and

Disease, diseased

- lung

- - interstitial J84.9

Apply the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses* to determine sequencing of the above codes.

Amendments will be considered for a future edition.

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

References:

Alba, MA, Flores-Suarez, LF, Henderson, AG, Xiao, H, Hu, P, Nachman, PH, Falk, RJ, Jennette, JC 2017, Interstitial lung disease in ANCA vasculitis, *Autoimmunity Reviews*, vol 16, (7), pp.722-729, viewed 30 June 2017, http://www.sciencedirect.com/science/article/pii/S1568997217301283

Katsumata, Y, Kawaguchi, Y Yamanaka, H 2015, Interstitial lung disease with ANCA-associated vasculitis, *Clinical Medicine insights: Circulatory, Respiratory and Pulmonary Medicine*, vol 9 (Suppl1), pp.51–56, published online, viewed 30 June 2017, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4583098/

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Ref No: Q3174 | Published On: 15-Dec-2017 | Status: Current

Percutaneous paravalvular leak closure with vascular plug device

Q:

What code is assigned for percutaneous closure of paravalvular leak with vascular plug device?

A:

Paravalvular leak (PVL) may occur after aortic or mitral heart valve replacements. The condition is treated by closure with a device that is inserted through a catheter via femoral vein access and trans-septal puncture, or via the femoral artery. As there are only a few devices designed specifically for closure of PVL, occluder devices used for closure of septal defects or vascular plugs are mostly used (Kapadia et al. 2014; Rihal et al. 2012).

Assign 96222-00 **[626]** *Percutaneous mitral valvuloplasty using closure device* for closure of PVL occurring after mitral valve replacement.

Follow the Alphabetic Index:

Valvuloplasty

- heart (without valve replacement)

- - mitral valve (open)

- - - percutaneous (closed)

- - - - using

- - - - - closure device 96222-00 **[626]**

There is no corresponding code for closure of PVL occurring after aortic valve replacement. Whilst the aim of a percutaneous balloon aortic valvuloplasty for treatment of aortic stenosis is not exactly the same, the procedural concept is similar in that a catheter is inserted through the femoral artery with a device (ie a balloon or a closure device) guided to the aortic valve.

Assign 38270-01 **[622]** *Percutaneous balloon aortic valvuloplasty* as a best fit for closure of PVL occurring after aortic valve replacement.

Follow the Alphabetic Index:

Valvuloplasty

- heart (without valve replacement)

- - aortic valve (open)

- - - percutaneous balloon (closed) 38270-01 **[622]**

Amendments will be considered for a future edition

References:

Kapadia, S, Krishnaswamy, A Tuzcu, EM 2014, Percutaneous paravalvular leak closure, *Interventional Cardiology Review*, viewed 17 July 2017, http://dx.doi.org/10.15420/icr.2011.9.1.4

Rihal, C, Sorajja, P, Booker, JD, Hagler, DJ Cabalka, A 2012, Principles of percutaneous paravalvular leak closure, *Journal of American College of Cardiology Cardiovascular Interventions*, Vol.5 (2) viewed 17 July 2017, http://www.interventions.onlinejacc.org/content/5/2/121

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for implementation 01 January 2018.

Ref No: Q3177 | Published On: 15-Dec-2017 | Status: Updated | Updated On: 15-Jun-2022

Neuropathic cornea

Q:

What code is assigned for neuropathic cornea?

A:

Neuropathic cornea is defined as neuropathic pain of the cornea due to dysfunctional or damaged corneal nerves. The causes of corneal nerve dysfunction or damage may include: chronic ocular surface diseases such as dry eye syndrome, chemical burns, recurrent corneal erosions and ocular surface neoplasia. Other causes include post-surgical, diabetes mellitus, multiple sclerosis (MS), small fibre neuropathy, drug-induced keratopathy, exposure to radiation and ultraviolet light, and infection (American Academy of Ophthalmology 2017; Gayal & Hamrah 2016; Meszaros 2013).

- Assign H18.8 *Other specified disorders of cornea* for neuropathic cornea NOS (not otherwise specified) by following the ICD-10-AM Alphabetic Index:

  Disease

  - cornea

  - - specified NEC H18.8

  Assign additional codes for the underlying cause or external cause, if applicable to the documented case.

- Where corneal **neuropathic pain** is documented, assign R52.2 *Chronic pain* in addition to H18.8 in accordance with the *Instructional* note at R52.2:

  Code first the underlying cause and/or site of chronic pain, if applicable.

  Follow the ICD-10-AM Alphabetic Index:

  Pain(s)

  - neuropathic R52.2

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

References:

American Academy of Ophthalmology 2016, *Ocular Neuropathic Pain*, viewed 17 April 2017, http://eyewiki.aao.org/Ocular_Neuropathic_Pain

Goyal, S Hamrah, P 2016, 'Understanding Neuropathic Corneal Pain—Gaps and Current Therapeutic Approaches', *Seminars in Ophthalmology*, vol. 31, no. 1-2, pp. 59-70, viewed 17 April 2017, http://www.tandfonline.com/doi/full/10.3109/08820538.2015.1114853

Meszaros, L 2013, 'Recognizing causes, manifestations of chronic ocular pain', *Ophthalmology Times*, Ohio, viewed 17 April 2017, http://ophthalmologytimes.modernmedicine.com/ophthalmologytimes/content/tags/chronic-ocular-pain/recognizing-causes-manifestations-chronic-ocular

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Asbestos exposure

Q:

What code is assigned for asbestos exposure?

A:

Exposure to asbestos may occur in the workplace, home or community, and cause asbestosis, lung cancer, mesothelioma or other respiratory diseases. When asbestos is disturbed, tiny fibres become airborne, and are inhaled. Asbestos fibres accumulate and cause scarring and inflammation in the lungs. Symptoms of asbestos related disease may occur more than 20–30 years after the initial exposure (National Cancer Institute 2009; NSW Health 2007).

Exposure to asbestos is inherent in some ICD-10-AM codes. For example:

J61 *Pneumoconiosis due to asbestos and other mineral fibres*

J92.0 *Pleural plaque with presence of asbestos*

Where asbestos exposure is not inherent in a condition code, and:

- a condition is documented as being caused by occupational exposure to asbestos (eg exposure in the workplace during performance of occupational duties), assign Z57.2 *Occupational exposure to dust,* in addition to the condition code
- a condition is documented as being caused by exposure to asbestos in circumstances other than occupational exposure (eg in the home) or the circumstances of exposure are unknown/unspecified, assign Z58.1 *Exposure to air pollution* in addition to the condition code.

Follow the Alphabetical Index:

Exposure (to)

- dust NEC Z58.1

- - occupational Z57.2

Assign either Z57.2 or Z58.1 when asbestos exposure meets the criteria in ACS 0002 *Additional diagnoses*, or as per the Note (b) at the beginning of Chapter 21 *Factors influencing health status and contact with health services*:

> *When some circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury. Such factors may be elicited during population surveys, when the person may or may not be currently sick, or be recorded as an additional factor to be borne in mind when the person is receiving care for some illness or injury.*

Amendments will be considered for a future edition.

References:

National Cancer Institute 2009, *Asbestos exposure and cancer risk,* viewed 6 June 2017, https://www.cancer.gov/about-cancer/causes-prevention/risk/substances/asbestos/asbestos-fact-sheet

NSW Health 2007, *Asbestos and health risks,* viewed 6 June 2017, http://www.health.nsw.gov.au/environment/factsheets/Pages/asbestos-and-health-risks.aspx

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Ref No: Q3185 | Published On: 15-Dec-2017 | Status: Current

Ureteric stone with fragmentation by laser in the kidney

Q:

What code is assigned for a ureteric stone flushed into the kidney and fragmented by laser?

A:

Where there is documentation that a 'ureteric' calculus is flushed into the kidney during a procedure and subsequently fragmented in the kidney, it is classified as a ureteric calculus in ICD-10-AM.

Therefore, destruction of a ureteric calculus that has been flushed into the kidney (manipulated) prior to fragmentation is classified to 36809-01 **[1074]** *Endoscopic destruction of ureteric lesion,* with an additional code for 'manipulation' of the calculi, as this level of complexity is not a component of every destruction procedure.

Follow the Alphabetic Index:

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

- calculus, calculi (encrustation) (stone)

- - ureter (closed) (endoscopic) 36809-01 **[1074]**

and

Manipulation

- calculus (stone)

- - ureter

- - - endoscopic (via cystoscopy) 36857-00 **[1068]**

- - - - via ureteroscopy 36803-02 **[1068]**

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Ref No: Q3186 | Published On: 15-Dec-2017 | Status: Current

Sequencing of ACHI codes

Q:

Should procedures that are surgical in nature be sequenced before nonsurgical procedures?

A:

ACS 0016 *General procedure guidelines* provides a hierarchy for the sequencing of ACHI codes:

The order of codes should be determined using the following hierarchy:

- *procedure performed for treatment of the principal diagnosis*
- *procedure performed for treatment of an additional diagnosis*
- *diagnostic/exploratory procedure related to the principal diagnosis*
- *diagnostic/exploratory procedure related to an additional diagnosis for the episode of care.*

The standard does not instruct to sequence surgical procedures before nonsurgical procedures.

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Incomplete circumcision

Q:

What code is assigned for a diagnosis of incomplete circumcision?

A:

Admission for incomplete circumcision is the result of insufficient skin removal during the original procedure, resulting in redundant foreskin. The result is mainly cosmetic and may require a revision operation to remove the excess foreskin (Department of Health & Human Services, Victoria 2014; Krill, Palmer Palmer 2011).

Therefore, where incomplete circumcision meets the criteria for code assignment in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*, assign N47 *Redundant prepuce, phimosis and paraphimosis* by following the Alphabetic Index:

Excess, excessive, excessively

- foreskin N47

References:

Department of Health Human Services, State Government of Victoria, Australia in conjunction with the Urological Society of Australia and New Zealand 2014, *Circumcision,* Better Health Channel, viewed 14 August 2017, https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/circumcision

Krill, A, Palmer L Palmer, J 2011, 'Complications of circumcision', *Scientific World Journal,* vol. 11 pp.2458-2468, viewed 14 August 2017, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3253617/

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Ref No: Q3199 | Published On: 15-Dec-2017 | Status: Current

Brachial plexus nerve transfer

Q:

What code is assigned for a brachial plexus nerve transfer?

A:

Brachial plexus nerve transfer is a surgical technique used in brachial plexus injuries where the nerve root has been detached from the spinal cord. It may also be performed to accelerate muscle recovery when there is a complete loss of muscle function or sensation as a result of a nerve injury.

The procedure involves utilising a less crucial nerve (or nerve section) to attach the spinal cord to the damaged nerve to restore its function (Mayo Foundation for Medical Education and Research 2017; Washington University 2017).

Assign 39321-00 **[83]** *Transposition of nerve* for brachial plexus nerve transfer by following the Alphabetic Index:

Transposition (of)

- nerve 39321-00 **[83]**

Amendments will be considered for a future edition.

References:

Mayo Foundation for Medical Education and Research, Nerve transfer 2017, MFMER, Rochester, viewed 12 July 2017, http://www.mayoclinic.org/diseases-conditions/brachial-plexus-injury/multimedia/nerve-transfer/img-20008552

Washington University School of Medicine, Brachial Plexus Injury: Nerve Transfer 2017, WU, St. Louis, viewed 12July 2017, http://nerve.wustl.edu/nd_transfer.php?np=nerve_disorders

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Ref No: Q3210 | Published On: 15-Dec-2017 | Status: Current

Unstable diabetes mellitus with hypoglycaemia

Q:

What codes are assigned where a patient has unstable diabetes mellitus and hypoglycaemia meeting the criteria for code assignment?

A:

ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia/General classification rules for DM and IH/Rule 4a* states:

> *Rule 4a. All complications of DM or IH classified to category E09–E14 should always be coded to reflect the severity of DM or IH*

ICD-10-AM classifies:

- diabetes mellitus with hypoglycaemia to E1-.64 **diabetes mellitus with hypoglycaemia*
- unstable diabetes mellitus to E1-.65 **diabetes mellitus with poor control*

The above codes are not mutually exclusive. Therefore, where diabetes mellitus with hypoglycaemia, and unstable/poor control are both documented in an episode of care, assign E1-.64 and E1-.65.

Follow the Alphabetic Index:

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

Note: The three character subdivision for diabetes mellitus is:

0 Type 1 (IDDM)
1 Type 2 (NIDDM)
3 Other specified
4 Unspecified

- with
- - hypoglycaemia (coma) (convulsion) (fit) (seizure) E1-.64
- - poor control E1-.65
- uncontrolled E1-.65
- unstable E1-.65

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Ref No: Q3225 | Published On: 15-Dec-2017 | Status: Current

Administration of hepatitis B immunoglobulin (HBIG) to a newborn with a hepatitis B positive mother

Q:

What codes are assigned for a newborn with a hepatitis B positive mother, who is administered hepatitis B immunoglobulin (HBIG)?

A:

Vaccination/immunisation is the administration of a weakened/killed microbe to actively stimulate the immune system to produce antibodies to the microbe, thereby preventing disease (MedicineNet Inc. 2016). Hepatitis B vaccine is routinely administered to neonates in Australian facilities, and therefore does not require coding.

Passive immunotherapy (immunisation) is provided to patients who have a high risk of infection and insufficient time to actively develop their own immune response. The administration of hepatitis B immunoglobulin (HBIG) is an example of passive immunotherapy. Hepatitis B may be transmitted from an infected mother to her infant during delivery. Risk of transmission is reduced by the immediate postpartum administration of HBIG to the newborn (Keller Stiehm 2000).

Where a newborn with a hepatitis B positive mother is administered HBIG, assign:

Z29.1 *Prophylactic immunotherapy* by following the ICD-10-AM Alphabetic Index:

Administration, prophylactic

- immunoglobulin Z29.1

and

92176-00 **[1884]** *Passive immunisation with hepatitis B immunoglobulin* by following the ACHI Alphabetic Index:

Immunisation (against) (prophylactic)

- passive (with)

- - immunoglobulin

- - - hepatitis B 92176-00 **[1884]**

OR

Vaccination (against) (prophylactic)

- passive (with)

- - immunoglobulin

- - - hepatitis B 92176-00 **[1884]**

Amendments will be considered for a future edition.

References:

Keller, M Stiehm, E.R 2000, 'Passive Immunity in Prevention and Treatment of Infectious Diseases', *Clinical Microbiology Reviews,* 2000 Oct; 13(4): 602–614, viewed 19 July 2017, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC88952/

MedicineNet. Inc 2016, Medical definition of vaccination, viewed 24 July 2017, http://www.medicinenet.com/script/main/art.asp?articlekey=5925

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Ref No: Q3227 | Published On: 15-Dec-2017 | Status: Updated | Updated On: 15-Jun-2022

Re-positioning of neurostimulator wires/battery/IPG

Q:

What code(s) are assigned for re-positioning of an implantable impulse generator (IPG) and repositioning of stimulator wire/battery?

A:

A neurostimulator device, also referred to as an implantable pulse generator (IPG), is an implantable and programmable medical device that delivers small pulses of electricity to block or stimulate nerve signals at specific parts of the patient's brain, spinal cord or peripheral nervous system. This stimulation helps treat various conditions, including chronic pain, movement disorders, epilepsy and Parkinson's disease. Common complications following a neurostimulator implant include infection, lead movement, pain at the implant site, and loss of therapeutic effect (Medtronic 2017; Therapeutic Goods Administration 2014; Vaillancourt 2012).

When a patient is admitted for revision (meaning removal and re-insertion) of a neurostimulator, assign:

39135-00 **[1604]** *Removal of subcutaneously implanted neurostimulator,* and

39134-01 **[1604]** *Insertion of subcutaneously implanted neurostimulator*

Follow the ACHI Alphabetic Index:

Removal — *see also Excision*

- neurostimulator (epidural) (intracranial) (peripheral) (sacral) (vagus) 39135-00 **[1604]**

Insertion

- neurostimulator (epidural) (intracranial) (peripheral) (sacral) (vagus) 39134-01 **[1604]**

Where electrodes/leads/wires have been removed for adjustment/testing and then re-inserted, assign the adjustment of electrode code (by appropriate site).

Follow the ACHI Alphabetic Index:

Adjustment

- electrode(s) (for)
- - epidural 39131-00 **[43]**
- - - by laminectomy 39139-00 **[43]**

…

- - peripheral nerve NEC 39131-01 **[67]**
- - sacral nerve 36665-00 **[67]**
- - spinal — *see Adjustment/electrode(s)/epidural*

Amendments to ACHI will be considered for a future edition.

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

References:

Medtronic 2017, Surgery: what to expect – implanting the neurostimulator, USA, viewed 18 July 2017, http://www.medtronic.com/us-en/patients/treatments-therapies/drug-pump-chronic-pain/getting-a-device/neurostimulators-surgery.html

Therapeutic Goods Administration 2014, *Medtronic neurostimulation devices used for deep brain, spinal cord and peripheral nerve stimulation therapies - multiple models,* Australian Government Department of Health, viewed 18 July 2017, https://www.tga.gov.au/alert/medtronic-neurostimulation-devices-used-deep-brain-spinal-cord-and-peripheral-nerve-stimulation-therapies-multiple-models

Vaillancourt C 2012, *Implantable pulse generators 'stimulate' medical device industry*, Medical Design Technology Magazine, viewed 18 July 2017 https://www.mdtmag.com/article/2012/01/implantable-pulse-generators-stimulate-medical-device-industry

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Ref No: Q3229 | Published On: 15-Dec-2017 | Status: Current

Lipin 1 deficiency

Q:

What code is assigned for lipin 1 deficiency?

A:

Lipin 1 is a protein that is encoded by the LPIN 1 gene. Mutations in the LPIN 1 gene may result in lipin 1 deficiency, which clinically manifests as episodic myalgia and myoglobinuria, most often triggered by a febrile illness, and less commonly by prolonged exercise, fasting or anaesthesia (Meijer et al 2015). LPIN 1 gene mutations are also associated with conditions such as acute recurrent rhabdomyolysis (National Center for Biotechnology Information 2017).

Assign E88.8 *Other specified metabolic disorders* as a best fit for lipin 1 deficiency by following the Alphabetic Index:

Disorder (of)

- metabolism NEC

- - specified NEC E88.8

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

Amendments will be considered for a future edition.

References:

Meijer, I. A, Sasarman, F, Maftei, C, Rossignol, E, Vanasse, M, Major, P, Mitchell G.A, Brunel-Guitton, C 2015, Case Report LPIN1 deficiency with severe recurrent rhabdomyolysis and persistent elevation of creatine kinase levels due to chromosome 2 maternal isodisomy, viewed 25 July 2017, http://www.sciencedirect.com/science/article/pii/S2214426915300458

National Center for Biotechnology Information 2017, LPIN1 lipin 1 [Homo sapiens (human)], U.S. National Library of Medicine, viewed 25 July 2017, https://www.ncbi.nlm.nih.gov/gene/23175

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Ref No: Q3235 | Published On: 15-Dec-2017 | Status: Updated | Updated On: 15-Jun-2022

Viral induced wheeze

Q:

How do you code viral induced wheeze?

A:

Viral induced wheeze is caused by a viral infection, often starting with a cough or cold. The viral infection may cause narrowing of the airways, or increase mucus production in the lungs. Wheezing is the whistling sound heard when breathing out. Viral induced wheeze is common in young children, and may continue for some weeks after the infection (NHS 2015; SCHN 2017).

For viral induced wheeze not otherwise specified, assign:

R06.2 *Wheezing*

B97.89 *Viral agents as the cause of diseases classified to other chapters, not elsewhere classified*

Follow the ICD-10-AM Alphabetic Index:

Wheezing R06.2

Infection, infected (opportunistic) *(see also Infestation)*

- virus

- - as cause of disease classified to other chapters B97.89

If a specific virus has been documented as causing the infection, assign a specific code from the category B97 *Viral agents as the cause of diseases classified to other chapters* for the viral agent.

Amendments will be considered for a future edition.

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

References:

NHS Foundation Trust (NHS) – Royal United Hospitals Bath 2015, *Viral induced wheeze*, viewed 1 August 2017, http://www.ruh.nhs.uk/patients/services/clinical_depts/paediatrics/documents/patient_info/PAE007_Viral_induced_wheeze_information_and_management.pdf

The Sydney Children's Hospital Network (SCHN) 2017, *Wheeze – viral induced wheeze*, viewed 31 July 2017, https://www.schn.health.nsw.gov.au/parents-and-carers/fact-sheets/wheeze-viral-induced-wheeze

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Ref No: Q3161 | Published On: 15-Dec-2017 | Status: Updated | Updated On: 15-Jun-2022

External cause codes for drug-induced conditions

Q:

Is it mandatory to assign an external cause code for drug-induced conditions?

A:

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

> *The* Code also/Use additional code/Use additional external cause code *notes indicate that multiple codes are required, **if applicable** or **if known**, to fully describe a clinical concept.*
>
> *The Code also note is used to indicate that an additional code is required (to identify the underlying condition). The Use additional code and Use additional external cause code notes are used to identify a code that adds specificity.*

Therefore, assign an external cause code from Chapter 20 *External causes of morbidity and mortality,* to add specificity for a drug-induced condition if the health care record specifies the responsible drug.

Assignment of external cause codes for drug-induced conditions requires differentiation between poisoning (ie improper use) and adverse effect.

Example 1: Amphetamine induced cardiomyopathy, due to history of amphetamine use (ie no longer a current user).

Assign:

I42.7 *Cardiomyopathy due to drugs and other external agents*

F15.19 *Mental and behavioural disorders due to use of other stimulants, including caffeine, harmful use, other specified stimulants*

Where there is documentation indicating that the cardiomyopathy is due to past recreational use (ie improper use, which is classified as poisoning), assign T96 *Sequelae of poisoning by drugs, medicaments and biological substances* and external cause codes.

Where there is documentation indicating that the cardiomyopathy is due to an adverse effect following therapeutic use of amphetamines, follow the guidelines in ACS 1902 *Adverse effects*.

Example 2: Diarrhoea due to regular unprescribed overuse of laxatives.

Overuse of a drug is an example of improper use and is classified as poisoning.

Assign:

T47.3 *Poisoning by saline and osmotic laxatives*

K52.1 *Toxic gastroenteritis and colitis*

Y14 *Poisoning by and exposure to other and unspecified drugs, medicaments and biological substances, undetermined intent*

Place of occurrence and activity codes

F55.1 *Harmful use of laxatives*

Note that the *Conventions used in the ICD-10-AM Tabular List/Multiple condition coding* states:

> *In classifying a condition with an underlying cause, if the ICD-10-AM Alphabetic Index…or an* 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 *or ACS 0002* Additional diagnoses/Problems and underlying conditions*, and assign codes for both the condition and the underlying cause.*

T36–T50 *Poisoning by drugs, medicaments and biological substances* excludes nondependence-producing substance use disorder (F55). In this example, assignment of both T47.3 and F55.1 indicates that the episode of care classifies toxic gastroenteritis and colitis due to acute poisoning, in a patient with an underlying regular (harmful) use of laxatives.

See also ACS 0503 *Drug, alcohol and tobacco use disorders,* ACS 1901 *Poisoning*, ACS 1902 *Adverse effects,* and ACS 2005 *Poisonings and injuries – indication of intent.*

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Coding Rules

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Acquired brain injury (ABI) NOS

Q:

What code is assigned for acquired brain injury (ABI) NOS?

A:

Acquired brain injury (ABI) is a general term for any damage to the brain that is not congenital. ABI may be caused by trauma (traumatic brain injury), stroke (cerebrovascular accident), anoxia/hypoxia, brain aneurysm or tumour, or a degenerative neurological disorder (AIHW 2007, Ciuffreda et al 2012).

ABI is inherent in codes for the underlying cause (eg S06.- *Intracranial injury*, G93.1 *Anoxic brain damage, not elsewhere classified,* P11.1 *Other specified brain damage due to birth trauma*). ABI is also classified in combination with codes for a number of manifestations (eg F06.8 *Other specified mental disorders due to brain damage and dysfunction and to physical disease or condition*).

Where acquired brain injury is not otherwise specified (NOS), and not elsewhere classified (NEC) (that is, the underlying cause is not known/documented), and where the ABI meets the criteria for code assignment in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*, assign G93.9 *Disorder of brain, unspecified*.

Follow the ICD-10-AM Alphabetic Index:

Damage

- brain (nontraumatic) G93.9

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:

Australian Institute of Health and Welfare 2007, *Disability in Australia,* Bulletin 55, December 2007, viewed 7 February 2017, http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442453666%20

Ciuffreda, K, Kapoor, N 2012, *Visual diagnosis and care of the patient with special needs* in M B Taub, M Bartuccio, D Maino (eds.), viewed 7 February 2017, https://books.google.com.au/books?hl=en&lr=&id=e7vuKBfSCDQC&oi=fnd&pg=PA95&dq=acquired+brain+injury&ots=tq8pbuOW3p&sig=e6TK6tRjDKmEzLRZRkErNwP4vog#v=onepage&q=acquired%20brain%20injury&f=false

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Ref No: Q3154 | Published On: 15-Sep-2017 | Status: Updated | Updated On: 15-Jun-2022

Mast Cell Activation Syndrome

Q:

What code is assigned for Mast Cell Activation Syndrome (MCAS)?

A:

Clinical advice indicates that Mast Cell Activation Syndrome (MCAS) is an immunological condition where there is activation of mast cells causing them to release mediators, resulting in a range of disorders including anaphylaxis. MCAS may be either idiopathic or secondary to a trigger (for example, an allergic reaction). There is no increase in the number of mast cells in MCAS while in other mast cell activation diseases such as systemic mastocytosis or mast cell leukaemia there is proliferation or overproduction of mast cells.

In the absence of a specific code or index entries for *mast cell activation syndrome*, clinical advice supports the assignment of the following code:

D89.89 *Other specified disorders involving the immune mechanism, not elsewhere classified.*

U91 *Syndrome, not elsewhere classified*

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

References:

Molderings, G, Brettner, S, Homann, J and Afrin, L 2011, 'Mast cell activation disease: a concise practical guide for diagnostic workup and therapeutic options', Journal of Haematology & Oncology, vol. 4, no.10, pp. 2-8, viewed 5 May 2017, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3069946/

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Ref No: Q3146 | Published On: 15-Sep-2017 | Status: Updated | Updated On: 15-Jun-2019

Neonatal hypoglycaemia in infant of diabetic mother

Q:

If neonatal hypoglycaemia is documented by the clinician, is it necessary to seek clarification as per ACS 1602 *Neonatal complications of maternal diabetes*?

A:

Neonatal hypoglycaemia is common in neonates where the mother has either pre-existing or gestational diabetes mellitus.

ACS 1602 *Neonatal complications of maternal diabetes* states*:*

> *This diagnosis, code P70.1* Syndrome of infant of diabetic mother *or P70.0* Syndrome of infant of mother with gestational diabetes*, should be confirmed by laboratory reports and clarified with the clinician.*

This guideline is provided for cases where there is documentation of a transient decrease in blood sugar in an infant of a diabetic mother, but no documentation of hypoglycaemia.

Where there is clear documentation of hypoglycaemia in a neonate and it meets the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*, there is no need to further clarify with the clinician.

Assign as appropriate:

P70.0 *Syndrome of infant of mother with gestational diabetes*

OR

P70.1 *Syndrome of infant of a diabetic mother*

Amendments to ACS 1602 may be considered for a future edition.

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Facial palsy due to lacunar syndrome, injury, tumours or other disorders

Q:

What codes are assigned for facial palsy due to lacunar syndrome, without documentation of current or previous (sequela of) cerebral infarct? How do you code facial palsy due to injury, tumours or other disorders?

A:

Lacunar syndrome is a clinical syndrome where a series of lacunar infarcts occur. They present as small, circumscribed cerebral infarcts in the territory of a single penetrating artery. Lacunar syndrome may occur with other forms of cerebrovascular disease such as vasculitis affecting the cerebral circulation. However, in the absence of another cause, lacunar syndrome is best classified as a cerebral vascular accident.

Clinical advice suggests that facial palsy due to lacunar syndrome is likely an upper motor neurone facial palsy (due to a central lesion), not a facial nerve lesion.

Assign:

G83.81 *Facial paralysis due to cerebrovascular accident*

I63.9 *Cerebral infarction, unspecified*

G46.7 *Other lacunar syndromes (I60–I67+)*

Follow the Alphabetic Index:

Paralysis, paralytic

- facial

- - due to

- - - cerebrovascular accident G83.81

Infarct, infarction (of)

- cerebral I63.9

Syndrome — *see also Disease*

- lacunar NEC I67.9† G46.7*

Note: G46.7* *Other lacunar syndromes (I60–I67+)* includes a range of codes from categories I60 to I67. Assign code combinations as per the discrete code ranges listed in the Tabular List following ACS 0001 *Principal diagnosis (the 'dagger and asterisk' system).*

To determine sequencing of the codes, follow the guidelines in ACS 0001 *Principal diagnosis*.

In addition to inflammation of the facial nerve (Bell's palsy), facial paralysis may occur in association with:

- skull fracture or injury to the face
- head or neck tumour
- middle ear infection or other ear damage
- Lyme disease
- multiple sclerosis
- Guillain-Barre Syndrome.

Assign G83.9 *Paralytic syndrome, unspecified* if facial paralysis occurring in these conditions meets the criteria in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses* following the Alphabetic Index:

Paralysis, paralytic (complete) (incomplete) (*see also Paresis*) G83.9

Amendments to ICD-10-AM 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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Isolated ultrafiltration

Q.

What code is assigned for isolated ultrafiltration?

A.

Isolated ultrafiltration is most often used to remove excess fluid and is useful in patients with fluid overload; such as chronic kidney disease, acute pulmonary oedema and cardiac failure. A dialysis machine is utilised, however dialysis solution is not circulated through the machine. (Hunter New England Health Service 2010).

Assign 13100-01 **[1060]** *Intermittent haemofiltration* as a best fit for isolated ultrafiltration.

Amendments will be considered for a future edition of ACHI.

Reference:

Hunter New England Health Service 2010, 'Guidelines for Isolated Ultrafiltration', online guideline, viewed 12 December 2016 mylink.hnehealth.nsw.gov.au/pluginfile.php/.../Draft_Isolated_Ultrafiltration.doc

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Bone graft with open reduction and internal fixation of fracture

Q:

What code is assigned for a bone graft when performed in conjunction with an open reduction and internal fixation of fracture?

A:

Bone grafts may be performed in conjunction with an open reduction and internal fixation (ORIF) of a fracture to repair a defect or to add stability to the fractured bone. The bone graft itself may or may not also be held in place with internal fixation.

Where a bone graft is performed with ORIF and the bone graft is documented as being held in place with internal fixation, assign an appropriate code by following the Alphabetic Index at *Graft/bone/*by site*/with internal fixation.*

Where a bone graft is performed with ORIF but there is no documentation clearly indicating that the bone graft is being held in place with internal fixation, assign a code for the bone graft by following the Alphabetic Index at *Graft/bone/*by site (ie do not assign the listed option for 'with internal fixation').

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Aryepiglottoplasty/supraglottoplasty performed for laryngomalacia

Q:

What code is assigned for aryepiglottoplasty/supraglottoplasty, performed for laryngomalacia?

A:

Laryngomalacia is a congenital abnormality of the laryngeal cartilage resulting in collapse of the supraglottic structures during inspiration, leading to airway obstruction (Lovinsky-Desir 2017).

Surgical treatment for laryngomalacia is aryepiglottoplasty also known as supraglottoplasty. This procedure has many variations including trimming, division or ablation of redundant aryepiglottic folds of mucosa or edges of the epiglottis and epiglottopexy, usually performed with microlaryngoscopy (Whymark et al. 2006).

Clinical advice confirms that these procedures do not involve excision of the main structures of the larynx (that is, the epiglottis or arytenoids).

Assign 41876-02 **[526]** *Laryngoplasty*

and

41855-00 **[520]** *Microlaryngoscopy* as per the guidelines in ACS 0023 *Minimally invasive interventions*.

Amendments will be considered for a future edition.

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

References:

Lovinsky-Desir S, 2017, Laryngomalacia, Medscape, viewed 25 May 2017, http://emedicine.medscape.com/article/1002527-overview#showall

Whymark A et al, 2006, Laser epiglottopexy for laryngomalacia, JAMA otolaryngology – head and neck surgery, viewed 2 July 2017, http://jamanetwork.com/journals/jamaotolaryngology/fullarticle/484496

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Delirium due to opioids

Patients may be admitted with delirium due to opioid use or ingestion, with varied documentation affecting code assignment.

Guidelines regarding classification of drug-induced conditions are included in a number of standards:

ACS 0503 *Drug, alcohol and tobacco use disorders/Classification/General classification rules* states:

> *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.*
>
> …
>
> *Overdose… cases should be coded to the appropriate poisoning code from the Table of Drugs and Chemicals. …*

ACS 1902 *Adverse effects/Drugs states*:

> *Adverse effects of correct substances properly administered includes allergic reactions, hypersensitivity, idiosyncratic reaction, interaction of drugs (when each is the correct substance properly administered) and similar situations primarily involving proper use of drugs.*
>
> *Adverse effects of correct substances properly administered are classified according to the nature of the adverse effect. An external cause code must be assigned to indicate the drug or medicinal agent which caused the adverse effect.*

ACS 1901 *Poisoning states*:

> *Poisoning by drugs includes wrong drug given or taken in error, suicide and homicide, adverse effects of prescribed drugs taken in combination with self-prescribed drugs and intoxication.* ***Poisoning involves improper use****.*

Poisoning is classified to categories T36–T50 *Poisonings by drugs, medicaments and biological substances*. These codes describe the type of drug that was the cause of the poisoning.

In addition to the code for poisoning, an additional diagnosis code should be assigned to indicate any significant manifestation (eg coma, arrhythmia).

Note: the clinical concept of *intoxication* is classified in ICD-10-AM as either inebriation or poisoning, which are mutually exclusive as evidenced by the Alphabetic Index:

Intoxication

- meaning

- - inebriation – code to F10-F19 with 4th character .0

- - poisoning – *see Table of drugs and chemicals*

See also the *Excludes* notes at F1-.0 *Mental and behavioural disorders due to psychoactive substance use, acute intoxication, and T36-T50 Poisoning by drugs, medicaments and biological substances*.

For example:

Scenario 1. 'Delirium due to opioid intoxication due to accidental overdose'.

Classify as **poisoning** as per the guidelines in ACS 0503 and ACS 1901, and the *Excludes* note at F1-.0 (*Excludes*: intoxication meaning poisoning (T36–T50))

Assign:

T40.2 *Poisoning by other opioids*

F05.9 *Delirium, unspecified*

X42 *Accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified*

Appropriate place of occurrence and activity codes

Scenario 2. 'Delirium due to opioid medication correctly administered'.

Classify as an **adverse effect** as per the guidelines in ACS 1902.

Assign:

F05.9 *Delirium, unspecified*

Y45.0 *Opioids and related analgesics (causing adverse effects in therapeutic use)*

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

or

Y92.24 *Health service area, this facility*

as applicable

Scenario 3. 'Delirium due to opioids (NOS)'.

In this scenario, seek clarification (where possible) to determine if the delirium was an adverse effect or poisoning.

If documentation indicates delirium due to opioid ingestion, not otherwise specified (NOS) (that is, there is no further information or clinical clarification available to indicate whether it is an adverse effect in therapeutic use, or poisoning), assign:

F05.9 *Delirium, unspecified*

Scenario 4. 'Delirium due to opioid intoxication (NOS)'.

Assign F11.0 *Mental and behavioural disorders due to use of opioids, acute intoxication* following the Alphabetic Index:

Delirium, delirious (acute or subacute) (not alcohol- or drug-induced)

- due to (secondary to)

- - opioid intoxication (acute) F11.0

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

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Intrauterine hypoxia and fetal distress in labour

Q:

When are codes from category P20 *Intrauterine hypoxia* assigned?

A:

Clinically, fetal distress and intrauterine hypoxia are not synonymous terms. The principal aim of intrapartum fetal surveillance is to prevent adverse perinatal outcomes arising from intrapartum complications. Evidence of fetal distress (eg abnormal fetal heart rate, fetal scalp pH/lactate, fetal pulse oximetry) may occur with and without intrapartum complications (eg hypoxia).

Fetal distress during labour may be an indication for a change in management of the labour; however, this does not necessarily mean that the infant will be adversely affected.

Assign P20.- *Intrauterine hypoxia* **only** when there is documentation of intrauterine hypoxia in the infant's record, meeting the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses.*

Where there is documentation of fetal distress or intrauterine hypoxia in the mother's record, and as a result the newborn is observed/evaluated but no abnormal condition is identified, assign Z03.79 *Observation of newborn for other suspected condition* as per the guidelines in ACS 1611 *Observation and evaluation of newborn and infants for suspected condition not found*:

> *Z03.7*- Observation and evaluation of newborn for suspected condition not found *codes are for use in limited circumstances on records of otherwise healthy newborns, who are suspected to be at risk for an abnormal condition which requires study, but after examination and observation, it is determined that there is no need for further treatment or medical care.*

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Transfer following a procedure

Q:

When is Z48.8 *Other specified surgical follow-up care* assigned?

A:

ACS 2103 *Admission for post acute care* states the following key points:

> *For classification purposes post acute care, also described as aftercare or postoperative convalescence, is care provided to patients* ***toward the end of an acute phase of treatment****…These patients are still receiving some ongoing review for their condition but they* ***no longer require significant management****.*
>
> *This standard is* ***not applicable to all transfers between hospitals****. It is applicable to the receiving facility where patients have been transferred for continuing care after surgical or medical treatment, where the initial treatment phase has occurred in another facility.*
>
> - *If the patient is transferred for post-surgical aftercare, assign as principal diagnosis Z48.8* Other specified surgical follow-up care*. Assign an additional code for the condition that required surgery.*
> - *If the patient is transferred for* ***continued active treatment*** *of a condition, do not assign an aftercare code, instead follow ACS 0001* Principal diagnosis*.*

Please also note the following points:

- The terms ‘post acute care’, ‘aftercare’ or ‘postoperative convalescence’ do not have to be documented to assign Z48.8 *Other specified surgical follow-up care* or Z51.88 *Other specified medical care*
- Transfers between campuses of the same hospital, or between two facilities for overnight **care** (eg care of in situ drain) and observation following a day procedure, are not classified as aftercare as the patient is still receiving active treatment
- Routine allied health or nursing care is not considered active treatment, as demonstrated by ACS 2103 Example 1.

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Diabetes mellitus with ketoacidosis due to broken insulin pump

Q:

How do you code a patient with diabetes mellitus admitted with ketoacidosis due to a broken insulin pump?

A:

Major amendments were made to ACS 1904 *Procedural complications* for Tenth Edition which states:

> ***Intraoperative/postoperative medical conditions***
>
> *Some conditions, especially medical conditions commonly seen intraoperatively and in the postoperative period, are not solely related to the procedure performed, but are related to the complex interaction between the disease process and the procedure (that is, the cause of the condition is multifactorial). These conditions are not classified as procedural complications unless the causal relationship is clearly documented as per dot point one above. Assign code(s) for these medical conditions in accordance with ACS 0001* Principal diagnosis *or ACS 0002* Additional diagnoses

Where documentation clarifies that ketoacidosis in a patient with diabetes mellitus is due to breakdown of their insulin pump, assign T85.69 *Mechanical complication of internal prosthetic devices, implants and grafts, not elsewhere classified* by following the Alphabetic Index at:

Breakdown

- device, implant or graft

- - specified NEC T85.69

Assign an appropriate diabetes mellitus code by following the Alphabetic Index at:

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

- with

- - ketoacidosis (without coma) E1-.11

- - - with coma E1-.12

- - - and lactic acidosis (without coma) E1-.15

- - - - with coma E1-.16

Sequence T85.69 before the diabetes mellitus (DM) code as per the guidelines in ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia/General classification rules for DM and IH/Rule 5*:

> Where the classification (Alphabetic Index) has linked a condition with DM, yet a specific **cause other than DM is documented** as the cause of the condition, then a code for the causal condition should be sequenced before the DM code(s)

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Postcaesarean observation of neonate

Q:

What code is assigned for neonates admitted to special care for postcaesarean observation, with no condition suspected or found?

A:

Assign Z76.22 *Health supervision and care of other infant or child, not elsewhere classified,* which includes infant for postcaesarean observation, is listed under a number of lead terms in the Alphabetic Index including:

Care (following) (for) (of)

- infant NEC Z76.22

and

Supervision (of)

- infant NEC Z76.22.

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

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Coding Rules

Published 15 June 2017

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Y95 *Nosocomial condition*

Q:

Is Y95 *Nosocomial condition* a redundant code due to the use of the condition onset flag (COF)?

A:

Y95 *Nosocomial condition* is assigned to identify the external cause of any condition that is **documented** as nosocomial, hospital or healthcare acquired, excluding U92 *Healthcare associated Staphylococcus aureus bloodstream infection [HA-SABSI].*

The condition onset flag (COF) is assigned to differentiate conditions that were present on admission (COF 2) from those that arose during an episode of care (COF 1).

An appropriate COF flag is assigned with Y95 as per the guidelines in ACS 0048 *Conditions onset flag/Guide for use/point 7*:

> *The COF value assigned to external cause, place of occurrence and activity codes should match that of the corresponding injury or disease code.*

Therefore, Y95 is assigned with:

- COF 1 when it is the external cause of a condition, documented as above, that arose during the admission
- COF 2 when it is the external cause of a condition, documented as above, that was present on admission.

Although the assignment of Y95 with COF 1 is redundant, the assignment of Y95 with a COF 2 provides additional information about a condition present on admission, that has been identified as acquired in a healthcare setting, for example, a transfer from one facility to another or a readmission to the same facility.

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: Q3053 | Published On: 15-Jun-2017 | Status: Current

Use of trache shield/tracheostomy collars

Q:

Is the use of a trache shield or tracheostomy collar following cessation of Continuous Ventilatory Support (CVS) counted in the calculation of CVS hours?

A:

A tracheostomy bypasses the upper airway and therefore prevents normal humidification and filtration of inhaled air. Unless air inhaled via the tracheostomy tube is humidified, the epithelium of the trachea and bronchi will become dry which increases the potential for tube blockage.

A trache (trachy) shield is a device used for the purposes of humidification and transfer of oxygen in a tracheostomy patient. The trache shield is often used in conjunction with a speech enabling valve (such as the Passy-Muir valve) to ensure humidification is maintained during speech.

A tracheostomy collar is a soft plastic mask that fits over and around the tracheostomy tube. It allows humidified oxygen to be delivered via a noninvasive modality such as continuous positive airway pressure (CPAP).

Clinical advice confirms that the presence of a trache shield or tracheostomy collar is not indicative of a continuous ventilatory support (CVS) intervention, rather it is a facilitating device to the tracheostomy and may be present with and without CVS. Thus the use of a trache shield or collar following cessation of CVS is not counted in the calculation of CVS hours.

Amendments will be considered for a future edition of ACHI and ACS.

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Ref No: Q3053 | Published On: 15-Jun-2017 | Status: Current

Oxygen use in weaning

Q:

Does the term 'oxygen delivery' in ACS 1006 *Ventilatory support* mean any oxygen delivery can be counted as weaning?

A:

Clinical advice confirms that the presence of a tracheshield or tracheostomy collar is not indicative of a continuous ventilatory support (CVS) intervention, rather it is a facilitating device to the tracheostomy and may be present with and without CVS being undertaken.

ACS 1006 *Ventilatory support* states:

> *'…Where there is documentation of weaning from CVS, such as the use of positive pressure ventilation or oxygen delivery via a tracheostomy collar, include the weaning in the duration of CVS up to a maximum of 24 hours following the cessation of CVS, or the removal of the tracheostomy. Where CVS via the tracheostomy recommences > 24 hours following cessation of CVS a new period of ventilation commences.'*

The advice that 'oxygen delivery via a tracheostomy collar is one modality for weaning' should not be interpreted to mean any method of oxygen delivery can be counted as weaning. If documentation is unclear as to whether weaning has occurred, clarify with the clinician.

Amendments will be considered for a future edition of ACHI and ACS.

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Ref No: Q3079 | Published On: 15-Jun-2017 | Status: Current

Cardiac arrest with resuscitation prior to admission

Q:

Can I46.0 be assigned when the patient has a cardiac arrest and resuscitation has been performed prior to admission?

A:

Cardiac arrest occurs when the heart stops pumping blood around the body. This is usually the result of an underlying heart condition such as ventricular fibrillation but may also be the result of non-cardiac causes such as respiratory arrest, choking, trauma, electric shock or drowning.

Where a patient has a cardiac arrest prior to admission, and is admitted following successful resuscitation (eg performed by paramedics):

- if there is documentation of an underlying cause (see examples above), assign a code for the underlying cause only
- if there is no documentation of an underlying cause, assign I46.0 *Cardiac arrest with successful resuscitation*

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Ref No: Q3089 | Published On: 15-Jun-2017 | Status: Current

Varicella-zoster meningitis

Q:

Is varicella-zoster meningitis classified as varicella meningitis or zoster meningitis?

A:

Varicella zoster virus (VZV) is part of the herpes virus family along with herpes simplex virus (HSV)-1, HSV-2, Epstein-Barr virus (EBV), cytomegalovirus (CMV), and human herpesvirus-6) which are common causes of viral meningitis.

VZV causes two clinically different forms of disease. The initial infection causes varicella (chickenpox). After resolution of the initial varicella infection, the VZV virus remains latent in the dorsal root and cranial nerve ganglia. When VZV is reactivated it results in herpes zoster (shingles). Varicella occurs once only and the disease recurs in the form of herpes zoster thereafter. Therefore, varicella (chickenpox) and herpes zoster (shingles) cannot occur together (Albrecht 2016, Meningitis Research Foundation 2016).

VZV meningitis may occur with the initial varicella infection or when it recurs as herpes zoster. The pathology will report VZV for either condition; the distinction is based on history of a previous manifestation.

In the absence of clear documentation, seek clinical clarification to determine if VZV meningitis is due to varicella or herpes zoster; it is not the responsibility of the clinical coder to diagnose the condition.

When clinical clarification is not possible, the following is a guide based on clinical advice:

- Where there is documentation of a **history of chickenpox or varicella infection**, assign B02.1 *Zoster meningitis* by following the Alphabetic Index:

  Meningitis (basal) (cerebral) (spinal)

  - in (due to)

  - - herpes (simplex) virus

  - - - zoster B02.1

- Where there is **no** documentation of a **history of chickenpox or varicella infection**, or there is documentation of varicella-zoster meningitis not otherwise specified (NOS), assign B01.0 *Varicella meningitis* by following the Alphabetic Index:

  Meningitis (basal) (cerebral) (spinal)

  - in (due to)

  - - varicella B01.0

Do not assign both B01.0 and B02.1 for varicella-zoster meningitis.

References:

Albrecht, MA 2016, Epidemiology and pathogenesis of varicella-zoster virus infection: Herpes zoster, UpToDate, U.S., viewed 02 November 2016, http://www.uptodate.com/contents/epidemiology-and-pathogenesis-of-varicella-zoster-virus-infection-herpes-zoster?source=see_link

Meningitis Research Foundation, Adult Meningitis caused by herpes viruses 2016, Meningitis Research Foundation, Bristol, viewed 15 December 2016, http://www.meningitis.org/completed-projects/adult-meningitis-caused-by-29901

Meningitis Research Foundation, Viral Meningitis 2016, Meningitis Research Foundation, Bristol, viewed 14 December 2016, http://www.meningitis.org/disease-info/types-causes/viral-meningitis

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Ref No: Q3099 | Published On: 15-Jun-2017 | Status: Current

Botox injections to multiple sites

Q:

How many times is the code for botox injection assigned, where there are multiple injections into both arms and legs during the same visit to theatre?

A:

Botox injections into multiple muscles, performed during one visit to theatre, is classified as per the guidelines in ACS 0020 *Bilateral/multiple procedures/Multiple procedures/Classification, point 4* which states:

> *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.*

Therefore, assign 18360-01 **[1552]** *Administration of agent into soft tissue, not elsewhere classified* as many times as performed by following the Alphabetic Index:

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

- type of agent

- - botulinum toxin (Botox) (Botoxin) (onabotulinumtoxinA) (soft tissue) (type A) NEC *(see also Administration/indication OR Administration/specified site)* 18360-01 **[1552]**

or

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

- specified site

- - muscle NEC 18360-01 **[1552]**

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Ref No: Q3121 | Published On: 15-Jun-2017 | Status: Current

Biliary sludge

Q:

What is the correct code to assign in relation to biliary sludge?

A:

Biliary sludge occurs normally in the body as a result of the gallbladder concentrating bile. It consists of sediment (calcium bilirubin, cholesterol crystals and other calcium salts) that arises as water is extracted from the bile. Mucus from the gallbladder lining mixes with the sediment to form 'sludge'.

Biliary sludge often occurs in patients who are pregnant, obese, who have undergone rapid weight loss (including as a result of surgery), or following administration of total parenteral nutrition (TPN). It may also occur following the administration of certain drugs (such as ceftriaxone and octreotide), or in transplant patients.

The body's normal processes ensure that sludge is usually cleared from the gallbladder without complication. However, biliary sludge may be a precursor to biliary stones, acute cholecystitis/cholangitis or acute pancreatitis.

Documentation of biliary sludge without the presence of biliary stones, acute cholecystitis/cholangitis, or acute pancreatitis does not require assignment of an ICD-10-AM code.

Where biliary sludge does result in biliary stones, biliary duct obstruction, acute cholecystitis/cholangitis, or acute pancreatitis meeting the criteria for code assignment in ACS 0002 *Additional diagnoses*, assign a code for the resultant condition.

Where the documentation is of biliary sludge without a resultant condition but the patient is presenting with symptoms (such as abdominal pain), code the appropriate ICD-10-AM code(s) for the symptoms where they meet the criteria for code assignment in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses.*

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Ref No: Q3122 | Published On: 15-Jun-2017 | Status: Current

SpyGlass™ cholangioscopy

Q:

Should an additional code be assigned for SpyGlass™ cholangioscopy performed with ERCP?

A:

Cholangioscopy, also known as cholangiopancreatoscopy, is the direct visual examination of the bile ducts using a fibre optic endoscope. Cholangioscopy is often used in conjunction with endoscopic retrograde cholangiopancreatography (ERCP).

The use of the Spyglass™ system (duodenoscope-assisted cholangiopancreatoscopy) is an extension of a conventional ERCP.

Therefore, when the Spyglass™ system is used in conjunction with ERCP, assign 96224-00 **[957]** *Cholangiopancreatoscopy* by following the Alphabetic Index:

Cholangiopancreatoscopy (DACP) (duodenoscope-assisted) (with biopsy) (with brushing(s)) (with washing(s) for specimen collection) 96224-00 **[957]**

or

DACP (duodenoscope-assisted cholangiopancreatoscopy) (with biopsy) (with brushing(s)) (with washing(s) for specimen collection) 96224-00 **[957]**

Do not assign an additional code for the ERCP, as it is a component of the cholangiopancreatoscopy/DACP.

Amendments to ACHI will be considered for a future edition.

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Laparotomy with ‘milking’ of bezoar from small intestine

Q:

How do you code laparotomy with ‘milking’ of bezoar from the small intestine?

A:

A bezoar is an indigestible, solid foreign body in the digestive system that may lead to obstruction:

- Phytobezoars are composed of indigestible food fibres (such as cellulose that occur in fruits and vegetables) and are the most common type of bezoar
- Trichobezoars are composed of hair or hair-like fibres (such as carpet or clothing fibres)
- Pharmacobezoars are composed of medications that don’t properly dissolve in the digestive tract (Picco 2012).

‘Milking’ of a bezoar in the small intestine involves laparotomy, followed by manipulating (squeezing) the bezoar from a narrow section into a larger section of the intestine, to allow it to pass naturally. There is no incision into the intestine involved in this procedure.

Where laparotomy with milking of bezoar is the only procedure performed, assign 30373-00 **[985]** *Exploratory laparotomy* as a best fit.

When the above procedure is unsuccessful, an enterotomy (incision into the intestine) may be required to remove the bezoar; assign 30375-03 **[893]** *Enterotomy of small intestine* in this scenario.

Amendments to ACHI will be considered for a future edition.

Reference:

Picco, M 2012, *I’ve heard that eating certain foods can cause bezoars. What are bezoars?* Mayo Foundation for Medical Education and Research (MFMER), viewed 9 January 2017 http://www.mayoclinic.org/diseases-conditions/gastroparesis/expert-answers/bezoars/faq-20058050.

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Capsulectomy/capsulotomy of the breast

Q:

What codes are assigned where a capsulectomy or capsulotomy of the breast is performed without the removal/replacement of the breast prosthesis?

A:

Capsular (scar) formation is the body's natural response to a foreign body, such as a breast implant. In some cases, the capsule contracts causing pain, deformity or displacement of the implant, and surgery is required to release (capsulotomy) or remove the scar tissue (capsulectomy). This may be performed with or without replacement of the implant(s). (Department of Health and Human Services 2016; Headon et al, 2015; Swanson 2016)

There are no index entries or codes in ACHI for a capsulotomy or capsulectomy of the breast performed without the removal/replacement of the breast prosthesis.

Therefore, where a capsulectomy of the breast has been performed without removal/replacement of the breast prosthesis, assign 31500-00 **[1744]** *Excision of lesion of breast* as a best fit, by following the Alphabetic Index:

Excision

- lesion(s)

- - breast (complete) (local) (wide) 31500-00 **[1744]**

Where a capsulotomy of the breast has been performed without removal/replacement of the breast prosthesis, assign 31551-00 **[1742]** *Incision and drainage of breast* as a best fit, by following the Alphabetic Index:

Incision

- breast 31551-00 **[1742]**

Improvements to ACHI will be considered for a future edition.

References:

Department of Health and Human Services 2016, *Breast implants and your health,* Better Health Channel, viewed 21 February 2017, https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/breast-implants-and-your-health

Headon, H, Kasem, A Mokbel, K 2015, 'Capsular Contracture after Breast Augmentation: An Update for Clinical Practice', *Archives of Plastic Surgery*, vol. 42, no. 5, pp. 532–543, viewed 21 February 2017, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4579163/

Swanson, E 2016 'Open Capsulotomy: An Effective but Overlooked Treatment for Capsular Contracture after Breast Augmentation', *Plastic and Reconstructive Surgery Global Open*, *4*(10), viewed 18 April 2017, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5096543/

Published 15 June 2017,
for implementation 01 July 2017.

Ref No: Q3137 | Published On: 15-Jun-2017 | Status: Current

Microsurgery (use of operating microscope) on blood vessels

Q:

What codes are assigned for microscopic repair/anastomosis/graft of blood vessels, or described as repair/anastomosis/graft performed under microscope?

A:

Microsurgery is defined as an intervention using an operating microscope (and other specialised instruments). The term microscopic (or performed under microscope) is synonymous with microsurgery in ACHI.

Microvascular refers to very small blood vessels (eg capillaries, venules, arterioles). The terms are not interchangeable; however microsurgical techniques are usually used on microvascular structures.

The block titles (and codes) in blocks **[1694]**, **[1695]** and **[1696]** include the term 'microsurgical':

[1694] *Microsurgical repair for restoration of continuity of blood vessel of distal extremity or digit*

[1695] *Microsurgical anastomosis of blood vessel*

[1696] *Microsurgical graft of blood vessel*

Codes in the above blocks are assigned when microsurgical techniques are used to repair/anastomose/graft blood vessels; this may be, but is not exclusively for, microvascular structures.

Therefore, where 'microsurgical' repair/anastomosis/graft/suture of a blood vessel is documented (that is, microscopic repair/anastomosis/graft/suture of a blood vessel/using an operating microscope), assign an appropriate code from blocks **[1694]**, **[1695]** and **[1696]** by following the Alphabetic Index:

Anastomosis

- artery

- - for

- - - free flap

- - - - with anastomosis of vein 45502-02 **[1695]**

- - - reimplantation of limb or digit 45502-00 **[1695]**

- - - - with anastomosis of vein 45502-02 **[1695]**

…

- - microsurgical 45502-00 **[1695]**

- - - with anastomosis of vein 45502-02 **[1695]**

…

- vein
- - for
- - - free flap
- - - - with anastomosis of artery 45502-02 **[1695]**
- - - reimplantation of limb or digit 45502-01 **[1695]**
- - - - with anastomosis of artery 45502-02 **[1695]**

…

- - microsurgical 45502-01 **[1695]**
- - - with anastomosis of artery 45502-02 **[1695]**

Graft

- artery, arterial
- - by microsurgical technique 45503-00 **[1696]**
- - - with venous graft 45503-02 **[1696]**

…

- - microsurgical 45503-00 **[1696]**
- - - with venous graft 45503-02 **[1696]**

…

- vein, venous
- - by microsurgical technique 45503-01 **[1696]**
- - - with arterial graft 45503-02 **[1696]**

…

- - microsurgical 45503-01 **[1696]**
- - - with arterial graft 45503-02 **[1696]**

Suture

- artery
- - by microsurgical techniques, for restoration of continuity of artery of distal extremity or digit 45500-00 **[1694]**
- - - with suture of vein 45500-02 **[1694]**

…

- vein
- - by microsurgical techniques, for restoration of continuity of vein of distal extremity or digit 45500-01 **[1694]**
- - - with suture of artery 45500-02 **[1694]**

Where documentation is unclear, advice must be sought from the treating clinician to determine if 'microsurgical' techniques have been employed on the vessel.

Amendments to ACHI will be considered for a future edition.

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for implementation 01 July 2017.

Ref No: Q3141 | Published On: 15-Jun-2017 | Status: Current

Type 1 and type 2 myocardial infarction (MI)

Q:

How do you code type 1 and type 2 myocardial infarction (MI)?

A:

Type 1 and type 2 myocardial infarction (MI) are classifications of MI based on the different conditions that may lead to MI (that is, the underlying cause):

- Type 1 MI is due to a primary coronary event, for example, acute atherosclerotic plaque rupture, ulceration, fissuring, erosion, or dissection. Most (but not all) patients have underlying severe coronary artery disease (CAD)
- Type 2 MI is secondary to an ischaemic imbalance, where a condition other than CAD leads to a mismatch between myocardial oxygen supply and demand. Type 2 MI may also be caused by coronary vasospasm and/or endothelial dysfunction.

ICD-10-AM classifies MI based on site, depth and presence of ST elevation. The subtypes above, based on causality, are not classifiable to the current MI codes, however an additional code may be assigned for the underlying condition, where documented (as per the guidelines in ACS 0001 *Principal diagnosis/Problems and underlying conditions* and ACS 0002 *Additional diagnoses/Problems and underlying conditions*).

Choose a specific option from the subterms listed in the Alphabetic Index if further descriptors of the MI are documented (eg transmural, nontransmural, ST elevation (STEMI), non-STEMI)):

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

…

- - transmural NEC I21.3

Where type 1 or type 2 MI NOS is documented, assign as a default I21.9 *Acute myocardial infarction, unspecified.*

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

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for implementation 01 July 2017.

Ref No: Q3156 | Published On: 15-Jun-2017 | Status: Current

Oxygen desaturation without mention of respiratory failure

Q:

How do you code oxygen desaturation without mention of respiratory failure?

A:

Oxygen desaturation is determined by measuring the amount of oxygen bound to haemoglobin in the blood with a pulse oximeter or by taking a blood sample from an artery.

Low oxygen saturation in the blood (oxygen desaturation) is also known as hypoxaemia. Normal pulse oximeter readings range from 95 to 100 per cent. During hypoxaemia, the oxygen saturation in the body is less than 90 per cent. Oxygen desaturation/hypoxaemia may have a number of underlying causes, including COPD, emphysema, some heart conditions, high altitude, during sleep, cystic fibrosis.

Note that the terms hypoxaemia and hypoxia are often used interchangeably. Clinical consultation indicates that while hypoxaemia is not synonymous with hypoxia (defined as the deficiency of oxygenation at the tissue level), they are similar clinically.

Therefore, where there is documentation of hypoxaemia/oxygen desaturation not otherwise specified (NOS) and it meets the criteria in ACS 0002 *Additional diagnoses*, assign R09.0 *Asphyxia* as the best fit following the Alphabetic Index:

Hypoxia — *see also Anoxia*

and

Anoxia R09.0

or

Deficiency, deficient

- oxygen R09.0

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

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for implementation 01 July 2017.

Ref No: Q3163 | Published On: 15-Jun-2017 | Status: Current

Removal of migrated subdermal hormone implant

Q:

What codes are assigned for removal of a subdermal hormone implant that has migrated from the incision site?

A:

Subdermal (contraceptive) hormone implants (eg Implanon or Nexplanon) are inserted into the subcutaneous tissue in the upper arm. The implants are composed of a nonbiodegradable material containing synthetic progestin etonogestrel (Organon Pharmaceutical 2011).

Distal migration of an implant greater than 2 centimetres from the insertion site is rare. Implants have been reported in sites such as the biceps muscle, the axilla and the pulmonary artery. Admission for removal of the implants in these cases may be necessary in order to accurately locate the device using imaging techniques (Berhe et al 2014, Heudes et al 2015).

Admission for removal of a subdermal hormone implant that has migrated from the incision site (for example, to a site other than the subcutaneous tissue), is classified as a mechanical complication. Assign:

T85.69 *Mechanical complication of internal prosthetic devices, implants and grafts, not elsewhere classified*

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

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

OR

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

Follow the ICD-10-AM Alphabetic Index:

Displacement, displaced

- device, implant or graft (see also Complication(s)/by site and type/mechanical) T85.69

Follow the External causes of injury Alphabetic Index:

Complication(s) (delayed) (medical or surgical procedure) (of or following)

- procedures other than surgical operation NEC (*see also Complication(s)/by type of procedure*) Y84.9

- - specified Y84.8

For removal of the device, assign 30062-00 **[1908]** *Removal of subdermal hormone implant*, by following the ACHI Alphabetic Index:

Removal — *see also Excision*

- implanon 30062-00 **[1908]**

Note: the term ‘subdermal hormone implant’ is the name of the device, not its location.

References:

Berhe, Y, Hagos, G Wal, L Lewis 2014, *Axillary migration of an Implanon® contraceptive rod: case report*, Open access journal of contraception 2014:5 49-51, Dove Medical Press Limited, viewed 7 February 2017, https://www.dovepress.com/axillary-migration-of-an-implanonreg-contraceptive-rod-case-report-peer-reviewed-article-OAJC

Heudes, P-M, Querat ,V, Darnis, E, Defrance, C, Douane, F Frampas, E 2015, *Case reports in women's health* Volume 8, October 2015, pages 6-8, viewed 7 February 2017, http://www.sciencedirect.com/science/article/pii/S2214911215300072

Organon Pharmaceuticals USA 2011, *Implanon – etonogestrel implant*, viewed 7 February 2017, https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=63647

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for implementation 01 July 2017.

Coding Rules

Published 15 March 2017

Ref No: Q3116 | Published On: 15-Mar-2017 | Status: Updated | Updated On: 15-Jun-2022

Dialysis dysequilibrium syndrome

Q:

How do you code dialysis dysequilibrium syndrome?

A:

Dialysis dysequilibrium syndrome (DDS) is a rare complication of haemodialysis. DDS is a clinical syndrome of neurological deterioration. Presenting symptoms involve the neurological system (eg mental confusion, headache, muscle twitching) and are thought to be the result of increased intracranial pressure/cerebral oedema (following movement of water into the cerebrospinal fluid (CSF) due to CSF urea concentrations being higher than blood urea concentrations).

ACS 1904 *Procedural complications* states:

> *Conditions…should be assigned procedural complication codes only if they meet the following criteria:*
>
> - *Certain conditions where the relationship is inherent in the diagnosis*
>
> *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.*

As DDS is a known complication of haemodialysis (ie the relationship is inherent) and it involves neurological symptoms (ie is related to a body system), assign G97.8 *Other intraoperative or postprocedural disorders of nervous system*.

Follow the ICD-10-AM Alphabetic Index:

Complication(s)(from) (of)

- nervous system

- - intraoperative or postprocedural

- - - specified NEC G97.8

Assign additional diagnoses codes from Chapters 1 to 18 to identify symptoms/manifestations, and U91 *Syndrome, not elsewhere classified* to flag they are manifestations of a syndrome.

Also assign the following external cause codes:

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*.

Do not follow the ICD-10-AM Alphabetic Index at *Complication(s)/dialysis/specified NEC* to assign T80.8 *Other complications following infusion, transfusion and therapeutic injection,* as DDS is a complication related to a body system.

Amendments to ICD-10-AM 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:

Mailloux, L 2016, Dialysis disequilibrium syndrome, UpToDate, viewed 13 October 2016, http://www.uptodate.com/contents/dialysis-disequilibrium-syndrome

Zepeda-Orozco, D & Quigley, R 2012, 'Dialysis disequilibrium syndrome', Pediatric nephrology, 2012 Dec; 27(12): 2205-2211, viewed 13 October 2016, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3491204

Published 15 March 2017,
for implementation 01 April 2017.

Ref No: Q3075 | Published On: 15-Mar-2017 | Status: Updated | Updated On: 01-Jul-2017

Lords plication of hydrocele

Q:

What code is assigned for Lord's plication of hydrocele?

A:

Lord's plication is undertaken on medium sized and thin walled hydroceles. The hydrocele is opened with a small skin incision, the testis lifted out and the hydrocele sac plicated (reduced) by suture to the junction of the testis and epididymis.

In the absence of index entries or a specific code for plication of hydrocele, assign 30631-00 **[1182]** *Excision of hydrocele* as a best fit.

Note: 37604-17 **[1171]** *Percutaneous aspiration or drainage of scrotum or tunica vaginalis* is not appropriate as Lord's plication opens the hydrocele sac for reduction.

Amendments will be considered for a future edition of ACHI.

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 2017.

Ref No: Q2937 | Published On: 15-Mar-2017 | Status: Updated | Updated On: 15-Jun-2022

Iliac artery stenosis with Type 2 diabetes mellitus and peripheral vascular disease

Q:

What is the correct code assignment for iliac artery stenosis in a Type 2 diabetes mellitus patient with peripheral vascular disease (PVD)?

Can an additional code from I70.21–I70.24 be assigned, if intermittent claudication, rest pain, gangrene or ulceration are also present?

A:

The abdominal aorta divides to form the common iliac arteries in the pelvis. Each common iliac artery branches into an internal and an external iliac artery. The internal iliac artery provides blood supply to the pelvic organs while the external iliac artery provides the main blood supply to the lower limbs.

ACS 0941 *Arterial disease point 9. Stenosis* states:

> *…stenosis of other arteries that is not documented as due to another cause is to be assigned the appropriate atherosclerosis code.*

Clinically iliac artery stenosis may be considered as peripheral vascular disease (PVD) however, in ICD-10 (and ICD-10-AM) PVD is classified as arteriosclerosis of the extremities. Therefore, for classification purposes, iliac artery stenosis is not classified as PVD.

For iliac artery stenosis with Type 2 diabetes mellitus and PVD, assign:

I70.8 *Atherosclerosis of other arteries*

and

E11.51 *Type 2 diabetes mellitus with peripheral angiopathy, without gangrene*

following the Alphabetic index:

Arteriosclerosis, arteriosclerotic

- specified artery NEC I70.8

and

Diabetes, diabetic

- with

- - angiopathy, peripheral (without gangrene) E1-.51

- - peripheral vascular disease (PVD) — *see Diabetes/with/angiopathy, peripheral*

To determine if an additional code from I70.21-I70.24 is required for Type 2 diabetes mellitus with complicated PVD (ie with claudication, rest pain, gangrene or ulceration), follow the guidelines in ACS 0401 *Diabetes Mellitus and Intermediate hyperglycaemia/General classification rules for DM and IH/Rules 4b and 6* and the Alphabetic Index at *Diabetes, diabetic/with* for code assignment.

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

This advice has modifications 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: Q2984 | Published On: 15-Mar-2017 | Status: Current

Peripheral vascular disease with claudication

Q:

What is the correct code to assign for peripheral vascular disease with claudication, without documentation of intermittent?

A:

Intermittent claudication is defined as cramping pain and weakness in the legs, especially the calves on walking that disappears after rest and is usually associated with inadequate blood supply to the muscles (Merriam-Webster medical dictionary, 2017). The terms 'claudication' and 'intermittent claudication' are used interchangeably to describe the same condition. The term 'intermittent' implies that 'claudication' occurs off and on, usually with exercise and disappears with rest.

Peripheral vascular disease (PVD) or peripheral artery disease (PAD) is a progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel/artery. It is primarily the result of arteriosclerosis. The atheroma may gradually progress to complete occlusion of medium-sized and large arteries.

Assign I70.21 *Atherosclerosis of arteries of extremities with intermittent claudication* for PVD with claudication, with or without documentation of intermittent, by following the Alphabetic Index:

Arteriosclerosis, arteriosclerotic

- extremities

- - with

- - - intermittent claudication I70.21

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

References

Merriam-Webster medical dictionary, 2016, Intermittent claudication, viewed 30 January 2017, https://www.merriam-webster.com/medical/intermittent%20claudication

Published 15 March 2017,
for implementation 01 April 2017.

Ref No: Q3059 | Published On: 15-Mar-2017 | Status: Current

Callus reduction performed by Podiatrist

Q:

Should callus reduction performed on the ward by a Podiatrist be coded?

A:

Callus reduction by a podiatrist involves progressively reducing the thickness of the callus using either lateral cutting strokes from a scalpel blade, or the abrasive action of a diamond electro-deposition file, until callus removal is complete (NHS, 2012).

ACS 0032 *Allied health interventions* states:

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

Therefore, as there is no specific ACHI code for callus reduction, assign 95550-04 **[1916]** *Allied health intervention, podiatry*.

Amendments to the classification will be considered for a future edition.

Reference

Wirral Community NHS Trust 2012, Clinical procedure for podiatric callus and corn reduction (community podiatrists), viewed 13 October 2016, http://www.wirralct.nhs.uk/attachments/article/19/CP66SOPcallusandcornreduction12Oct12FINALCH.pdf

Published 15 March 2017,
for implementation 01 April 2017.

Ref No: Q3061 | Published On: 15-Mar-2017 | Status: Current

Ischaemic hepatitis

Q:

What code is assigned for ischaemic hepatitis?

A:

Ischaemic hepatitis (also referred to as shock liver or hypoxic hepatitis) is acute, diffuse liver damage due to an inadequate supply of blood or oxygen to the liver resulting in cell death (necrosis). The causes are often systemic and include sepsis, heart failure and respiratory failure.

Although the term 'hepatitis' usually implies inflammation of the liver, the liver is not inflamed in ischaemic hepatitis. Hepatitis also generally refers to any disorder in which liver enzymes called aminotransferases leak from damaged liver cells into the blood (such as with ischaemic hepatitis).

Assign K72.0 *Acute and subacute hepatic failure* for ischaemic hepatitis by following the Alphabetic Index:

Hepatitis

- acute NEC

- - non-viral K72.0

or

Hepatitis

- non-viral NEC

- - acute K72.0

Amendments to the ICD-10-AM Alphabetic Index will be considered in a future edition.

Published 15 March 2017,
for implementation 01 April 2017.

Ref No: Q3078 | Published On: 15-Mar-2017 | Status: Updated | Updated On: 15-Jun-2022

Per Oral Endoscopic Myotomy

Q:

What code is assigned for Per Oral Endoscopic Myotomy (POEM)?

A:

Per Oral Endoscopic Myotomy (POEM) is a relatively new procedure performed for achalasia and oesophageal motility disorders. POEM involves incision of the inner layer of muscle (myotomy) near the lower oesophageal sphincter, via endoscopy (ie oesophagoscopy).

Follow the ACHI Alphabetic Index at the lead term:

Oesophagomyotomy — *see Myotomy/oesophagogastric*

Myotomy/oesophagogastric lists code options differentiated by approach; abdominal, laparoscopic or thoracic approach.

Clinical advice confirms that the codes for POEM are:

30532-04 **[854]** *Oesophagogastric myotomy, thoracic approach*

30473-03 **[850]** *Oesophagoscopy*

Follow the Alphabetic Index:

Myotomy

- oesophagogastric

- - thoracic approach 30532-04 **[854]**

See also ACS 0023 *Minimally invasive interventions.*

Amendments to ACHI will be considered for a future edition.

This advice has modifications 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: Q3104 | Published On: 15-Mar-2017 | Status: Current

Hut lung

Q:

What code is assigned for hut lung?

A:

Hut lung, also known as domestically acquired particulate lung disease (DAPLD) is a non-infectious and non-malignant respiratory condition. It is caused by long term exposure to smoke derived from the burning of wood or charcoal in poorly ventilated huts, common in rural areas in some developing countries.

Hut lung manifests a broad range of pulmonary disorders from acute lower respiratory infections, such as bronchitis, to chronic obstructive pulmonary disease (COPD) to advanced interstitial lung diseases and malignancy. Similar to coalworker's pneumoconiosis, anthracotic plaques and diffuse anthracosis (accumulation of carbon in the lungs due to repeated exposure to air pollution or inhalation of smoke or coal dust particles) are often seen in this condition.

Assign J60 *Coalworker's pneumoconiosis* as a best fit for hut lung, by following the Alphabetic Index:

Anthracosis (lung) J60

Amendments to the Alphabetic Index will be considered for a future edition.

Published 15 March 2017,
for implementation 01 April 2017.

Ref No: Q3130 | Published On: 15-Mar-2017 | Status: Current

CT guided core biopsy of the lung

Q:

What is the correct code to assign for a CT guided core biopsy of the lung?

A:

A core biopsy involves inserting a hollow needle percutaneously (ie through the skin) to obtain a cylindrical sample of tissue. Guidance via computerised tomography (CT) ensures the needle is passed accurately into the target organ or tissue to obtain the biopsy.

Assign 38418-08 **[550]** *Other closed [needle] biopsy of lung* for a CT guided core biopsy of the lung by following the Alphabetic Index:

Biopsy

- lung (brush) (endoscopic) (needle)

- - percutaneous 38418-08 **[550]**

Improvements to ACHI will be considered for a future edition.

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for implementation 01 April 2017.

Ref No: Q3134 | Published On: 15-Mar-2017 | Status: Current

PTA (percutaneous transluminal angioplasty) of multiple peripheral vessels

Q:

Should one or multiple angioplasty codes be assigned where PTA is performed on multiple peripheral vessels?

A:

As per ACS 0020 *Bilateral/Multiple procedures/point 3* and Coding Rule (Q2882) *Thrombectomy and embolectomy of multiple arteries*, assign multiple ACHI codes when interventions are performed on multiple peripheral vessels, as the procedures are performed on different lesions.

For example, angioplasty performed on anterior tibial artery (ATA), tibial peroneal trunk (TPT), profunda femoral artery (PFA) and superficial femoral artery (SFA)); assign four ACHI codes for this scenario by following the Alphabetic Index at:

Angioplasty

- transluminal balloon

- - peripheral vessel (percutaneous)

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for implementation 01 April 2017.

Ref No: Q3140 | Published On: 15-Mar-2017 | Status: Current

Intranasal and oral (transmucosal) sedation

Q:

Should intranasal or oral sedation for anaesthesia be coded?

A:

Intranasal and oral sedation are both administered via a transmucosal delivery. They are used for management in minor procedures or for reduction of anxiety in children preoperatively. Oral sedation is not coded as per the guidelines in ACS 0031 *Anaesthesia*. Other transmucosal delivery methods (eg buccal, sublingual) are inherently similar to oral sedation, and as such also should not be coded.

Amendments to the ACS will be considered for a future edition.

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for implementation 01 April 2017.

Coding Rules

Published 15 December 2016

Ref No: Q3112 | Published On: 15-Dec-2016 | Status: Updated | Updated On: 15-Jun-2022

Nonaccidental injury

Q:

Can an injury documented as ‘non accidental’ be classified as assault?

A:

Category X85-Y09 *Assault* includes:

> *Injuries inflicted by another person with intent to injure or kill, by any means*

The term ‘nonaccidental’ indicates purposeful intent. Therefore, a nonaccidental injury inflicted by one person on another, is classified in ICD-10 and ICD-10-AM as assault (see also the *Instructional* notes at X85-Y09).

This is supported by the ICD-10-AM Alphabetic Index Section II: *External causes of injury*:

Injury, injured (accidental(ly))

- purposely (inflicted) by other person(s) *(see also Assault)* Y09.0-

Assault (by) (homicidal) (in) Y09.0-

The lead term *Assault* lists a number of subterms for mechanisms of injury (ie the cause of the injury, for example bite, fire, pushing). Where a non-accidental injury is inflicted by another person (ie an assault is perpetrated), assign:

- a code for the injury (S00–T98 – *see Alphabetic Index* Section I *Alphabetic index of diseases and nature of injury*)
- an external cause code for assault (see ICD-10-AM Alphabetic Index Section II *External causes of injury*: *Assault*)

Also assign codes for place of occurrence and activity.

Amendments to ICD-10-AM 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.

Published 15 December 2016,
for implementation 01 January 2017.

Ref No: Q3071 | Published On: 15-Dec-2016 | Status: Updated | Updated On: 01-Jan-2018

Retinal artery occlusion

Q:

What is the correct code to assign for retinal artery occlusion?

A:

Retinal artery occlusion occurs when a blood clot or fat deposits block the artery. The majority of retinal artery occlusions are caused by platelet fibrin thrombi and emboli as a result of atherosclerotic disease. It is also seen with conditions such as emboli from valvular heart diseases, diabetes mellitus, hypertension, atrial fibrillation and temporal arteritis. It is more likely to occur if there is atherosclerosis of the arteries in the eye.

ACS 0941 *Arterial disease/point 7 Occlusion* states:

> ”The term ‘occlusion’ is used to describe complete blockage or obstruction of a vessel, usually due to atherosclerosis. Occlusion of arteries that is not documented as due to another cause should be assigned the appropriate atherosclerosis code.”

Therefore, if retinal artery occlusion is documented and the underlying cause is unknown or not specified, assign I70.8 *Atherosclerosis of other arteries* following the Alphabetic index:

Atherosclerosis — *see Arteriosclerosis*

Arteriosclerosis, arteriosclerotic I70.9

- retina (vascular) I70.8

If the underlying cause of retinal artery occlusion is specified as a condition other than atherosclerosis, assign an appropriate code from H34 *Retinal vascular occlusions* with an additional code for the underlying cause.

For diabetes mellitus with retinal artery occlusion, follow the guidelines in ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia/General classification rules for DM and IH, Rule 3*.

Assign H34.2 *Other retinal artery occlusions* and E1-.39 ** diabetes mellitus with other specified ophthalmic complication* by following the Alphabetic Index:

Occlusion, occluded

- artery

- - retinal (branch) (partial) H34.2

and

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

- with

- - occlusion, retinal

- - - artery E1-.39

Apply the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses* to determine code sequencing.

Amendments to the classification will be considered for a future edition.

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Ref No: Q3072 | Published On: 15-Dec-2016 | Status: Updated | Updated On: 01-Jul-2017

Basilar artery coiling

Q:

What is the correct code assignment for coiling/stenting of basilar artery aneurysms?

A:

The basilar artery is a precerebral artery**,** which is an artery leading to the cerebrum, but not within the cerebrum.

A basilar artery aneurysm is classified in ICD-10-AM to I72.5 *Aneurysm and dissection of other precerebral arteries* following the Alphabetic Index:

Aneurysm (anastomotic) (artery) (cirsoid) (diffuse) (false) (fusiform) (micro) (multiple) (saccular)

- basilar (trunk) I72.5

Coiling of a basilar artery aneurysm is classified in ACHI to 35321-03 **[768]** *Transcatheter embolisation of blood vessels, face and neck* (as a best fit) following the ACHI Alphabetic Index:

Coiling

- aneurysm — *see Embolisation*

Embolisation

- aneurysm via surgical peripheral catheterisation — *see Embolisation/blood vessel, transcatheter/by site*

…

- blood vessel, transcatheter NEC

- - neck 35321-03 **[768]**

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: Q3074 | Published On: 15-Dec-2016 | Status: Current

External cause of injury code for tattoo complication

Q:

Which external cause of injury code should be assigned for a tattoo needle complication?

A:

Tattoos are a permanent or non-permanent mark or design made on skin. Typically, for permanent decorative tattoos, a powered hand tool is used to create a tattoo, with one or more needles piercing the skin repeatedly to insert coloured ink droplets into the dermis via the puncture sites.

The health risks associated with tattoos include allergic reactions to the tattoo dyes causing itch, dermatitis, acute inflammatory reactions, skin infections, keloid scars, granulomas, and blood borne diseases (eg hepatitis B and hepatitis C).

Where documentation clearly indicates that a condition has been caused by direct contact with a tattoo needle (for example, infection due to a contaminated tattoo needle), assign a code for the manifestation (eg the skin infection) with W29.8 *Contact with other specified powered hand tools and household machinery* by following the External Causes of Injury Alphabetic Index:

Contact (accidental)

- with

- - tool

- - - powered

- - - - specified NEC W29.8

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

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Ref No: Q3085 | Published On: 15-Dec-2016 | Status: Updated | Updated On: 15-Jun-2022

Removal of prosthetic arteriovenous access device

Q:

How do you code removal of prosthetic arteriovenous access device?

A:

Arteriovenous (vascular) access is created for patients requiring haemodialysis. There are three types of arteriovenous access:

- Arteriovenous fistula – the surgical joining of an artery to a vein
- Arteriovenous graft – insertion of a (synthetic) prosthetic device or biograft (eg xenograft (heterograft) or allograft (homograft)). The biograft or synthetic tube is inserted under the skin and is attached at one end to an artery, and at the other end to a vein
- External catheter (shunt) – insertion of a catheter to provide temporary vascular access.

In ACHI, the terminology used, and classification of arteriovenous fistula and graft are overlapping.

For removal of prosthetic arteriovenous access device, assign:

34130-00 **[765]** *Closure of surgically created arteriovenous fistula of limb*

Follow the ACHI Alphabetic Index:

Removal

- prosthesis, prosthetic device — *see also Removal/by type of device*

Removal

- arteriovenous
- - fistula
- - - surgically created 34130-00 **[765]**

Amendments to ACHI will be considered for a future edition.

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

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Ref No: Q3088 | Published On: 15-Dec-2016 | Status: Current

Sclerotherapy for varicose vein(s)

Q:

What is the correct code to assign when a single varicose vein is injected with sclerosing agent?

A:

ACHI Alphabetic Index does not contain a specific entry for injection of sclerosing agent or sclerotherapy into a single varicose vein. Injection of sclerosing agent (sclerotherapy) into varicose veins is an *Inclusion* term at 32500-01 **[722]** *Multiple injections of varicose veins.* ACHI references to disease conditions in multiple terms are applicable to single and vice versa (for example, varicose veins are interpreted as either varicose veins or varicose vein).

Therefore, assign 32500-01 **[722]** *Multiple injections of varicose veins* for injection of sclerosing agent into a single varicose vein, as a best fit.

Amendments to ACHI will be considered for a future edition.

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Deactivation of AICD for moribund patient

Q:

How do you code deactivation of an AICD (automatic implantable cardiac defibrillator) for a patient who is near the end of life?

A:

Deactivation of an AICD (automatic implantable cardiac defibrillator) is a non-invasive procedure performed when a patient is near the end of life. The purpose of the deactivation is to prevent the AICD activating due to the expected alteration in the patient's cardiac rhythm.

Assign Z45.0 *Adjustment and management of cardiac device* as an additional diagnosis to the documented principal diagnosis.

As per ACS 0042 *Procedures normally not coded,* the resources used to perform the deactivation are reflected in Z45.0. Therefore, it is not necessary to assign an ACHI code (eg adjustment of cardiac defibrillator generator) for deactivation of the AICD.

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

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Ref No: Q3117 | Published On: 15-Dec-2016 | Status: Updated | Updated On: 15-Jun-2022

Repair of diastasis recti

Q:

What ACHI code is assigned for repair of diastasis recti (recti divarication)?

A:

The rectus abdominis muscle is part of the musculoaponeurotic layer of the anterior abdominal wall. Diastasis recti (also known as rectus abdominis diastasis or recti divarication) are separation of the two rectus muscles. In severe cases, surgical closure of the separated muscles may be required.

Assign 45570-00 **[1000]** *Closure of abdomen with repair of musculoaponeurotic layer* for repair of diastasis recti (recti divarication) by following the Alphabetic Index:

Repair

- abdominal wall

- - musculoaponeurotic layer 45570-00 **[1000]**

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

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Coding Rules

Published 15 September 2016

Ref No: Q3057 | Published On: 15-Sep-2016 | Status: Updated | Updated On: 15-Jun-2022

Cerebellar ataxia, neuropathy, vestibular areflexia syndrome (CANVAS)

Q:

What is the correct code to assign for CANVAS (cerebellar ataxia, neuropathy, vestibular areflexia syndrome)?

A:

CANVAS (cerebellar ataxia, neuropathy, vestibular areflexia syndrome) is a slowly progressive ataxic disorder of unknown aetiology. The main clinical features of CANVAS are cerebellar ataxia, (sensory) neuropathy and bilateral vestibulopathy.

ICD-10-AM does not have a unique code for CANVAS syndrome. Appropriate codes to classify the components of CANVAS syndrome are:

Ataxia, ataxy, ataxic

- brain (hereditary) G11.9

G11.9 *Hereditary ataxia, unspecified*

Neuropathy, neuropathic

- peripheral (nerve) *(see also Polyneuropathy)* G62.9

G62.9 *Polyneuropathy, unspecified*

Disorder (of)

- vestibular function
- - specified NEC H81.8

H81.8 *Other disorders of vestibular function*

Assign codes for manifestations of CANVAS relevant to the patient, and U91 *Syndrome, not elsewhere classified* as an additional diagnosis.

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: Q3098 | Published On: 15-Sep-2016 | Status: Updated | Updated On: 01-Jul-2017

Injection of sclerosing agent with aspiration of hydrocele

Q:

How should injection of sclerosing agent when performed with aspiration of hydrocele be coded?

A:

Hydrocele is an abnormal fluid collection between layers of the tunica vaginalis in the scrotum. Injection of sclerosing agents such as alcohol, phenol, tetracycline (doxycycline) into the hydrocele sac causes scarring of the sac lining and reduces fluid production. Sclerotherapy is usually performed in conjunction with percutaneous aspiration of hydrocele where the sclerosing agent is injected through the same catheter used for aspiration of the hydrocele fluid. Therefore it is regarded as a component of the aspiration procedure and a separate code for injection of sclerosing agent is not warranted.

Where injection of sclerosing agent is performed with aspiration of hydrocele, assign 37604-17 [**1171**] *Percutaneous aspiration or drainage of scrotum or tunica vaginalis* following the Alphabetic Index:

Aspiration

- hydrocele (percutaneous) 37604-17 **[1171]**

Amendments to ACHI 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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Ref No: Q3070 | Published On: 15-Sep-2016 | Status: Updated | Updated On: 01-Jul-2017

External cause code for complication of percutaneous angioplasty with stenting of coronary arteries

Q:

What is the external cause code assigned for complication of percutaneous angioplasty with stenting of coronary arteries?

A:

As per the Coding Rule *Catheter based cardiac intervention with angiogram* (September 2014) cardiac catheterisation may be:

- performed alone as a diagnostic procedure, where the catheter is inserted into the heart chambers and valves to perform various tests
- inserted into the coronary arteries to evaluate coronary artery disease (ie coronary angiography)
- performed with a catheter based interventional procedure, where the cardiac catheterisation serves as a guiding catheter (eg percutaneous coronary angioplasty with stenting).

Where the external cause of a procedural complication is diagnostic cardiac catheterisation (ie cardiac catheterisation performed alone or with coronary angiography for purely diagnostic purposes), assign Y84.0 *Cardiac catheterisation* by following the Alphabetic Index:

Complication(s) (delayed) (medical or surgical procedure) (of or following)

- catheterisation

- - cardiac Y84.0

Where the external cause is a catheter based interventional procedure (ie where cardiac catheterisation has been performed as a guiding catheter), assign a code from category Y83 *Surgical operation and other surgical procedures as the cause of abnormal reaction, or of later complication, without mention of unintentional events at the time of the procedure.*

For example, where the external cause is percutaneous coronary angioplasty with stenting, assign Y83.1 *Surgical operation with implant of artificial internal device* by following the Alphabetic Index:

Complication(s) (delayed) (medical or surgical procedure) (of or following)

- implant, implantation (of)

- - artificial

- - - internal device (cardiac pacemaker) (electrodes in brain) (heart valve prosthesis) (infusion port) (orthopaedic) (Port-A-Cath) (reservoir) (vascular access device) Y83.1

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: Q2995 | Published On: 15-Sep-2016 | Status: Updated | Updated On: 15-Jun-2022

Revision of prosthetic device

Q:

When should codes for revision of a prosthetic device be assigned?

A:

There are no definitions in ACHI for revision of a prosthetic device; the term ‘revision’ is used inconsistently to mean replacement (removal and reinsertion), adjustment of a device or a subsequent intervention in the same area (ie reoperation).

However, the following general principles should be followed:

- Clinical coders must be guided by the documentation in the clinical record and operation report. Where ‘revision’ of a prosthetic device is documented, follow Alphabetic Index terms (lead or subterms) specifying ‘revision’ and assign appropriate codes.
- If revision is **not** documented, index terms for revision should not be followed, but instead the description of the procedure performed should be used to inform code assignment. Where the terms ‘removal’, ‘replacement’ or ‘adjustment’ are documented, follow the Alphabetic Index under these lead terms.

Further review of the classification of revision/replacement/adjustment of prosthetic devices in ACHI will be considered for a future edition.

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

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Ref No: Q3014 | Published On: 15-Sep-2016 | Status: Current

Subcutaneous implantable cardiac defibrillator (S-ICD) electrodes

Q:

What codes should be assigned for insertion, replacement, adjustment or removal of subcutaneous electrodes in a subcutaneous implantable cardiac defibrillator (S-ICD) system?

A:

The subcutaneous implantable cardiac defibrillator (S-ICD) system consists of a pulse generator implanted under the skin of the chest at the mid axillary line. The pulse generator is connected to the electrode (lead) which is implanted under the skin tunnelled across the ribcage above the heart and is anchored in place under the skin. The defibrillator electrode remains outside the chest cavity.

ACHI does not have specific codes for insertion, replacement, adjustment or removal of the subcutaneous electrode. Clinical advice indicates these procedures are similar to transvenous endocardial electrode procedures in terms of purpose, associated implantation and connection to a generator box. Therefore as a best fit assign the following codes as appropriate:

38390-02 **[648]** *Insertion of permanent transvenous electrode into other heart chamber(s) for cardiac defibrillator*

38350-03 **[654]** *Replacement of permanent transvenous electrode of other heart chamber(s) for cardiac defibrillator*

90203-08 **[654]** *Adjustment of transvenous electrode for cardiac defibrillator*

38350-04 **[654]** *Removal of permanent transvenous electrode of other heart chamber(s) for cardiac defibrillator*

Improvements to ACHI will be considered for a future edition.

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Ref No: Q3045 | Published On: 15-Sep-2016 | Status: Current

Eosinophilic oesophagitis

Q:

What is the correct code for eosinophilic oesophagitis?

A:

Eosinophilic oesophagitis (EoE) is a chronic inflammation of the oesophagus triggered by food allergens, where the mucosa is infiltrated by eosinophils (a type of white blood cell). EoE is also known as allergic oesophagitis. The majority of patients with EoE are children and young adults with other allergies such as allergic rhinitis or asthma. Patients may present with dysphagia and food bolus obstruction. Dietary modification after allergy testing has been shown to be an effective treatment, although clinical understanding of the disease process itself, and treatment protocols, are still evolving.

ICD-10-AM does not have a specific code for eosinophilic oesophagitis, therefore assign K20 *Oesophagitis* by following the Alphabetic Index:

Oesophagitis (acute) (alkaline) (chemical) (chronic) (infectional) (necrotic) (peptic) (postprocedural) K20

Eosinophilia is an increase in eosinophils in the peripheral blood, ie a systemic problem rather than just localised to the oesophagus as in EoE. Therefore, assignment of D72.1 *Eosinophilia* is not appropriate for eosinophilic oesophagitis.

Amendments to the classification will be considered for a future edition

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Ref No: Q3060 | Published On: 15-Sep-2016 | Status: Current

Component separation technique for incisional hernia repair

Q:

How do you classify component separation technique for repair of an incisional hernia?

A:

The component separation technique (CST) to repair an abdominal wall defect (usually an incisional hernia) is a type of rectus abdominis muscle advancement flap (Cone 2015).

CST is performed by dissecting between and separating a number of intra-abdominal muscles to enable closure of a large or complex abdominal wall defect. The use of mesh reinforcement is a modification of CST that has been proven to reduce hernia recurrence (Heller, Chuma Shengnan Xue 2012, Kim & Kim 2011).

Component separation technique for repair of incisional hernia is classified to 30405-00 **[993]** *Repair of incisional hernia with muscle transposition* by following the Alphabetic Index:

Repair

- hernia

- - incisional

- - - with

- - - - muscle transposition 30405-00 **[993]**

If mesh is inserted, also assign 30405-01 **[993]** *Repair of incisional hernia with prosthesis* by following the Alphabetic Index:

Repair

- hernia

- - incisional

- - - with

- - - - prosthesis (mesh) 30405-01 **[993]**

References:

Cone, J 2015, *Component separation repair of large or complex abdominal wall defects*, Up to Date, Wolters Kluwer, viewed 7 June 2016, http://www.uptodate.com/contents/component-separation-repair-of-large-or-complex-abdominal-wall-defects

Heller, L, Chuma, C-O Shengnan Xue, A 2012, *Abdominal wall reconstruction with mesh and components separation*, National Centre for Biotechnology Information, US National Library of Medicine, Bethesda, viewed 7 June 2016, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3348745/

Kim, Z Kim, Y 2011, 'Components separation technique for large abdominal wall defect', *Journal of the Korean Surgical Society,* 2011 Jun; 80(Suppl 1): S63-S66, viewed 7 June 2016, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3205369/

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Coding Rules

Published 15 June 2016

Ref No: Q3063 | Published On: 15-Jun-2016 | Status: Updated | Updated On: 15-Jun-2022

Lymph node neck dissection

Q:

What codes should be assigned for neck dissections described by levels rather than by the terms radical, modified radical and so on?

A:

Cancers in the head and neck commonly metastasise to cervical lymph nodes. Neck dissection refers to a surgical procedure in which the fibrofatty contents of the neck (including lymph nodes) are removed for treatment of cervical lymphatic metastases.

Neck lymph nodes are divided into seven different levels. There are five levels in the lateral compartment and two in the central compartment.

Radical neck dissection (also known as comprehensive neck dissection) involves the removal of all lymph nodes from levels I-V on one side of the neck, with sacrifice of internal jugular vein, spinal accessory nerve and sternocleidomastoid muscle.

Extended radical neck dissection involves radical neck dissection and removal of one or more lymph node groups or non-lymphatic structures not accounted for in the radical neck dissection.

Radical neck dissection has largely been replaced by the modified radical neck dissection.

Modified radical neck dissection involves removal of lymph node groups I to V, while sparing one or more of the three structures taken in the radical neck dissection (sternocleidomastoid muscle, internal jugular vein and spinal accessory nerve).

Assign 96245-01 **[806]** *Radical excision of lymphatic structure, neck* for a radical, extended radical or modified radical neck dissection (removal of lymph node levels I-V) following the Alphabetic Index:

Dissection, dissected

- lymph node — *see Excision/lymphatic structure (node)/by site*

Excision

- lymphatic structure (node)

- - neck (limited) (regional) (simple) (total)

- - - radical (complete) 96245-01 **[806]**

Selective neck dissection refers to a type of neck dissection in which one or more lymph node groups normally removed in a radical neck dissection are preserved. Selective neck dissections may be divided into the following categories: supraomohyoid neck dissection (levels I, II, III), lateral neck dissection (levels II, III, IV), anterior compartment neck dissection (VI), and posterolateral neck dissection (levels II, III, IV, V).

Assign 96244-01 **[806]** *Excision of lymphatic structure, neck* for a selective neck dissection following the Alphabetic Index:

Dissection, dissected

- lymph node — *see Excision/lymphatic structure (node)/by site*

Excision

- lymphatic structure (node)
- - neck (limited) (regional) (simple) (total) 96244-01 **[806]**

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: Q3001 | Published On: 15-Jun-2016 | Status: Updated | Updated On: 15-Jun-2019

Incision and drainage of abscess with curettage

Q:

When curettage is performed with an incision and drainage of an abscess, should this be coded to debridement?

A:

During incision and drainage of an abscess, a curette may be used to remove slough and/or debris from the abscess cavity. This is a component of the procedure and does not require an additional code as per the guidelines in ACS 0016 *General procedure guidelines/Procedure components*.

The correct code to assign for incision and drainage of an abscess with or without curettage is 30223-01 **[1606]** *Incision and drainage of abscess of skin and subcutaneous tissue*, following the lead terms *Drainage* or *Incision.*

Amendments to ACHI 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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Conditions described as secondary to or due to

Q:

Is there a hierarchy within the subsections of ACS 0001 *Principal diagnosis*?

Are episodes of care where delirium is precipitated by infection/dehydration or where acute renal failure (ARF) is precipitated by dehydration examples where ACS 0001 *Principal diagnosis/Problems and underlying conditions* apply? Or does ACS 0001 *Principal diagnosis/ Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis* apply?

A:

ACS 0010 *Clinical documentation and general abstraction guidelines* states:

> *Before classifying any documented clinical concept, the clinical coder must verify the presence and consistency of information on the front sheet and/or the discharge summary (or equivalent) with the relevant documentation within the body of the current episode of care.*
>
> and
>
> *A query to a clinician may be used where the documentation in an episode of care is insufficient for clinical coding purposes.*

Applying the above and gaining an understanding of the circumstances of an admitted episode of care is sufficient in most instances to establish the principal diagnosis in accordance with ACS 0001 *Principal diagnosis*. In addition, ACS 0001 provides specific guidelines for assignment of the principal diagnosis in various scenarios:

- Obstetrics
- Aetiology and manifestation (aka the ‘dagger and asterisk’ convention)
- Problems and underlying conditions
- Symptoms, signs and ill-defined conditions
- Acute and chronic conditions
- Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis
- Two or more diagnosis that equally meet the definition for principal diagnosis
- Codes from the Z03.0–Z03.9 series, medical observation and evaluation for suspected diseases and conditions
- Residual condition or nature of sequela.

The points above are discrete guidelines for different circumstances and a hierarchy was not explicitly intended.

The guidelines for *Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis* and *Two or more diagnoses that equally meet the definition for principal diagnosis* are not to be used as a default to assign 'the first mentioned condition' without applying the other criteria in ACS 0001.

Delirium precipitated by infection/dehydration and ARF secondary to dehydration, are examples where it is appropriate to apply ACS 0001 *Principal diagnosis/Problems and underlying conditions* as each describes a problem with an underlying condition ie there is a cause and effect (due to/secondary to) relationship. Codes for both the condition and its underlying cause may be assigned by applying the guidelines in ACS 0001 and ACS 0002 *Additional diagnoses/Problems and underlying conditions*, and specialty standards (where applicable).

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

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Endoscopic drainage (fenestration) of craniopharyngioma

Q:

What is the correct code to assign for endoscopic fenestration (drainage) of a craniopharyngioma cyst?

A:

A craniopharyngioma is a benign tumour with malignant behaviour that arises most frequently in the pituitary stalk and projects into the hypothalamus. It is a tumour that has both solid and cystic components.

ACHI classifies removal of craniopharyngioma to 39712-02 *Removal of craniopharyngioma* in block **[125]** *Other excision procedures on pituitary gland.* However, there is no specific code when the treatment is aimed at alleviating the symptomatic effect of the tumour on surrounding structures by fenestration of the cystic component; and where the solid component is not removed.

For endoscopic fenestration of a craniopharyngioma cyst assign 39703-01 **[8]** *Drainage of intracranial lesion or cyst* by following the Alphabetic Index:

Drainage

- intracranial (via burr holes) 39703-01 **[8]**

- - lesion 39703-01 **[8]**

or

Drainage

- intracranial (via burr holes) 39703-01 **[8]**

- - tumour 39703-01 **[8]**

As this was an endoscopic procedure, also assign 40903-00 **[1]** *Neuroendoscopy* in accordance with ACS 0023 *Minimally invasive interventions*.

Improvements to this area of the classification will be considered for a future edition of ACHI.

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

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Ref No: Q2903 | Published On: 15-Jun-2016 | Status: Current | Supersedes: Q2728

Diagnosis code assignment for admission for insulin pump

Q:

What is the correct principal diagnosis to assign when a patient with diabetes mellitus is admitted for connection of an insulin pump?

A:

Where adjustment, management, fitting or removal of the insulin pump is the principal reason for the admission (ie it meets the criteria for assignment as per ACS 0001 *Principal diagnosis*), the correct code to assign is Z45.1 *Adjustment and management of drug delivery device* followed by the appropriate code(s) for diabetes mellitus.

For classification advice related to ACHI codes for insulin pumps, refer to Coding Rule *Insulin pumps.*

Amendments to the classification will be considered for a future edition.

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Ref No: Q2953 | Published On: 15-Jun-2016 | Status: Updated | Updated On: 15-Sep-2023 | Supersedes: TN565

High flow therapy

Q:

What is the correct code to assign for high flow therapy when administered via nasal cannula or tracheostomy?

A:

High flow therapy (HFT), also known as high flow nasal cannula (HFNC) or high flow nasal prongs (HFNP), is a type of respiratory support introduced as an alternative to noninvasive ventilation (NIV). HFT is more than simple oxygen enrichment or humidification as it involves the administration of ventilatory support, therefore in ACHI HFT is classified as noninvasive ventilatory support.

High flow therapy devices, unlike conventional oxygen administration or NIV, use a system of heated humidification and large-bore nasal prongs to deliver oxygen at flows of up to 50–60 L/minute. This is usually used in conjunction with an oxygen blender, allowing delivery of precise inspired oxygen concentrations.

HFT is used on patients ranging in ages from preterm infants to adults who receive flow rates for respiratory support in a variety of conditions, such as:

- **Newborns:** used in the management of respiratory distress or apnoea and weaning from invasive forms of respiratory support. HFT is generally administered at 2–7 L/minute for neonate
- **Paediatrics:** used in conditions such as viral bronchiolitis, bacterial pneumonia and reactive airway disease. HFT is generally administered at 4–12 L/minute for infants and young children
- **Adults:** used in a variety of clinical care settings for patients with conditions such as type 1 (hypoxic) respiratory failure, pulmonary oedema, chronic obstructive pulmonary disease (COPD) and acute respiratory distress syndrome (ARDS). HFT is generally administered at 20–40 L/minute for adults.

HFT can also be delivered through a tracheostomy with an entrainment device.

Despite the similar description, *high flow* oxygen (or humidified oxygen) is not the same as *high flow therapy.* HFT depends on the device being able to generate a sufficient pressure gradient to improve oxygenation. While the required pressure can be generated through a nasal cannula (prongs), clinical advice confirms that it cannot be produced 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 oxygen must be delivered through a nasal cannula (prongs) or tracheostomy to be considered as high flow therapy and coded as noninvasive ventilation.

Clinical coders should assign high flow therapy based on clinical documentation and not on the basis of the delivery flow rates alone. Clinical documentation must be clear that *high flow therapy* is being provided (ie, high flow oxygen administered via nasal cannula/prongs or tracheostomy).

When HFT administered via the above techniques is documented in the clinical record, assign an appropriate code from block **[570]** *Noninvasive ventilatory support* following the lead terms:

HFNC (high flow nasal cannula) (heated) (humidified) — *see block **[570]***

HFT (high flow therapy) (heated) (humidified*)* — *see block **[570]***

High flow nasal cannula (HFNC) (heated) (humidified) — *see block **[570]***

Therapy

- high flow (heated) (HFT) (humidified) (nasal) — *see block **[570]***

Where high flow therapy is delivered via a tracheostomy, follow the *Excludes* note at block **[570]** *Noninvasive ventilatory support* to assign a code from block **[569]** *Ventilatory support.*

Do not assign a code from block **[570]** *Noninvasive ventilation* where clinical documentation indicates that high flow therapy is delivered via a face mask.

Improvements will be considered for a future edition.

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Adverse effect of Champix (varenicline)

Q:

What is the correct external cause code to assign for adverse effect of Champix (varenicline) in therapeutic use?

A:

Champix (varenicline) belongs to the class of medications called smoking cessation therapies. It is used to help people quit smoking when nicotine replacement therapy has not been effective. Varenicline works in the brain to reduce cravings and withdrawal symptoms. It also decreases the pleasure that people derive from smoking and is thought to produce these effects by acting on the same receptors in the brain as nicotine in cigarettes.

ICD-10-AM does not have a specific code for adverse effect of varenicline (Champix) in therapeutic use. Assign Y57.8 *Other drugs and medicaments* by selecting *Nicotine/medicinal, Adverse effect in therapeutic use* in the *Table of Drugs and Chemicals.*

Improvement to the ICD-10-AM Alphabetic Index, *Table of Drugs and Chemicals* will be considered for a future edition.

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Ref No: Q2994 | Published On: 15-Jun-2016 | Status: Current

Intramuscular sedation for anaesthesia

Q:

Should sedation administered intramuscularly (IM) be coded (eg a paediatric patient with a fractured radius reduced under IM sedation)?

A:

Intramuscular (IM) sedation is given where rapid onset/short term anaesthesia is required, without a full general anaesthetic effect (ie without loss of respiratory drive or protective airway tone). This is often administered in paediatric patients, or other patients who require sedation to evaluate and treat their injuries whilst limiting distress. IM sedation is used to facilitate patient cooperation during imaging studies or during painful procedures such as fracture reductions, abscess incision and drainage, lumbar puncture, or complex laceration repairs (Madati 2011).

ACS 0031 *Anaesthesia* instructs that sedation may be assigned where anaesthetic is administered as per general anaesthesia (intravenous or inhalational or both) and there is no documentation of the use of an artificial airway. It also instructs that oral sedation is not to be coded, however there is no instruction regarding intramuscular sedation.

Given the increasing use of sedation administered intramuscularly 92515-XX **[1910]** *Sedation* is to be assigned for intramuscular sedation, when administered for anaesthetic effect.

Consideration will be given to updating ACS 0031 *Anaesthesia* to include instruction for the use of intramuscular sedation for a future edition of the ACS.

Reference:

Madati PJ 2011, 'Ketamine: Procedural Pediatric Sedation In The Emergency Department', *EB Medicine Pediatric Emergency Medicine Practice (Journal)*, vol. 8, no.1, viewed 15 February 2016, https://www.ebmedicine.net/topics.php?paction=showTopictopic_id=247

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for implementation 01 July 2016.

Ref No: Q3018 | Published On: 15-Jun-2016 | Status: Current

Neonatorum in the Alphabetic Index

Q:

When is it appropriate to follow the entries in the Alphabetic Index with a subterm ‘neonatorum’?

A:

The term neonatorum is synonymous with neonatal. A condition so described indicates it is arising in the neonatal period, for example polycythaemia neonatorum, urticaria neonatorum, ophthalmia neonatorum.

Therefore, it is appropriate to use the subterm neonatorum in the ICD-10-AM Alphabetic Index to classify conditions in a neonate or arising in the neonatal period.

Amendments to the classification will be considered for a future edition.

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Labile diabetes

Q:

Can labile diabetes mellitus be assigned to unstable diabetes mellitus?

A:

In the context of diabetes mellitus the term labile is used to describe wide, recurrent fluctuations in blood glucose levels. Synonymous terms include unstable or brittle diabetes.

While unstable diabetes may be associated with any form of diabetes mellitus, brittle diabetes is associated specifically with E10 *Type 1 diabetes mellitus* as listed in the *Includes* note.

Where labile diabetes is documented assign E1-.65 * *diabetes mellitus with poor control* following the Alphabetic Index:

Diabetes, diabetic

- unstable E1-.65

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

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for implementation 01 July 2016.

Ref No: Q3036 | Published On: 15-Jun-2016 | Status: Current

Mittendorf dot

Q:

What is the correct code to assign for a Mittendorf dot?

A:

A Mittendorf dot is a small, circular opacity on the posterior lens capsule, classically nasal in location, which represents the anterior attachment of the hyaloid artery. The hyaloid artery is present during gestation and typically regresses completely. Failure to do so results in an embryonic remnant of the hyaloid artery (also described as a persistent hyaloid artery) and to benign findings, such as a Mittendorf dot (Weed, 2013).

The correct code to assign for a Mittendorf dot is Q14.0 *Congenital malformation of vitreous humour* following the Alphabetic Index:

Persistence, persistent (congenital)

- hyaloid

- - artery (generally incomplete) Q14.0

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

References:

Weed, M 2013, *Mittendorf dot*, University of Iowa Healthcare, Ophthalmology and Visuals Sciences, viewed 15 February 2016, http://www.eyerounds.org/atlas/pages/mittendorf-dots.htm

Published 15 June 2016,
for implementation 01 July 2016.

Ref No: Q3049 | Published On: 15-Jun-2016 | Status: Current

Vascularised Lymph Node Transfer

Q:

What procedure code should be assigned for vascularised lymph node transfer?

A:

Vascularised lymph node transfer (VLNT) is a procedure where lymph nodes are transferred as a stand-alone block of tissue, harvested commonly from the groin, but can be from other lymph node areas. The blood supply to the transplanted lymph nodes is connected to local blood vessels in the recipient site (usually the axilla, wrist or antecubital area) as part of the transfer.

There is no specific code in ACHI for VLNT, therefore assign 90283-00 **[812]** *Other procedures on lymphatic structures* following the Alphabetic Index:

Transplant, transplantation

- lymphatic structure(s) (peripheral) 90283-00 **[812]**

As microvascular anastomosis is inherent in a vascularised lymph node transfer, it is unnecessary to assign a separate code for the microsurgical anastomosis as per the guidelines in ACS 0016 *General procedure guidelines, Procedure components*.

Improvements to the classification will be considered for a future edition of ACHI.

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for implementation 01 July 2016.

Ref No: Q3054 | Published On: 15-Jun-2016 | Status: Current | Supersedes: Q2642

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 an **acute stress reaction** or an **adjustment disorder** classifiable to category F43 *Reaction to severe stress, and adjustment disorders*.

When clinical advice is unavailable or there is uncertainty regarding whether the patient has an acute stress reaction or adjustment disorder, 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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for implementation 01 July 2016.

Coding Rules

Published 15 March 2016

Ref No: Q2998 | Published On: 15-Mar-2016 | Status: Updated | Updated On: 15-Jun-2019

External cause code for allergic reaction to over the counter hair dye

Q:

What is the correct external cause code to assign for an allergic reaction to personal use of over the counter hair dye?

A:

The Table of Drugs and Chemicals (ICD-10-AM Alphabetic Index) has the following index entries:

Hair

- dye T49.4	X44	X64	Y14	Y56.4
- preparation NEC.....T49.4	X44	X64	Y14	Y56.4

The appropriate external cause code for the scenario cited is Y37.8 *Allergy to other specified allergen*.

The code for adverse effect in therapeutic use, Y56.4 *Keratolytics, keratoplastics and other hair treatment drugs and preparations*, is only applicable for those indexed substances being used for therapeutic purposes. The scenario in the query does not indicate any therapeutic purpose.

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 2016.

Ref No: Q3034 | Published On: 15-Mar-2016 | Status: Current

Vasa praevia as the indication for elective caesarean section

Q:

Is O69.4 *Labour and delivery complicated by vasa praevia* the correct code to assign when vasa praevia is documented as the indication for elective caesarean section and therefore there is no labour?

A:

Vasa praevia occurs when the fetal/umbilical vessels cross the membranes of the lower uterine segment above the cervix (internal cervical os) and below the fetal presenting part. These vessels are unprotected and unsupported by the umbilical cord or placental tissue and are therefore at risk of rupturing at the time of membrane rupture, resulting in fetal haemorrhage.

Risk factors for vasa praevia include:

- placenta praevia
- bilobed placenta/succenturiate lobe
- velamentous cord insertion
- IVF pregnancy
- Multiple pregnancy

Antenatal diagnosis of vasa praevia allows for elective caesarean section (prior to the onset of labour) to be performed, in order to avoid membrane rupture (spontaneous or artificial) with subsequent fetal haemorrhage.

If vasa praevia is undiagnosed antenatally, patients may present in labour with variable decelerations and palpable vessels with intact membranes, and/or intrapartum vaginal haemorrhage with acute fetal distress following rupture of membranes. This situation requires delivery by emergency caesarean section due to the significant risk to the fetus.

Vasa praevia is classified to O69.4 *Labour and delivery complicated by vasa praevia*

following the index entry:

Vasa praevia O69.4

As per ICD-10-AM Tabular List Conventions, the term *and* in the code title (O69.4 *Labour and delivery complicated by vasa praevia*) means and/or. Therefore O69.4 is the correct code to assign even when there is no labour. For example, vasa praevia is a complication of the delivery when it is documented as the indication for an elective caesarean section.

References:

Mount Sinai Hospital, Sinai Health System 2016, *Vasa previa* viewed 2 February 2016, http://www.mountsinai.on.ca/care/placenta-clinic/complications/vasa-previa

Royal College of Obstetricians and Gynaecologists 2011, *Placenta praevia, placenta praevia accrete and vasa praevia: diagnosis and management,* RCOG Green-top Guideline No. 27 viewed 2 February 2016, https://www.ranzcog.edu.au/doc/rcog-placenta-**praevia**-accreta.html

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists 2015, *Vasa praevia,* RANZCOG College Statement C-Obs 47, viewed 2 February 2016, https://www.ranzcog.edu.au/doc/vasa-praevia.html [PDF]

Published 15 March 2016,
for implementation 01 April 2016.

Ref No: Q3029 | Published On: 15-Mar-2016 | Status: Current

External cause of injury code for golf buggy (cart)

Q:

What is the correct external cause of injury code to assign for a passenger falling from a golf buggy (cart)?

A:

Golf buggies (carts) use specially designed tyres that can manoeuvre the different terrains of a golf course such as turf, bitumen, smooth paved surfaces, wooded areas, sand and mud and therefore meet the definition of a special all-terrain vehicle in the Tabular List/External Causes of Morbidity and Mortality/Accidents/Transport Accidents, under point (x) of *Definitions Related to Transport* which states:

> *A special all-terrain vehicle is a motor vehicle of special design to enable it to negotiate rough or soft terrain or snow…*

The appropriate external cause of injury code to assign for a passenger falling from a golf buggy (cart) is V86.62 *Passenger of all-terrain or other off-road motor vehicle injured in nontraffic accident, four-wheeled special all-terrain or other off-road motor vehicle*, following the index pathway:

Accident

- transport

- - all-terrain or off-road vehicle (nontraffic)

- - - passenger V86.6-

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

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Ref No: Q3025 | Published On: 15-Mar-2016 | Status: Updated | Updated On: 15-Jun-2022

Small versus extensive split skin grafts

Q:

Are there any definitions or criteria in ACHI for the terms *small* and *extensive* split skin grafts?

A:

The terms *small*, *extensive* and *granulating* are included in ACHI codes due to the MBS item descriptors that they are based on:

- 45400 FREE GRAFTING (split skin) of a granulating area, small
- 45403 FREE GRAFTING (split skin) of a granulating area, extensive
- 45439 FREE GRAFTING (split skin) to 1 defect, including elective dissection, small
- 45442 FREE GRAFTING (split skin) to 1 defect, including elective dissection, extensive

These terms are applied in ACHI differently for split skin graft (SSG) to burn and non-burn wounds.

Split skin graft to burn

Codes for SSG to burn are located in blocks:

- **[1643]** Split skin graft to burn of specific sites
- **[1641]** Split skin graft to granulating burn site.

The terms *small* and *extensive* for SSG to burn are only applicable to block **[1641]**:

- *small* is applicable to (unspecified or) less than 3 per cent of body surface area (BSA) grafted:

  45400-01 **[1641]** *Split skin graft of small granulating burn site, less than 3 per cent of body surface area grafted*

- *extensive* is applicable 3 per cent or more of BSA grafted:

  45403-01 **[1641]** *Split skin graft of extensive granulating burn site, 3 per cent or more of body surface area grafted*

Follow the ACHI Alphabetic Index:

Graft
- skin
- - for burn
- - - specified site NEC
- - - - split thickness (less than 3 per cent body surface area (BSA))
- - - - - granulating 45400-01 **[1641]**
- - - - - - 3 per cent or more of BSA 45403-01 **[1641]**

(See also *Split skin graft to granulating area*, below).

Split skin graft to non-burn wounds

Codes for SSG of non-burn wounds are located in blocks:

- **[1645]** *Other split skin graft, small,*
- **[1646]** Other split skin grafts, extensive
- **[1642]** Other split skin graft to granulating area.

There are no definitions or criteria in ACHI for *small* and *extensive* SSG to non-burn wounds. Where these terms are not documented in the clinical record/operation report, clinical coders should clarify with clinicians to determine if a grafted area is *small* or *extensive*, or apply the guidelines in ACS 0038 *Procedures distinguished on the basis of size, time, number of lesions or sites:*

> *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.*

Split skin graft to granulating area

Although there is no definition in ACHI for *granulating* area, the clinical definition is *healing skin/tissue;* granulation tissue is a normal part of the wound healing process. For some wounds, particularly burns, the process of granulation is undesirable, as granulation tissue is excessively vascular and therefore prone to haemorrhaging. Granulation tissue may also cause shrinkage at the burn/wound site and may slow the rate of healing. As a result, granulation tissue may require surgical removal and application of grafted skin to promote healing and avoid localised blood loss. ACHI codes for SSG to non-burn wound specifying *granulating area* are only assigned when this term is documented, or following advice from a clinician. Assign either of the following codes for SSG *to granulating area of a non-burn wound* (see above for advice regarding assignment of SSG *to granulating burn site*):

45400-00 **[1642]** *Split skin graft of small granulating area*

45403-00 **[1642]** *Split skin graft of extensive granulating area*

Follow the index pathways:

Graft

- skin

- - granulating area

- - - extensive 45403-00 **[1642]**

- - - small 45400-00 **[1642]**

(See above for advice regarding the terms *small* and *extensive*).

Amendments to the indexing of SSG for burn and non-burn wounds will be considered for a future edition of ACHI.

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

References:

Burn Centre Care 2006, 'Problems due to burned skin', viewed 7 December 2015, http://burncentrecare.co.uk/complications_burn_wounds.htm

Clinimed 2014, 'Phases of wound healing', viewed 7 December 2015, http://www.clinimed.co.uk/Wound-Care/Education/Wound-Essentials/Phases-of-Wound-Healing.aspx

MedicineNet Inc 2015, 'Definition of granulation', viewed 7 December 2015, http://www.medicinenet.com/script/main/art.asp?articlekey=11385

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Ref No: Q3010 | Published On: 15-Mar-2016 | Status: Current

Nasendoscopy with view to the larynx

Q:

What is the correct code to assign for a nasendoscopy with views to the larynx? Should the instruction in ACS 0024 *Panendoscopy* to code to the furthest site viewed be applied to assign a code for laryngoscopy?

A:

Panendoscopy is a generic term for an endoscopy of the upper gastrointestinal tract (ie oesophagus, stomach and duodenum) or aerodigestive tract (ie pharynx, larynx, upper oesophagus). ACS 0024 *Panendoscopy* states:

> *The term panendoscopy can also be used to mean endoscopies of the respiratory tract and the urinary system and therefore nongastrointestinal endoscopies should be coded appropriately, to the furthest site viewed*

This advice only applies where the term panendoscopy is documented. Where specific types of endoscopes (nasendoscopy, laryngoscopy) are documented these should be coded as such. For example, if documentation indicates a nasendoscopy with views to the larynx has been performed, assign 41764-00 **[370]** *Nasendoscopy*. A separate code from block **[520]** *Examination procedures on larynx* should be assigned if documentation indicates a laryngoscopy has also been performed.

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for implementation 01 April 2016.

Ref No: Q3003 | Published On: 15-Mar-2016 | Status: Current

Respiratory acidosis in a diabetes mellitus patient

Q:

What is the correct code assignment for respiratory acidosis in a patient with diabetes mellitus?

A:

Respiratory acidosis is a metabolic derangement of acid-base balance where the blood pH is abnormally low. Respiratory acidosis will occur if the lungs are not ventilating properly resulting in an excess of carbon dioxide in the body (Mondofacto, 1999).

Respiratory acidosis may have a variety of different causes, including:

- COPD
- Neuromuscular diseases
- Chest wall disorders
- Obesity-hypoventilation syndrome
- Obstructive sleep apnoea (OSA)
- Central nervous system (CNS) depression
- Other lung and airway diseases (Medscape, 2015).

ICD-10-AM does not assume a causal link between diabetes mellitus and respiratory acidosis when both are documented.

ICD-10-AM does however assume a causal link where there is documentation of lactic acidosis or ketoacidosis as per the index pathway below:

Diabetes, diabetic

- with

- - acidosis — see also Diabetes/with/ketoacidosis

- - - lactic (without coma) E1-.13

- - - - with coma E1-.14

- - - - and ketoacidosis (without coma) E1-.15

- - - - - with coma E1-.16

For a patient with respiratory acidosis and diabetes mellitus assign:

E87.2 *Acidosis* following the index below with the appropriate diabetes mellitus code and sequence according to ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*.

Acidosis (lactic) (respiratory) E87.2

See also Coding Rule, *Metabolic acidosis in a diabetes mellitus patient*, published 15 September 2015.

References:

Mondofacto online medical dictionary, 25 Jun 1999,
viewed 24 February 2016 http://www.mondofacto.com/facts/dictionary?respiratory%20acidosis

Byrd, RP Jr, '*Respiratory* Acidosis', Medscape, 31 July 2015, viewed 4 March 2016 http://emedicine.medscape.com/article/301574-overview#a7

Published 15 March 2016,
for implementation 01 April 2016.

Ref No: Q2982 | Published On: 15-Mar-2016 | Status: Updated | Updated On: 15-Jun-2022

Hyperbaric oxygen therapy

Q:

Should multiple codes be assigned for hyperbaric oxygen therapy if performed multiple times within an episode?

A:

The codes for hyperbaric oxygen therapy are based on the duration of each session. Assign multiple codes to represent the number of sessions based on the duration of each session not the cumulative duration and irrespective of the condition being treated.

ACS 0020 *Bilateral/multiple procedures* states that:

> *A procedure which is repeated during the episode of care at different visits to theatre should be coded as many times as it is performed.*
>
> *Theatre should be interpreted as an operating theatre or any other place where a procedure is performed during an inpatient episode of care*.

Therefore, the following codes should be assigned as many times as they are performed, based on the time per session, within an episode of care:

96191-00 **[1888]** *Hyperbaric oxygen therapy, 90 minutes or less*

13020-00 **[1888]** *Hyperbaric oxygen therapy, more than 90 minutes to 3 hours*

13025-00 **[1888]** *Hyperbaric oxygen therapy, more than 3 hours*.

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

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for implementation 01 April 2016.

Coding Rules

Published 15 December 2015

Ref No: Q2985 | Published On: 15-Dec-2015 | Status: Updated | Updated On: 15-Jun-2022

Elevated PSA

Q:

What is the principal diagnosis where elevated PSA is documented as the indication for a procedure, but the histopathological finding is BPH or adenocarcinoma?

A:

An elevated PSA is an abnormal test result that is commonly used as an indicator for a number of male urogenital disorders such as prostate cancer, benign prostatic hypertrophy (BPH), urinary tract infection (UTI) and prostatitis. If such conditions are identified or confirmed on histopathology, then these conditions should be coded and not the abnormal test result (elevated PSA) as per ACS 0001 *Principal diagnosis*/*Problems and underlying conditions*.

However, if no such condition is identified by the clinician or there was no clear finding confirmed on the histopathology report, assign R79.82 *Elevated prostate specific antigen* for the elevated prostate specific antigen (PSA) only, following the index pathway:

Elevated, elevation

- prostate specific antigen (PSA) R79.82

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

Published 15 December 2015,
for implementation 01 January 2016.

Ref No: TN1029 | Published On: 15-Dec-2015 | Status: Updated | Updated On: 15-Jun-2022

Osteoarthritis and ACS 0003 *Supplementary codes for chronic conditions*

Q:

A patient is admitted for a total knee replacement due to osteoarthritis (OA) in the knee, but also has clinical documentation of OA in the shoulder (which does not meet the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*). Should U86.2 *Arthritis and osteoarthritis [primary]* be assigned in addition to M17.1 *Other primary gonarthrosis*?

A:

Osteoarthritis (OA) is a degenerative disease that may affect any joint of the body. Depending on the progression, it may affect different joints at different times.

ACS 0003 *Supplementary codes for chronic conditions* states that the supplementary codes are not to be assigned in addition to another chapter code for the same condition.

Therefore, once OA of a specific site meets the criteria for code assignment as per ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*, do not assign U86.2 *Arthritis and osteoarthritis [primary]* for OA of another site.

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

Published 15 December 2015,
for implementation 01 January 2016.

Ref No: Q2989 | Published On: 15-Dec-2015 | Status: Updated | Updated On: 15-Jun-2022

Multiple osteotomies and procedures performed in combination on the maxilla and mandible (Le Fort I segmental (sectional) maxillary osteotomy)

Q:

What is the correct code to assign for a Le Fort I segmental (sectional) maxillary osteotomy?

A:

The Le Fort I osteotomy is one of the most commonly used procedures to correct midface deformities. It allows for correction in three dimensions including advancement, retrusion, elongation, and shortening. Various osteotomies are used to correct midfacial deformities and the choice of the procedure depends on the specific deformity.

A Le Fort I osteotomy is a bilateral procedure on the maxilla. The traditional Le Fort I osteotomy with advancement is standard treatment and adequate for most midfacial maxillofacial deformities. There are two codes in ACHI for Le Fort I osteotomy depending on whether or not internal fixation is used:

45726-01 **[1705]** *Osteotomy of maxilla, bilateral*

45729-01 **[1706]** *Osteotomy of maxilla with internal fixation, bilateral*

However, a standard Le Fort I osteotomy may be modified to address specific clinical situations. It is also often indicated in conjunction with a bilateral sagittal split (ramal) osteotomy (a procedure performed on the mandible).

If the transverse dimension of the maxilla needs to be altered (expanded) or if there are steps in the occlusion, a segmental (multi-piece) Le Fort I osteotomy, a variant of the standard Le Fort I (one-piece) osteotomy, proceeds after the down-fracturing of the Le Fort I segment. Segmentation is then effected through additional osteotomies. Once the osteotomies are completed, the segments are mobilised and a splint used to position the maxilla in the appropriate place.

Le Fort I sectional maxillary osteotomy in the literature is more commonly referred to as Le Fort I segmental maxillary osteotomy and as noted above is a variant of the standard Le Fort I osteotomy. While ACHI does not have a specific code for this variant of the Le Fort I osteotomy it provides codes for multiple osteotomies and procedures performed in combination on the maxilla and mandible.

Where multiple (more than two) osteotomy procedures are performed on the maxilla, such as occurs in a segmental (sectional) osteotomy or where a combination of procedures are performed on the maxilla and mandible, such as occurs when a standard Le Fort I osteotomy is performed in combination with bilateral sagittal split (ramal) osteotomy, follow the excludes notes in blocks **[1705]** and **[1706]** and assign an appropriate code from block **[1707]** *Osteotomy or ostectomy of mandible or maxilla, procedures in combination* or **[1708]** *Osteotomy or ostectomy of mandible or maxilla with internal fixation, procedures in combination* as appropriate.

Count the procedures according to the number of osteotomies performed, for example:

- a standard Le Fort I osteotomy with bilateral sagittal split (ramal) osteotomy equals four procedures; bilateral osteotomy (two procedures) on maxilla plus bilateral osteotomy (two procedures) on mandible.
- a segmental (sectional) Le Fort I osteotomy equals two procedures for the standard Le Fort I osteotomy plus the number of additional osteotomies performed as part of the segmental (sectional) osteotomy variant of the procedure.

Therefore, a Le Fort I segmental (sectional) osteotomy with bilateral sagittal split (ramal) osteotomy is classified to block **[1707]** or **[1708]** (depending on whether internal fixation is used) and equals a minimum of four procedures plus the number of additional osteotomies performed as part of the segment (sectional) variant. Often it will equate to ≥ 6 procedures:

45747-00 **[1707]** *Osteotomies or ostectomies of mandible and maxilla, 6 or more procedures*

or

45752-00 **[1708]** *Osteotomies or ostectomies of mandible and maxilla, 6 or more procedures, with internal fixation*.

Improvements to this area of the classification will be considered for a future edition of ACHI.

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

Published 15 December 2015,
for implementation 01 January 2016.

Ref No: Q3008 | Published On: 15-Dec-2015 | Status: Updated | Updated On: 15-Jun-2022

Assignment of U codes from patient documentation

Q:

On the patient's preoperative questionnaire in response to the question "Are you being treated for high blood pressure", the answer is 'Yes' and anti-hypertensive medication is included in the list of current medications. There is no other mention of hypertension in the record (same-day episode). Should a 'U' code for hypertension be assigned when it has not been documented by the clinician?

A:

ACS 0010 *Clinical documentation and general abstraction guidelines* states:

> *Accurate clinical documentation is the responsibility of the treating clinician.*

Assignment of codes for diagnoses and procedures assumes that these have been documented by a clinician. This principle applies to the assignment of supplementary codes for chronic conditions.

While it is not expected that clinical coders should follow-up clinicians for assignment of 'U' codes, it is assumed they should be allocated to conditions that have been documented by a clinician.

Therefore, in the absence of supporting clinical documentation, a 'U' code should not be assigned based on documentation of patient response(s) alone. This includes where the form has been signed by a clinician, which confirms the form has been completed or sighted but does not necessarily corroborate the clinical content.

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

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Ref No: Q3012 | Published On: 15-Dec-2015 | Status: Current

Admission for removal of ureteric stent; calculus is still present, stent left in situ

Q:

Is it correct to assign Z46.6 *Fitting and adjustment of urinary device* if a patient has been admitted for removal of a ureteric stent, but after review the stent is left in situ due to the presence of ureteric calculus?

A:

The note at Z40**–**Z54 *Persons encountering health services for specific procedures and health care* states:

Categories Z40–Z54 are intended for use to indicate a reason for care. They may be used for patients who have already been treated for a disease or injury, but who are receiving follow-up or prophylactic care, convalescent care, or care to consolidate the treatment, to deal with residual states, to ensure that the condition has not recurred, or to prevent recurrence.

- Where a patient is admitted for removal of a ureteric stent (ureteric calculus has not recurred or is not still present and the stent is removed), assign:

  Z46.6 *Fitting and adjustment of urinary device*

  by following the index pathway:

  Removal

  - ureteral stent Z46.6

- Where a patient is admitted for removal of a ureteric stent, but the clinician indicates that the calculus is still present and therefore the stent is not removed as planned, assign a code for the calculus as principal diagnosis. For example:

  N20.1 *Calculus of ureter*

  Assign Z96.0 *Presence of urogenital implants* as an additional diagnosis if the stent is left in situ.

If the stent is removed and another stent is inserted (ie the stent is replaced), assign a code for the calculus as principal diagnosis. It is not necessary to assign Z46.6 or Z96.0 in this scenario.

Published 15 December 2015,
for implementation 01 January 2016.

Coding Rules

Published 15 September 2015

Ref No: Q2928 | Published On: 15-Sep-2015 | Status: Updated | Updated On: 15-Jun-2019

Coblation of the laryngotrachea

Q:

How do you code coblation of the laryngotrachea?

A:

Coblation (cold or controlled ablation) of the laryngotrachea is a destruction procedure most commonly performed for the treatment of papillomatosis.

Coblation of the laryngotrachea is an endoscopic procedure, usually performed with a microlaryngoscope, however it may also be performed using a bronchoscope extended to the laryngotracheal region.

Although there is no specific block for destruction procedures on the larynx and/or trachea in ACHI, endoscopic excision procedures on the larynx and/or trachea are classified to block **[523]** *Laryngoscopy with excision* (which includes tracheoscopy).

Therefore, where coblation of the laryngotrachea is performed, assign either:

41852-00 **[523]** *Laryngoscopy with removal of lesion*

OR

41864-00 **[523]** *Microlaryngoscopy with removal of lesion*

as a best fit, by following the index pathway:

Endoscopy, endoscopic

- larynx

- - with removal of lesion 41852-00 **[523]**

OR

Destruction

- lesion (tumour)

- - larynx

- - - with microlaryngoscopy 41864-00 **[523]**

Enhancements to ACHI 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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Ref No: Q2970 | Published On: 15-Sep-2015 | Status: Current

Vascular closure devices

Q:

Should an ACHI code be assigned when Angio-seal™ (or another vascular closure device) is used following an arterial catheterisation?

A:

Angio-seal™ is a brand of vascular closure device deployed following arterial catheterisation procedures. The purpose of the device is to achieve haemostasis by creating a mechanical seal at the arteriotomy site (that is, the puncture site in the artery used for access of the catheter – usually the femoral artery).

It is not necessary to assign a procedure code for use of a vascular closure device, as it is an inherent part of a catheterisation procedure, as per the guidelines in ACS 0016 *General procedure guidelines, Procedure components*:

> 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.

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Ref No: Q2917 | Published On: 15-Sep-2015 | Status: Updated | Updated On: 15-Jun-2022

Injury and external cause codes for leech bite

Q:

What injury and external cause codes should be assigned for a leech bite on the ankle?

A:

Leeches belong to the family of Annelids (segmented worms) that live on land as well as in water; and are not insects. They attach themselves to a host using suckers and then bite into the host using their teeth. They release an anaesthetic in their saliva which prevents the host from feeling them as well as an anti-coagulant called hirudin which keeps the blood flowing. Leeches carry a bacterium in their gut known as *Aeromonas hydrophilia* which can then infect the host through the bite.

The following injury and external cause codes for a leech bite on the ankle should be assigned:

S91.0 *Open wound of ankle*

following the index entries:

Bite(s)

- animal *(see also Wound, open)* T14.1

then

Wound, open (animal bite) (cut) (laceration) (puncture wound) (shot wound)

- ankle S91.0

Assign W64 *Exposure to other and unspecified animate mechanical forces* following the index entry:

Bite, bitten by — *see also Contact/with/by type of bite*

- animal NEC W64

with appropriate activity and place of occurrence codes.

Code and sequence any associated cellulitis, infection and infectious agent(s) as per ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses.*

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

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Ref No: Q2930 | Published On: 15-Sep-2015 | Status: Current

Metabolic acidosis in a diabetes mellitus patient

Q:

What is the correct code assignment for metabolic acidosis in a patient with diabetes mellitus?

A:

Metabolic acidosis occurs when the body produces too much acid, or when the kidneys are not removing enough acid from the body. The different types of metabolic acidosis are:

- Diabetic acidosis (also called diabetic ketoacidosis and DKA) which develops when acidic substances known as ketone bodies build up in the body. This commonly occurs with uncontrolled type 1 diabetes mellitus but can occur with type 2 diabetes mellitus.
- Hyperchloraemic acidosis which results from excessive loss of sodium bicarbonate from the body. This can occur with severe diarrhoea.
- Lactic acidosis results from a buildup of lactic acid. It can be caused by alcohol, diabetes, cancer, exercising intensely, liver failure, medications, such as salicylates, prolonged lack of oxygen from shock, heart failure, severe anaemia and seizures.

Other causes of metabolic acidosis include:

- Kidney disease (distal renal tubular acidosis and proximal renal tubular acidosis)
- Poisoning by aspirin, ethylene glycol (found in antifreeze), or methanol
- Severe dehydration

(National Institute of Health, 2013).

ICD-10-AM does not assume a causal link between diabetes mellitus and metabolic acidosis NOS when both are documented. However, it does assume a causal link where there is documentation of lactic acidosis or ketoacidosis as per the index pathway below:

Diabetes, diabetic

- with

- - acidosis — *see also Diabetes/with/ketoacidosis*

- - - lactic (without coma) E1-.13

- - - - with coma E1-.14

- - - - and ketoacidosis (without coma) E1-.15

- - - - - with coma E1-.16

Clarification should be sought from the treating clinician as to the specific type of metabolic acidosis to assign E1-.13 – E1-.16. When clarification is not possible, assign E87.2 *Acidosis* following the index pathway:

Acidosis (lactic) (respiratory) E87.2

- diabetic — see Diabetes/with/acidosis
- metabolic NEC E87.2

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

References:

National Institute of Health (2013). *Metabolic acidosis*. Retrieved from: http://www.nlm.nih.gov/medlineplus/ency/article/000335.htm

The Merck Manual. (2013). *Metabolic acidosis*. Retrieved from: http://www.merckmanuals.com/professional/endocrine_and_metabolic_disorders/acid-base_regulation_and_disorders/metabolic_acidosis.html

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Ref No: Q2932 | Published On: 15-Sep-2015 | Status: Current

Transmastoid repair of tegmen defect with ossicular chain reconstruction (OCR)

Q:

What is the correct procedure code for transmastoid repair of tegmen defect with ossicular chain reconstruction (OCR)?

A:

Transmastoid repair of tegmen defect is a surgical repair of the bony defect of tegmen (part of the temporal bone) with a piece of auricular cartilage via a mastoidectomy. The bony defect is usually the result of a lesion such as a cholesterol granuloma or other disease process. The procedure involves a classical incision behind the ear with removal of part of the bony wall of the mastoid to allow the surgeon to remove the lesion and/or access the bony defect with direct visualisation. Once the tegmen defect is identified, a cartilage graft is harvested and placed in the defect area. Reshaping of patient's existing bone (i.e. ossicular chain reconstruction) or repositioning of the prosthetic bone (e.g. partial ossicular replacement prosthesis) may be performed as needed.

A transmastoid repair of tegmen defect with ossicular chain reconstruction (OCR) is also described as a 'canal wall up mastoidectomy' meaning the external auditory canal is kept intact i.e. an intact canal wall technique is used.

Therefore the correct code for this procedure is 41554-00 **[326]** *Mastoidectomy by intact canal wall technique with myringoplasty and ossicular chain reconstruction,* following the index pathway:

Mastoidectomy (cortical) (simple)

- intact canal wall technique (with atticotomy)

- - with myringoplasty

- - - and ossicular chain reconstruction (graft) (prosthesis) 41554-00 **[326]**

If a mastoidectomy is described as 'canal wall down', it includes a complete mastoidectomy in addition to removal of the posterior auditory canal (i.e. not an intact canal wall technique). For these procedures clarification is required as to whether the procedure is a modified radical mastoidectomy or a radical mastoidectomy. Assign an appropriate mastoidectomy code by following the index pathway:

Mastoidectomy (cortical) (simple)

- modified radical

…

- radical

Improvements to ACHI will be considered for a future edition.

References:

Isaacson, B 2013, *Mastoidectomy*, Medscape, viewed 12 May 2015, http://emedicine.medscape.com/article/1890933-overview#a15

Patel, NS, Canopy, E and Sheykholeslami, K 2013, *Trans-Mastoid Management of Temporal Bone Tegmen Defects, Encephaloceles and CSF Leaks,* J Otol Rhinol 2:1, doi:10.4172/2324-8785.1000109.

Published 15 September 2015,
for implementation 01 October 2015.

Ref No: Q2948 | Published On: 15-Sep-2015 | Status: Updated | Updated On: 15-Jun-2022

Panniculitis and calcific (uraemic) arteriolopathy (calciphylaxis)

Q:

How do you code panniculitis and calcific uraemic arteriolopathy (calciphylaxis), when a patient presents with both conditions during an episode of care?

A:

Panniculitis is broad term for inflammatory disorders of subcutaneous adipose (fat) tissue; lobular panniculitis is one of two types and is further described as with or without vasculitis. Calcific (uraemic) arteriolopathy/calciphylaxis is sometimes classified as a type of 'mostly lobular panniculitis without vasculitis'. However, it is also described as a completely separate entity to panniculitis, although the conditions are often seen together.

The following are definitions for these conditions:

Calcific (uraemic) arteriolopathy (calciphylaxis) is a life-threatening vasculopathic disorder characterized by painful cutaneous ischaemia and infarction due to calcification, intimal fibroplasia, and thrombosis of subcutaneous arterioles. It is most commonly associated with end-stage kidney disease or renal transplantation, particularly in the context of longstanding diabetes mellitus. Affected skin, commonly on the hips and thighs, appears mottled, grey and devitalized before progressing to full thickness infarction and deep ulceration. These changes may be accompanied by indurated subcutaneous plaques indicating an underlying calcifying panniculitis. The condition may be but is not always associated with hyperparathyroidism or an elevated calcium-phosphate product.

Calcific panniculitis presents as discrete, firm subcutaneous masses, often affecting the thighs and hips. It is strongly associated with hyperparathyroidism, particularly in the context of chronic renal failure. It may occur in conjunction with but is clinically distinct from calcific arteriolopathy (calciphylaxis).

ICD-10 and hence ICD-10-AM do not link these conditions and therefore both conditions should be coded and sequenced as per the principles of ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*, as follows:

M79.38 *Panniculitis, unspecified, other site*

by following the index pathway:

Panniculitis M79.3-

and assigning a fifth character 8 for other (site)

I70.8 *Atherosclerosis of other arteries*

by following the index pathway:

Calciphylaxis

- artery – *see Arteriosclerosis*

Arteriosclerosis, arteriosclerotic (with calcification)

- specified artery NEC I70.8

Assign additional diagnosis codes (for diabetes mellitus, chronic kidney disease etc), as appropriate.

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

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Ref No: Q2962 | Published On: 15-Sep-2015 | Status: Current

Serial transverse enteroplasty procedure (STEP)

Q:

How do you code serial transverse enteroplasty procedure (STEP)?

A:

Serial transverse enteroplasty procedure (STEP) is performed on parenteral nutrition-dependent patients with short bowel syndrome (SBS). The purpose of the intervention is to lengthen the shortened small intestine, with the ultimate aim of increasing nutritional absorption by expanding the surface area of intestine in contact with the blood supply from the mesentery. This allows patients to better tolerate nutritional intake through the gastrointestinal tract and therefore cease the need for parenteral nutrition.

STEP is performed using a stapler, through the mesentery. The small intestine is stapled and dissected on alternating sides in a direction perpendicular to its long axis, resulting in a zigzag appearance.

ACHI does not currently include a code for STEP. Although the term 'enteroplasty' implies repair, STEP is not a true repair procedure; it alters the existing anatomy to optimise performance. Therefore, assign the following code as a best fit:

90307-00 **[903]** *Other procedures on small intestine*

by following the index pathway:

Procedure

- intestine

- - small NEC 90307-00 **[903]**

Improvements to ACHI will be considered for a future edition.

References:

Australia and New Zealand Horizon Scanning Network. Australian Government. Department of Health and Ageing. (2008).(updated 2010). *Horizon scanning technology prioritising summary. Serial transverse enteroplasty.* Retrieved from http://www.horizonscanning.gov.au/internet/horizon/publishing.nsf/Content/8DA46B03741CB76FCA2577570016E96C/$File/PS%20Update%20Serial%20Transverse%20Enteroplasty%20.pdf

Boston Children's Hospital. (2015). *International STEP data registry*. Boston Children's Hospital. Retrieved from https://apps.childrenshospital.org/clinical/step/

National Institute for Health and Clinical Excellence. (2012). *Serial transverse enteroplasty procedure (STEP) for bowel lengthening in parenteral nutrition-dependent children.* Retrieved from http://www.nice.org.uk/guidance/ipg232

Published 15 September 2015,
for implementation 01 October 2015.

Ref No: Q2969 | Published On: 15-Sep-2015 | Status: Current

Injection of botulinum toxin (Botox) for manifestations of cerebral palsy

Q:

What is the principal diagnosis for a patient with manifestations of cerebral palsy admitted for injection of Botox?

A:

Cerebral palsy (CP) describes a group of disorders associated with movement and posture that are attributed to non-progressive disturbances that occurred in the developing brain. It occurs in about two per 1000 live births.

There are four main types of cerebral palsy:

- Spastic CP is the most common type, characterised by stiffness or tightness of the muscles, which is most obvious when the person tries to move.
- Athetoid CP is characterised by uncontrolled movements and often leads to erratic movements.
- Ataxic CP is the least common type of cerebral palsy and is characterised by a lack of balance and coordination. It often presents as unsteady, shaky movements or tremors.
- Mixed CP may involve a combination of types of cerebral palsy.

Muscle spasms, spastic movements, spasticity and other muscular related features such as muscle contracture and excessive drooling are characteristic of some types of CP and are classified by the type of cerebral palsy at G80.- *Cerebral palsy*. Therefore, do not assign additional codes such as R25.2 *Cramp and spasm* when one of these features is documented as the indication for the episode of care (eg injection of botulinum toxin). That is, where documentation indicates that the patient has CP and the admission is for injection of botulinum toxin for spasticity (eg focal spasticity, muscle spasticity), assign a code from G80.- *Cerebral palsy*, by following the index pathway:

Palsy

- cerebral

References:

Ameri, A, Mirmohammadsadeghi, A, Makateb, A, Bazvand, F, and Hosseini, S 2015, 'Clinical Outcomes of Botulinum Toxin Injection in Patients with Cerebral Palsy and Esotropia'. *Strabismus.* March 2015, Vol. 23, No. 1, Pages 8-13. viewed 11 June 2015 http://www.medscape.com/viewarticle/550741

Criswell, S, Crowner, B & Racette, B 2006, 'The Use of Botulinum Toxin Therapy For Lower-Extremity Spasticity in Children With Cerebral Palsy'. *Neurosurgical focus.* 2006; 21(2):1 viewed 11 June 2015 http://www.medscape.com/viewarticle/550741

State Government of Victoria 2015, Cerebral palsy, viewed 8 September 2015, http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/cerebral_palsy_causes_and_implications

Stern Law Group PLLC 2015, Botulinum Toxin, or Botox. viewed 11 June 2015 http://cerebralpalsy.org/about-cerebral-palsy/treatment/medication/botox/

The Royal Children's Hospital Melbourne n.d., *Cerebral palsy* viewed 8 September 2015 http://www.rch.org.au/clinicalguide/guideline_index/Cerebral_Palsy/

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for implementation 01 October 2015.

Coding Rules

Published 15 June 2015

Ref No: Q2938 | Published On: 15-Jun-2015 | Status: Updated | Updated On: 15-Jun-2019

Drug-induced anaemia

Q:

How do you code drug-induced anaemia when the type of anaemia has not been specified?

A:

Drug-induced anaemia may manifest as haemolytic anaemia (due to erythrocyte injury in peripheral blood) or megaloblastic anaemia, ringed sideroblastic anaemia or pure red cell aplasia (due to damage of erythroid progenitor cells or erythroblasts). Pharmacotherapy (antineoplastic cytotoxic agents), particularly, may reduce haemoglobin levels by inducing a suppressive effect on bone marrow and toxic effects on erythrocytes.

ICD-10 and ICD-10-AM list a number of specific types of anaemia; some of the specific types are further specified as drug-induced (eg aplastic, haemolytic etc). These options should only be coded when the type of anaemia is documented.

Where drug-induced anaemia is documented without specification of the type of anaemia, assign:

D64.9 *Anaemia, unspecified*

with an additional code from Y40-Y59 Drugs, medicaments and biological substances causing adverse effects in therapeutic use to identify the external cause (see Alphabetic Index/Table of Drugs and Chemicals)

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.*

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

Reference:

Dan, K. (2008). Drug-induced anemia. Japanese Journal of Clinical Medicine [2008, 66(3):540-543]. Retrieved from http://europepmc.org/abstract/med/18326323

Wilson, S., Silberstein, P. and Aldoss, I. (2008). Chemotherapy-induced anaemia. *Asia-Pacific oncology & haematology,* 2008;1(1):24-6. Retrieved from http://www.touchoncology.com/articles/chemotherapy-induced-anaemia

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for implementation 01 July 2015.

Ref No: Q2933 | Published On: 15-Jun-2015 | Status: Current

Interpretation of ACS 0020 *Bilateral/multiple procedures* for bilateral insertion of ureteric stents

Q:

How do you apply ACS 0020 *Bilateral/multiple procedures* when coding bilateral insertion of ureteric stents? Is the procedure coded once or twice?

A:

Insertion of bilateral ureteric stents meets the definition of bilateral procedures in ACS 0020 *Bilateral/multiple procedures*:

> *Bilateral procedures are those which involve the same organ/structure on different sides of the body at the same operative episode*.

Therefore assign 36821-01 **[1114]** *Endoscopic insertion of ureteric stent* twice as per *Bilateral Procedures*, 3. *Procedures with no code option for bilateral*.

ACS 0020 *Bilateral/multiple procedures* has been flagged for review in a future edition of the Australian Coding Standards.

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Ref No: Q2926 | Published On: 15-Jun-2015 | Status: Current

Classifying a procedure under investigation in a randomised and placebo-controlled clinical trial

Q:

Is it necessary to assign a procedure code or a Z code to identify patients who are undergoing treatment as part of a clinical trial that is both randomised and placebo-controlled? For example, a patient with acute myocardial infarction who is participating in a placebo-controlled clinical trial (AMICI: Allogeneic Mesenchymal Precursor Cell Infusion in Myocardial Infarction), where the patient may receive either an infusion of stem cells or a placebo directly into a diseased coronary artery following angioplasty.

A:

A placebo-controlled clinical trial is a method of study in which both investigators and participants are blinded as to who received an intervention or a placebo.

Do not assign a code for a procedure that is part of a clinical trial that is placebo-controlled as:

- the purpose and methodology for collecting data for clinical trials are different to data collected for the Admitted Patient Care National Minimum Data Set (APC NMDS)
- information related to clinical trials are gathered and managed through clinical trial data collection systems
- clinical trials are usually reimbursable through separate grants
- there is no uniform policy or practice across hospitals and jurisdictions that requires clinical trial related activity to be recorded in clinical records.

Do not assign Z00.6 *Examination for normal comparison and control in clinical research programme* to flag patients undergoing treatment as part of a clinical trial. Codes in category Z00 are intended to classify individuals undergoing examination for specific purposes without complaint or reported diagnosis. Codes from this category should not be assigned when there is a documented definitive diagnosis as the indication for treatment.

See also Coding Rules: *Same-day chemotherapy for neoplasm; participant in clinical drug trial*.

Improvement to ACS 0026 *Admission for clinical trial or therapeutic drug monitoring* will be considered for a future edition.

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for implementation 01 July 2015.

Ref No: Q2934 | Published On: 15-Jun-2015 | Status: Updated | Updated On: 15-Jun-2022

Acute bronchitis with COPD

Q:

How do you code acute streptococcal bronchitis with chronic obstructive pulmonary disease?

A:

In ICD-10-AM, acute bronchitis is classified to J20-J22 *Other acute lower respiratory infections,* which excludes J44.0 *Chronic obstructive pulmonary disease with acute lower respiratory infection.* Chronic obstructive pulmonary disease (COPD) includes chronic bronchitis with obstruction, therefore J44.0 classifies acute on chronic bronchitis with obstruction.

ACS 1008 *Chronic obstructive pulmonary disease (COPD)* states*:*

> Infective exacerbation of COPD does not require an additional code to reflect the infective description unless the infective condition is a condition in its own right, such as pneumonia (see *COPD with pneumonia*). If there is no documented infective disorder, a diagnosis of 'infective exacerbation of COPD' or 'chest infection exacerbating COPD' should be assigned the code J44.0 *Chronic obstructive pulmonary disease with acute lower respiratory infection*.

Where there is documentation of acute bronchitis due to a specific organism (eg acute streptococcal bronchitis) exacerbating COPD, assign the following codes:

J44.0 *Chronic obstructive pulmonary disease with acute lower respiratory infection*

B95.5 *Unspecified Streptococcus as the cause of diseases classified to other chapters*

by following the above guidelines in ACS 1008 and the index pathways:

Bronchitis

- with
- - COPD (chronic obstructive pulmonary disease)
- - - with (acute)
- - - - exacerbation NEC
- - - - - infective J44.0
- - - - lower respiratory infection J44.0

Infection

- Streptococcus, streptococcal NEC
- - as cause of disease classified to other chapters B95.5

A review of ACS 1008 *Chronic obstructive pulmonary disease (COPD)* will be considered for a future edition.

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

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Ref No: Q2929 | Published On: 15-Jun-2015 | Status: Current

Closure of nasal septal perforation with cartilage graft

Q:

How do you code a cartilage graft when coding closure of perforation of nasal septum?

A:

For repair of nasal septal perforation with cartilage graft assign:

41671-01 **[379]** *Closure of perforation of nasal septum*

alone, following the index pathway:

Closure

- perforation

- - nasal septum 41671-01**[379]**

A locally harvested cartilage graft is inherent in the above code and therefore does not require a separate code to be assigned for the graft component.

Amendments to ACHI will be considered for a future edition.

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Ref No: Q2923 | Published On: 15-Jun-2015 | Status: Current

Radial scar of breast

Q:

What is the correct code assignment for radial scar of the breast?

A:

Radial scar also called complex sclerosing lesion is a benign breast lesion with a stellate architecture that may simulate invasive carcinoma mammographically, clinically, grossly and microscopically (Kempson, R, 2006). Despite being considered benign lesions, radial scars of the breast often demonstrate suspicious imaging features that prompt imaging-guided core needle biopsy as a significant percentage of these lesions are known to be associated with malignancy.

Assign N64.8 *Other specified disorders of breast* for radial scar of the breast following the index pathway:

Disease, diseased

- breast

- - specified NEC N64.8

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

References:

Kempson, R, (2006). Radial scar of the breast. Stanford University School of Medicine. Retrieved from:http://surgpathcriteria.stanford.edu/breast/radscar/printable.html

Knipe, H and Jones, J (2014). Radial scar. Radiopedia.org. Retrieved from: http://radiopaedia.org/articles/radial-scar

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for implementation 01 July 2015.

Ref No: Q2914 | Published On: 15-Jun-2015 | Status: Current

Synonymous terms for palliative care

Q:

What are acceptable synonymous terms for palliative care? Some terms are clearly synonymous with palliative care such as ‘end of life care’ and ‘terminal care’; however is documentation of ‘comfort measures only’ considered synonymous with palliative care?

A:

The ACS for palliative care has been revised and relocated in Ninth Edition and has clarified that terminology such as ‘end of life care’ and ‘terminal care’ are synonymous terms used to describe episodes of palliative care. However, the phrase ‘comfort measures’ may be more widely applied and therefore on its own does not qualify for assignment of Z51.5 *Palliative care*.

Clinical coders should refer to ACS 2116 *Palliative care* to determine code assignment. If the documentation is unclear, Z51.5 should not be assigned.

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for implementation 01 July 2015.

Ref No: Q2927 | Published On: 15-Jun-2015 | Status: Current

Endoscopic dilation of duodenal stricture

Q:

How do you code endoscopic dilation of duodenal stricture?

A:

Where endoscopic dilation of the duodenum is performed without insertion of a prosthesis (stent), assign as a best fit:

30475-01 **[882]** *Endoscopic dilation of gastroduodenal stricture*

by following the index pathway:

Dilation

- duodenum

- - and gastric stricture (endoscopic) 30475-01 **[882]**

Dilation of the duodenum is included in the ACHI codes for endoscopic insertion/replacement of duodenal prosthesis (stent):

92068-00 Endoscopic insertion of duodenal prosthesis

Endoscopic insertion of duodenal stent:

• metal (Wallstent)

• plastic

Includes: dilation of duodenum

92068-01 Endoscopic replacement of duodenal prosthesis

Endoscopic replacement of duodenal stent:

• metal (Wallstent)

• plastic

Includes: dilation of duodenum

Amendments to ACHI will be considered for a future edition.

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for implementation 01 July 2015.

Ref No: Q2936 | Published On: 15-Jun-2015 | Status: Current

Replacement of stent in an ileal conduit

Q:

How do you code replacement of a stent in an ileal conduit?

A:

Memokath stents are Nickel-Titanium stents with thermal shape-memory effect for treating urinary tract obstructions (Endotherapeutics, 2012).

An ileal conduit is a type of urostomy that uses a segment of ileum to connect the ureters to the external body, through the abdominal wall. The segment of ileum is no longer considered part of the gastrointestinal tract; it acts as part of the urinary tract and is an extension of the ureters.

There are no specific code(s) for stenting of an ileal conduit in ACHI. As a best fit, for replacement of a stent in an ileal conduit, assign:

36608-00 **[1069]** *Percutaneous replacement of ureteric stent*

by following the index pathway

Replacement

- ureteric stent

- - percutaneous (through bladder) (through ileal conduit) 36608-00 **[1069]**

Percutaneous replacement through ileal conduit is an includes note at 36608-00 **[1069]**.

Enhancements to ACHI will be considered for a future edition.

Reference

Endotherapeutics. (2012). Memokath stents [product information]. Retrieved from http://www.endotherapeutics.com.au/memokath

Published 15 June 2015,
for implementation 01 July 2015.

Coding Rules

Published 15 March 2015

Ref No: Q2906 | Published On: 15-Mar-2015 | Status: Updated | Updated On: 15-Jun-2019

Same-day chemotherapy for neoplasm; participant in clinical drug trial

Q:

A patient is admitted for same-day pharmacotherapy as part of a drug trial. What is the principal diagnosis?

A:

Where there is a clinical indication for same-day pharmacotherapy (for neoplasm), regardless of whether the pharmacotherapy was part of a drug trial, assign Z51.1 *Pharmacotherapy session for neoplasm* as principal diagnosis with an additional diagnosis code for the neoplasm.

Do not assign Z00.6 *Examination for normal comparison and control* for the above scenario. Z00.6 is located in category Z00 *General examination and investigation of persons without complaint or reported diagnosis*; codes from this category should not be assigned when there is a documented definitive diagnosis as the indication for pharmacotherapy.

Assign Z00.6 where the reason for admission is stated as being for a clinical trial for the purposes of research (without documentation of a clinical diagnosis).

Amendments to ACS 0026 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.

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for implementation 01 April 2015.

Ref No: Q2872 | Published On: 15-Mar-2015 | Status: Updated | Updated On: 15-Jun-2022

Gastroenteritis or diarrhoea due to Norovirus

Q:

What is the correct code assignment for gastroenteritis or diarrhoea due to Norovirus?

A:

Norovirus was previously referred to as “Norwalk-like viruses”, Norwalk viruses, and small round-structured viruses.

Intestinal infections due to norovirus should be assigned A08.1 *Acute gastroenteropathy due to Norovirus,* following the index pathway:

Gastroenteritis

- viral

- - Norovirus (Norwalk agent) A08.1

Diarrhoea caused by Norovirus should also be assigned A08.1 *Acute gastroenteropathy due to Norovirus*, following the index pathway:

Diarrhoea, diarrhoeal

- due to

- - virus (*see also Enteritis/viral*)

and

Enteritis

- viral

- - small round structured A08.1

Improvements to the Alphabetic Index with respect to norovirus may be considered for a future edition of ICD-10-AM.

Reference:

World Health Organization (WHO) (2015). ICD-11 Beta version, joint linearization for mortality and morbidity statistics. Retrieved from http://apps.who.int/classifications/icd11/browse/l-m/en

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 2015.

Ref No: Q2887 | Published On: 15-Mar-2015 | Status: Updated | Updated On: 15-Jun-2019

E13 *Other specified diabetes mellitus*

Q:

Can you assign multiple codes when documentation indicates that a patient has type 1 or type 2 diabetes mellitus AND diabetes mellitus classifiable to E13?

A:

ICD-10-AM classifies diabetes mellitus to the following categories:

E10 *Type 1 diabetes mellitus*

E11 *Type 2 diabetes mellitus*

E13 *Other specified diabetes mellitus*

E14 *Unspecified diabetes mellitus*

E13 *Other specified diabetes mellitus* cannot be assigned in addition to E10 *Type 1 diabetes mellitus* or E11 *Type 2 diabetes mellitus,* as these codes are mutually exclusive.

E13.- is assigned by following the index pathway *Diabetes/specified NEC*. The NEC (not elsewhere classified) indicates that if the diabetes is classifiable to a specified category (E10 or E11), that category takes precedence over the 'other' (residual) category (E13).

Therefore, E13 should never be assigned when documentation confirms diabetes mellitus as type 1 or type 2.

See *Conventions and general arrangement of the ICD-10-AM Alphabetic Index/ NEC (not elsewhere classified)*.

Documentation issues

The above advice is applicable to cases where type 1 or type 2 diabetes mellitus are **correctly identified and documented** in the clinical record.

Clinicians may incorrectly document the type of diabetes and/or use terms interchangeably, especially in relation to insulin use. For example:

- patient with type 2 diabetes mellitus (T2DM) on insulin, incorrectly documented as IDDM (insulin dependent diabetes mellitus) or type 1 diabetes mellitus (T1DM)
- patient with T2DM on insulin, inconsistently documented as T1DM or T2DM within the one episode
- patient with diabetes mellitus due to a specified cause treated with insulin, incorrectly documented as T1DM or IDDM.

The following should be noted:

- IDDM and NIDDM (noninsulin dependent diabetes mellitus) are outdated terminology
- IDDM and NIDDM are not types of diabetes; they are descriptors of insulin usage
- IDDM does not always mean T1DM; it may mean T2DM treated with insulin or DM due to a specified cause (eg post pancreatectomy) treated with insulin.

Where documentation is conflicting or inconsistent within the current episode regarding the type of diabetes mellitus, coders should check previous admissions and/or correspondence and/or consult with the treating clinician to determine if the patient has T1DM, T2DM or diabetes mellitus due to a specified cause (meaning not type 1 or type 2).

See also ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia, 2. Specific classification principles for DM and IH*

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: Q2882 | Published On: 15-Mar-2015 | Status: Updated | Updated On: 01-Jul-2017

Thrombectomy and embolectomy of multiple arteries

Q:

Should site specific procedure codes for thrombectomy/embolectomy be assigned when thrombectomy/embolectomy is performed on multiple vessels or does the second dot point of Point 2 *Multiple procedures* in ACS 0020 Bilateral/*multiple procedures* apply?

A:

Site specific procedure codes should be assigned when thrombectomies/embolectomies are performed on multiple vessels as the procedures are performed on different lesion, for example thrombus of tibial artery and thrombus of femoral artery. The second dot point of Point 2 *Multiple procedures* in ACS 0020 *Bilateral/multiple procedures* which states 'embolisation of left and right uterine arteries' applies to treating the same condition/lesion which is uterine fibroid.

Q:

What is the correct code to assign thrombectomy/embolectomy of one artery and stent of another for atherosclerosis?

A:

A code for insertion of stent should be assigned in addition to the thrombectomy/embolectomy code in this scenario as two different conditions/lesions; thrombus/embolus of one artery and atherosclerosis of another artery were treated. The includes note 'that with stenting' at block **[702]** *Arterial embolectomy or thrombectomy* only applies if the stenting is performed to the same artery.

Improvements to ACHI 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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Ref No: Q2874 | Published On: 15-Mar-2015 | Status: Updated | Updated On: 15-Jun-2022

Interpretation of ACS 0936 *Cardiac pacemakers and implanted defibrillators*

Q:

What is the correct interpretation of the following sentences in ACS 0936 *Cardiac pacemakers and implanted defibrillators* regarding the classification of insertion of electrode(s) for implanted cardioverter defibrillators (ICDs)?

> *"The code(s) should be assigned based on the type of electrode (pacemaker or defibrillator) and the route (transvenous, epicardial etc) regardless of how, or if, they are subsequently used."*
>
> "*Where an electrode has both pacing and defibrillating functionality, apply the hierarchy and assign defibrillator electrode code(s) only."*

A:

Most modern implanted cardioverter defibrillators (ICDs) have the functions of both pacing and defibrillation as rate-responsive bradycardia pacing is now standard in all ICDs. Some types of ICDs only have one electrode (lead) which has both pacing and defibrillating functionality while others have multiple electrodes with the addition of a pacemaker electrode that can sense the atrial electrical activity.

For initial insertion of an ICD with single electrode, assign a code for the ICD generator and a code for a defibrillator electrode only as per the hierarchy specified in ACS 0936 *Cardiac pacemakers and implanted defibrillators*. For example, initial insertion of a single chamber ICD with an electrode positioned in the right ventricle via transvenous route, assign:

38393-00 **[653]** *Insertion of cardiac defibrillator generator*

and

38390-02 **[648]** *Insertion of permanent transvenous electrode into other heart chamber(s) for cardiac defibrillator*

For initial insertion of an ICD that has multiple electrodes, assign a code for the ICD generator and codes for each type of electrode (not device/generator). For example, initial insertion of a dual chamber ICD with one defibrillator lead fixed in the right ventricle and an additional pacemaker lead fixed in the right atrium via transvenous route, assign:

38393-00 **[653]** *Insertion of cardiac defibrillator generator*

and

38390-02 **[648]** *Insertion of permanent transvenous electrode into other heart chamber(s) for cardiac defibrillator*

and

38350-00 **[648]** *Insertion of permanent transvenous electrode into other heart chamber(s) for subcutaneous cardiac pacemaker*

To assist with the correct code assignment for insertion of ICDs, review the documentation in the clinical record as to both the functionality and location of the electrode(s). In the absence of documentation of this information, assign the default code 38390-02 **[648]** *Insertion of permanent transvenous electrode into other heart chamber(s) for cardiac defibrillator*, by following the ACHI Alphabetic Index:

Insertion

- electrode(s) lead(s)

- - cardiac (for)

- - - defibrillator (automatic)

- - - - permanent

- - - - - transvenous (atrium) (right ventricle) 38390-02 **[648]**

Assign an additional code 38390-01 **[648]** *Insertion of permanent transvenous electrode into left ventricle for cardiac defibrillator* for insertion of an electrode into left ventricle if it is for a biventricular defibrillator.

Improvements to this area of classification will be considered for a future edition.

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

Reference:

Bänsch, D., Schneider, R., Akin, I. & Nienaber, C. A. 2015, 'A New Single Chamber Implantable Defibrillator with Atrial Sensing: A Practical Demonstration of Sensing and Ease of Implantation', *Journal of Visulized experiments: JoVE*, vol. 60, http://www.jove.com/video/3750/a-new-single-chamber-implantable-defibrillator-with-atrial-sensing

Rüdiger, K.; Klaus-Peter; H. & Robert, P. S. (2012). Defibrillators and ICD systems. *Springer Handbook of Medical Technology*.

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Ref No: Q2886 | Published On: 15-Mar-2015 | Status: Current

Skin rollering

Q:

What is the correct procedure code to assign for skin rollering?

A:

Skin rollering is also known as skin needling or percutaneous collagen induction therapy. A dermaroller with tiny stainless steel acupuncture needles causes multiple tiny pinpoint puncture wounds to the dermis. This dermal damage induces the production of new collagen and elastin, resulting in smooth skin, soft lines and reduction of stretch mark and scars through the skin's natural wound healing process. Skin rollering creates damage to the dermis but without the removal of the healthy epidermis, which happens with other resurfacing techniques.

As there is no specific ACHI code for skin rollering procedure, assign:

90676-00 **[1660]** *Other procedures on skin and subcutaneous tissue* following the index pathway:

Procedure

- skin (subcutaneous tissue) NEC 90676-00 **[1660]**

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Coding Rules

Published 15 December 2014

Ref No: P182 | Published On: 15-Dec-2014 | Status: Updated | Updated On: 15-Jun-2019

Middle East Respiratory Syndrome (MERS)

Q:

How do you code Middle East Respiratory Syndrome (MERS)?

A:

Middle East respiratory syndrome (MERS) is a condition caused by an infection with a new virus; Middle East Respiratory Syndrome coronavirus (MERS-CoA) (also known as novel coronavirus (nCoV) and human coronavirus-EMC (for Erasmus Medical Center)). It is suspected that some cases have originated from exposure to dromedary camels that were infected by carrier bats. Person-to-person transmission has also occurred, especially in healthcare settings.

The condition was first reported in the Middle East in 2012 and all cases to date have lived in or travelled to the Middle East, or have had close contact with people who acquired the infection in the Middle East (eg family members and healthcare personnel). Cases have been treated in the United Kingdom, Europe, the Netherlands, Egypt, Malaysia, the Phillipines and the United States of America. There have been no cases identified in Australia.

The syndrome usually manifests as a severe acute respiratory illness, such as pneumonia or acute respiratory distress syndrome (ARDS). Patients may also develop manifestations such as acute kidney injury, gastrointestinal symptoms, pericarditis or septic shock. Many of those who manifested with severe respiratory illness required admission to intensive care units, mechanical ventilation or extracorporeal membrane oxygenation.

There is no specific code for MERS in ICD-10 or ICD-10-AM; classification requires assignment of codes for any documented manifestations with an additional code for the aetiological organism (ie coronavirus).

For example:

J12.8 *Other viral pneumonia*

B97.2 *Coronavirus as the cause of diseases classified to other chapters*

and

U91 *Syndrome, not elsewhere classified*.

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

References:

Australian Government Department of Health. (2014). Information for clinicians, laboratories and public health personnel on MERS coronavirus. Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/Content/ohp-mers-cov-info-clphp.htm

Australian Government Department of Health. (2014). Middle East Respiratory Syndrome Coronavirus (MERS-CoV). Retrieved from http://www.health.gov.au/MERS-coronavirus

Centers for Disease Control and Prevention. (USA). (2014). Middle East Respiratory Syndrome (MERS). Retrieved from http://www.cdc.gov/coronavirus/MERS/index.html

McIntosh, K. (2014). Middle East respiratory syndrome coronavirus. Retrieved from http://www.uptodate.com/contents/middle-east-respiratory-syndrome-coronavirus (Topic 89705 Version 46.0).

Published 15 December 2014,
for implementation 01 January 2015.

Ref No: Q2892 | Published On: 15-Dec-2014 | Status: Current

Coats' disease and Eales' disease with diabetes mellitus

Q:

Should Coats' disease and Eales' disease be linked with diabetes mellitus? Both are classified to H35.0 *Background retinopathy and retinal vascular changes*, however they are not specifically indexed under the lead term Diabetes, nor are they listed as inclusions in code E1-.31 * *Diabetes mellitus with background retinopathy*.

A:

Neither Coats' disease nor Eales' disease are specified in the Alphabetic Index as either 'diabetic' or 'diabetes/with'. Although both conditions are classified to H35.0 *Background retinopathy and retinal vascular changes*, neither is associated with diabetes.

Eales' disease is an idiopathic obliterative vasculopathy that usually involves the peripheral retina of young adults.

Coats' disease, also called retinal telangiectasis, is an idiopathic disorder characterised by a defect of retinal vascular development that results in vessel leakage, subretinal exudation, and retinal detachment. The majority of Coats' disease is diagnosed between ages 8 and 16.

Therefore, Coats' disease and Eales' disease should not be linked to E1-.31 * *Diabetes mellitus with background retinopathy*.

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

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Ref No: Q2901 | Published On: 15-Dec-2014 | Status: Current

Radiofrequency pain management procedures

Q:

What are the correct procedure codes to assign for radiofrequency treatment of the medial branch nerve and superior cluneal nerve of the spinal nerves?

A:

Radiofrequency treatment or denervation of the medial branch of the spinal nerves is a percutaneous procedure performed to treat neck or back pain arising from facet joints of the spine. Facet joints are innervated by the medial branch of the dorsal rami of the spinal nerve. Damage to the facet joints such as injury (whip lash injury), inflammation or age leading to cervical, thoracic or lumbar back pain is treated by inserting a radiofrequency needle to disrupt the medial branch nerves.

The correct code to assign for radiofrequency denervation of the medial branch of the spinal nerves is 39118-00 **[72]** *Percutaneous neurotomy for facet joint denervation by radiofrequency* following the index pathway:

Denervation

- spinal facet

- - peripheral nerve, by

- - - radiofrequency (percutaneous) 39118-00 **[72]**

The superior cluneal nerve arises from the lateral branch of the posterior rami of the upper lumbar spinal nerves. Low back pain resulting from entrapment of the superior cluneal nerve is treated by radiofrequency destruction or by cluneal nerve block with injection of anaesthetic and steroid agents.

The correct code to assign for radiofrequency treatment of superior cluneal nerve is 39323-00 **[72]** *Other percutaneous neurotomy by radiofrequency* following the index pathways:

Destruction

- nerve — *see also Neurotomy*

AND

Neurotomy

- spinal

- - percutaneous

- - - branch, by

- - - - radiofrequency 39323-00 **[72]**

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Ref No: Q2806 | Published On: 15-Dec-2014 | Status: Current

Reactive arthritis due to LRTI

Q:

How do you code reactive arthritis due to lower respiratory tract infection (LRTI)?

A:

Reactive arthritis is an uncommon condition where there is inflammation of the joints in reaction to an infection elsewhere in the body that may or may not be present on admission. It is important to note that the infection is not within the affected joints themselves.

As per the note in the Tabular at M00–M03, indirect infections are referred to as a 'reactive arthropathy' or 'postinfective arthropathy':

- Direct infections of the joint are classified to:

  M00 *Pyogenic arthritis*
  M01* *Direct infections of joint in infectious and parasitic diseases classified elsewhere*

- Indirect infections of the joint are classified to:

  M02 *Reactive arthropathies*
  M03* *Postinfective and reactive arthropathies in diseases classified elsewhere*

The indexing under the lead terms Arthritis and Arthropathy, based on ICD-10, is inconsistent. Index options for M00–M01 should not be assigned for reactive arthritis as it is an indirect infection. Codes from the rubric M03* should only be assigned as per the specific infectious conditions listed (eg syphilitic, postmeningococcal, gastrointestinal conditions etc).

Therefore, the most appropriate classification for reactive arthritis NEC is M02 *Reactive arthropathies*.

For reactive arthritis post lower respiratory tract infection (LRTI), assign:

M02.8- *Other reactive arthropathies*

J22 *Unspecified acute lower respiratory infection*

using the following index pathways:

Arthropathy (see also Arthritis)

- reactive

- - specified NEC M02.8-

Infection, infected (opportunistic) (see also Infestation)

- respiratory (tract) NEC

- - lower (acute) J22

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

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for implementation 01 January 2015.

Ref No: Q2878 | Published On: 15-Dec-2014 | Status: Current

Principal diagnosis selection for a patient admitted with acute myocardial infarct (AMI) or acute coronary syndrome (ACS) with coronary artery bypass grafting (CABG) consequently performed

Q:

How do you apply ACS 0001 *Principal diagnosis* (and Example 1), to assign the principal diagnosis when a patient presents with an acute myocardial infarction (AMI) or acute coronary syndrome (ACS) and during the admission coronary artery bypass grafting (CABG) is performed?

A:

Example 1 in ACS 0001 *Principal diagnosis* illustrates the concept of 'after study' and describes how the principal diagnosis is determined after examining the entire clinical record. In this example, the patient is admitted with severe chest pain, but after study, it was determined that the acute myocardial infarction (AMI) was the condition 'chiefly responsible for occasioning the episode of care.'

Even though the coronary artery disease (CAD) was investigated and consequently treated, the primary focus of the episode of care was the diagnosis and treatment of AMI; firstly by confirmation of the AMI and secondly by rapid access to reperfusion therapy. Reperfusion therapy is treatment that prevents or minimises further tissue damage to the heart by restoring blood flow through blocked coronary arteries. It includes thrombolytic drugs, coronary artery angioplasty or coronary artery bypass grafting. Early reperfusion therapy is critical for eligible patients with AMI as the restored blood flow reintroduces oxygen within cells of the heart, resulting in improved cellular activity and heart function, ultimately reducing the probability of heart failure, arrhythmias and death.

ACS 0940 *Ischaemic heart disease* previously contained sequencing instructions for unstable angina and myocardial infarct and ACS 0909 *Coronary artery bypass grafts* contained sequencing instructions for angina and coronary artery disease These instructions did not follow the principles of ACS 0001*Principal diagnosis* in some episodes of care; for example, where a patient is admitted specifically for a coronary artery angiogram or bypass graft following recent AMI or refractory angina. In those circumstances it would be correct to assign CAD as the principal diagnosis.

Consequently the sequencing instructions in ACS 0909 *Coronary artery bypass grafts* and ACS 0940 *Ischaemic heart disease* were removed in the Seventh Edition and statements were added to specify that clinical coders should apply ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses* for sequencing of code assignment.

Improvements to the ACS in relation to the sequencing of AMI and CAD will be considered for a future edition.

Bibliography:

Mann D.L., Zipes D.P., Libby P. and Bonow R.O. (2011). Braunwald's Heart Disease: A Textbook of Cardiovascular Medicine, 9th edition. Elsevier Sanders.

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for implementation 01 January 2015.

Ref No: Q2902 | Published On: 15-Dec-2014 | Status: Current

Haemorrhoidal Artery Ligation and Rectal Anal Repair (HAL RAR)

Q:

What is the correct code for haemorrhoidal artery ligation and rectal anal repair (HAL RAR) procedure OR transanal haemorrhoidal dearterialisation (THD) with haemorrhoidopexy?

A:

Haemorrhoidal artery ligation and rectal anal repair (HAL RAR), also known as transanal haemorrhoidal dearterialisation (THD) with haemorrhoidopexy, is a minimally invasive procedure to treat haemorrhoids. The procedure usually consists of two components: haemorrhoid artery ligation (HAL) and transanal rectal repair (RAR).

HAL involves the use of a Doppler proctoscope, through which the arteries feeding the haemorrhoid are identified and ligated by placing stitches around the artery. Once all the blood vessels supplying the haemorrhoid have been tied off, the haemorrhoid shrinks and falls off.

The second part of the operation, known as RAR or haemorrhoidopexy, is performed to reduce the prolapse of the haemorrhoid and rectoanal mucosa by placing stitches to pull the haemorrhoid tissue back up into the upper anal canal.

Currently there is no specific code in ACHI for this procedure. Assign 32135-00 **[941]** *Rubber band ligation of haemorrhoids* for Doppler guided haemorrhoidal artery ligation (HAL) or transanal haemorrhoidal dearterialisation (THD), following the index pathway:

Ligation

- haemorrhoids (rubber band) 32135-00 **[941]**

If an adjunctive mucosal plication of rectal prolapse (RAR component of the procedure) or haemorrhoidopexy is performed, 32120-00 **[929]** *Insertion of anal suture for anorectal prolapse* should also be assigned, following the index pathway:

Repair

- prolapse, prolapsed
- - anorectal
- - - by insertion of anal suture (Thiersch wire) 32120-00 **[929]**

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

References:

Tsikitis, V. L. and Leeds, M.D. (2013). Anal Surgery for Haemorrhoids. Medscape. Retrieved from http://emedicine.medscape.com/article/1582358-overview#a15

McKay, G. (2013). Doppler-guided haemorrhoid artery ligation (HAL). Retrieved from http://colorectalsurgeonssydney.com.au/wp-content/uploads/2013/11/HAL-RAR.pdf

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for implementation 01 January 2015.

Coding Rules

Published 15 September 2014

Ref No: Q2802 | Published On: 15-Sep-2014 | Status: Updated | Updated On: 15-Jun-2022

Paediatric Autoimmune Neuropsychiatric Disorders (PANDAS)

Q:

What codes are assigned for a principal diagnosis of PANDAS, admitted for IV Intragam?

A:

PANDAS is an acronym for Paediatric Autoimmune Neuropsychiatric Disorders associated with group A ß-haemolytic streptococcal infections. Children and adolescents present with rapid onset of obsessive-compulsive disorder (OCD) and/or tic disorders. Treatment includes cognitive behavioural therapy, and pharmacotherapy with antibiotics to treat the streptococcal infection, intravenous (IV) immunoglobulin therapy and neuropsychiatric drugs. Symptoms usually persist for weeks to months with a slow, gradual improvement with some patients placed on prophylactic antibiotic therapy to prevent further streptococcal infections.

There is no specific code in ICD-10-AM for Paediatric Autoimmune Neuropsychiatric Disorders (PANDAS), therefore, apply the guidelines in ACS 0005 *Syndromes* and assign codes based on documentation in the health care record.

For the scenario cited, where the principal diagnosis in the health care record is specified as PANDAS and the admission is for IV administration of Intragam, assign:

M35.9 *Systemic involvement of connective tissue, unspecified*, as the principal diagnosis.

F06.7 *Mild cognitive disorder*as an additional diagnosis.

Follow the ICD-10-AM Alphabetic Index:

Disease, diseased

- autoimmune (systemic) NEC M35.9

Disorder (of) — *see also Disease*

- cognitive

- - due to or secondary to

- - - general medical condition F06.7

Also assign U91 *Syndrome, not elsewhere classified* to flag that the manifestations are related to a syndrome.

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

References:

U.S. National Institute of Mental Health (NIMH) 2012, *Intramural Research Program*, viewed September 2014, <http://intramural.nimh.nih.gov/pdn/web.htm>.

Published 15 September 2014,
for implementation 01 October 2014.

Ref No: Q2863 | Published On: 15-Sep-2014 | Status: Updated | Updated On: 01-Jul-2015

Catheterisation and cannulation in neonates

Q:

Is there a difference between catheterisation and cannulation in terms of ACS 1615? Does it refer only to catheterisation?

A:

There is no difference between these terms in ACS 1615 *Specific diseases and interventions related to the sick neonate*; it refers to both catheterisation and cannulation. Clinical advice has confirmed that the terms catheterisation and cannulation are used interchangeably and for classification purposes they are assigned to the same code.

Q:

For administration of IV antibiotics or other substance in a neonate, is it the expectation that a code would automatically be assigned for the catheterisation as an additional code?

A:

Where the catheter is used to administer antibiotics or other substance and meets the criteria in ACS 1615, two codes would be assigned, for example documentation of IV antibiotics via scalp vein would have the following codes assigned:

13300-01 **[738]** *Scalp vein catheterisation/cannulation in neonate*

96199-02 **[1920]** *Intravenous administration of pharmacological agent, anti-infective agent*

(96199-02 **[1920]** should only be assigned when antibiotics are given for >24 hours as per ACS 1615).

Where the site of the catheter is not specified and clinical confirmation cannot be sought, then a code for the catheterisation cannot be assigned.

Documentation of the site of the catheterisation is required as only the following catheterisations are to be coded as per ACS 1615:

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*

34524-00 **[694]** *Catheterisation/cannulation of other artery*

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: Q2689 | Published On: 15-Sep-2014 | Status: Current

Intensity Modulated Radiotherapy (IMRT)

Q:

When coding Intensity modulated radiation therapy (IMRT) is it correct to assign both 15524-01 **[1799]** *Dosimetry by CT interfacing computer* for intensity modulated radiation therapy [IMRT] and a code from block **[1788]** *Megavoltage radiation treatment* to indicate the linear accelerator used or is the use of the code 15524-01 **[1799]** *Dosimetry by CT interfacing computer* for intensity modulated radiation therapy [IMRT] sufficient?

A:

Intensity modulated radiation therapy (IMRT) uses a linear accelerator (LINAC) to deliver radiation in three-dimensional patterns that corresponds to the exact tumour location while sparing normal surrounding tissue (Radiological Society of North America, 2013).

Before IMRT is delivered, an individualised course of treatment is planned where a radiation physicist ensures the linear accelerator delivers the precise radiation dose and the computerised dose calculations are accurate. A dosimetrist works with the medical physicist to calculate the IMRT exposures and beam configurations necessary to deliver the dose prescribed by the radiation oncologist. The final treatment plan is verified on the machine with measurement by the medical physicist before being delivered to the patient (Radiological Society of North America, 2013).

This planning process is known as radiation dosimetry which is the calculation and assessment of the radiation dose received by the human body from external irradiation and is almost entirely computer based using CT data sets.

Clinical advice has confirmed that planning (dosimetry) and the actual radiation treatment (IMRT) are distinct processes and almost never undertaken on the same day. IMRT requires detailed planning which is completed days to weeks in advance of IMRT delivery.

If a patient is admitted for dosimetry planning, assign:

- 15524-01 **[1799]** *Dosimetry by CT interfacing computer for intensity modulated radiation therapy [IMRT]*

If a patient is admitted for radiation treatment with IMRT, assign:

- an appropriate code from block **[1788]** *Megavoltage radiation treatment*.

References:

Radiological Society of North America. (2014). Intensity modulated radiation therapy (IMRT).Retrieved from: http://www.radiologyinfo.org/en/info.cfm?pg=imrt

Radiological Society of North America. (2014). Linear accelerator. Retrieved from:http://www.radiologyinfo.org/en/info.cfm?pg=linac

Published 15 September 2014,
for implementation 01 October 2014.

Ref No: Q2908 | Published On: 15-Sep-2014 | Status: Current

Catheter based cardiac intervention with angiogram

Q:

Should a procedure code be assigned for cardiac catheterisation or coronary angiogram when they are performed with a catheter based cardiac intervention, e.g. percutaneous heart valve replacement?

A:

The term ‘cardiac catheterisation’ is a broad term for several related procedures. Cardiac catheterisation can be a purely diagnostic procedure where a catheter is inserted into heart chambers and valves to do various tests such as measuring intra-cardiac pressures, testing for cardiac shunts, and measuring cardiac output and flow. When the catheter is inserted into coronary arteries to evaluate coronary artery diseases, it is termed coronary angiogram. In recent decades, cardiac catheterisation has evolved from a purely diagnostic method into many important catheter based interventional procedures where cardiac catheterisation serves as a guiding catheter through which various instruments pass into the target site to perform specific procedures.

Classification:

When a cardiac catheterisation is performed alone (i.e. not in conjunction with other cardiac procedures), as a purely diagnostic procedure, assign an appropriate code from block **[667]** *Cardiac catheterisation*.

When a cardiac catheterisation is performed with coronary angiogram, assign an appropriate code from block **[668]** *Coronary angiography*.

When a cardiac catheter is performed in conjunction with a catheter based cardiac intervention e.g. percutaneous heart valve replacement, it is considered as an approach only, inherent in the procedure and therefore an additional code for cardiac catheterisation is not required.

When a coronary angiography is performed as an additional procedure during a catheter based cardiac intervention, assign 38215-00 *Coronary angiography*.

The ‘code also when performed coronary angiography’ instruction notes in Chapter 8 *Procedures on cardiovascular system* will be reviewed for a future edition of ACHI. Consideration will also be given to reviewing the codes in block **[667]** *Cardiac catheterisation* and block **[668]** *Coronary angiography* and relocating these codes to Chapter 20 Imaging services where they would be more appropriately located.

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for implementation 01 October 2014.

Coding Rules

Published 15 June 2014

Ref No: Q2720 | Published On: 15-Jun-2014 | Status: Updated | Updated On: 15-Jun-2022

Excision of neuroblastoma

Q:

What code is assigned for excision of spinal neuroblastoma?

A:

Assign 43987-02 **[80]** *Excision of neuroblastoma, not elsewhere classified* for excision of spinal neuroblastoma.

Follow the ACHI Alphabetic Index:

Excision

- neuroblastoma NEC 43987-02 **[80]**

This code is assigned for excision of neuroblastoma of an unspecified site or any site other than intra-abdominal or intrathoracic. In accordance with the *Conventions of the ACHI Alphabetic Index*:

> *NEC is listed in the ACHI Alphabetic Index after terms classified to unspecific codes, and to terms that are ill-defined, as a warning that specified forms of the intervention are classified differently.*

It does not indicate that another index subterm (such as *spinal extradural lesion*) may be followed to select another code.

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: Q2830 | Published On: 15-Jun-2014 | Status: Updated | Updated On: 15-Jun-2022

Necrotic leg ulcer with diabetes mellitus and peripheral vascular disease (PVD)

Q:

What is the correct code assignment for a principal diagnosis of leg (not foot) ulcer with necrotic tissue, on a background of type 2 diabetes with PVD; where the PVD meets the criteria for code assignment as per ACS 0002 *Additional diagnoses*, but there is no documentation of a clear relationship between the ulcer, gangrene and PVD. Should L97 or I70.23 be assigned as the principal diagnosis?

A:

The Alphabetic Index provides a 'with' association for peripheral vascular disease and ulceration of the extremities, so there is no need to identify a relationship between the ulcer, gangrene and PVD. The appropriate codes to assign for a leg ulcer with necrotic tissue, on a background of type 2 diabetes mellitus with peripheral vascular disease (PVD) are:

I70.23 *Atherosclerosis of arteries of extremities with ulceration*

E11.69 *Type 2 diabetes mellitus with other specified complication*

E11.52 *Type 2 diabetes mellitus with peripheral angiopathy, with gangrene*

following the Alphabetic Index:

Arteriosclerosis, arteriosclerotic

…

- extremities

- - with

- - - ulceration I70.23

Diabetes, diabetic

- with

…

- - angiopathy, peripheral – *see Diabetes/with/arterial disease, peripheral*

…

- - arterial disease, peripheral (without gangrene) E1-.51

- - - with

- - - - foot ulcer — *see ACS 0401 Diabetes mellitus and intermediate hyperglycaemia/6 Diabetic foot*

- - - - gangrene E1-.52

- - - - - and foot ulcer — *see ACS 0401 Diabetes mellitus and intermediate hyperglycaemia/6 Diabetic foot*

…

- - peripheral vascular disease (PVD) — *see Diabetes/with/arterial disease, peripheral*

…

- - ulcer, skin

- - - lower extremity E1-.69

- Diabetes with peripheral vascular disease with necrosis is classified to E11.52 *Type 2 diabetes mellitus with peripheral angiopathy, with gangrene*.
- Peripheral vascular disease with ulceration is classified to I70.23 *Atherosclerosis of arteries of extremities with ulceration*.
- E11.69 *Type 2 diabetes mellitus with other specified complication* is assigned following Rule 4a in ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* to classify diabetes with leg ulcer.
- Neither I70.24 *Atherosclerosis of arteries of extremities with gangrene* or L97 *Ulcer of lower limb, not elsewhere classified* are assigned as per Rule 6 of ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia.*

Also note, that I70.2- codes are not mutually exclusive, more than one can be assigned where multiple manifestations of PVD are documented.

Indexing 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.

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for implementation 01 July 2014.

Ref No: Q2768 | Published On: 15-Jun-2014 | Status: Updated | Updated On: 01-Jul-2017

Contrast induced acute kidney failure (injury)

Q:

What is the correct code to assign for contrast induced Acute Kidney Failure (AKF) or contrast-induced Acute Kidney Injury (AKI)?

A:

Contrast induced AKF (now commonly known as AKI) refers to an abrupt deterioration in kidney function which occurs after exposure to contrast media. The codes below are commonly assigned for this condition by following the index pathway ***Failure****/kidney/acute* and reinforced by Example 6 in ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia:*

- N17.9 *Acute kidney failure, unspecified*
- Y57.5 *X-ray contrast medium causing adverse effects in therapeutic use*

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

OR

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

However, assignment of N17.9 is incorrect if the excludes note (which is consistent with ICD-10) at N17-N19 *Kidney failure* is followed:

> "*Excludes: drug- and heavy-metal-induced tubulo-interstitial and tubular conditions* (N14.-)"

Analysis of code assignment in the data suggests it would be a major change in coding practice to assign N14.1 *Nephropathy induced by other drugs, medicaments and biological substances* rather than N17.9 *Acute kidney failure, unspecified* for contrast induced acute kidney failure (injury), therefore clinical coders should continue to assign N17.9 until further notice.

The classification for contrast induced AKI will be reviewed 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.

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U73.8 *Other specified activity*

Q:

When should U73.8 *Other specified activity* be assigned?

A:

The index pathway *Activity/specified NEC* should be followed and U73.8 *Other specified activity* assigned when an activity cannot be classified to any of these specified categories:

- *While engaged in sports or leisure* (U50–U72):
- U50–U71 specified sports/leisure activities
- U72 *Leisure activity, not elsewhere classified*
- *While engaged in other activity* (U73):
- U73.0 *While working for income*
- U73.1 *While engaged in other types of work*
- U73.2 *While resting, sleeping, eating or engaging in other vital activities*

Therefore, where an activity is specified but it is not listed under the lead term ***Activity*** and it cannot be classified to any of the above categories, assign U73.8 *Other specified activity.*

Note that for the code range V00–V99 *Transport accidents*, where the activity at the time of the accident is not specified as sport, leisure or working for an income, assign U73.9 *Unspecified activity*.

Note also that U72 *Leisure activity, not elsewhere classified* may be assigned for a wide range of activities that are not classified as sport (U50–U71) or work (U73.0 and U73.1), for example, walking the dog.

For sexual intercourse NEC assign U73.2 *While resting, sleeping, eating or engaging in other vital activities*.

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

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for implementation 01 July 2014.

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Aspiration pneumonia

Q:

Is it mandatory to assign an external cause code with J69.0 *Pneumonitis due to food and vomit* for documentation of aspiration pneumonia?

A:

Codes U50–Y98 must be assigned (as additional codes) to identify the external cause of conditions classified in Chapter 19 *Injury, poisoning and certain other consequences of external causes* (S00–T98) and with codes Z04.1–Z04.5 (see ACS 2001 *External cause code use and sequencing*).

An external cause code may also be assigned for conditions outside of this range to specify the external cause of a condition.

The instructional note at J69 *Pneumonitis due to solids and liquids – Use additional external cause code (Chapter 20) to identify cause* – is consistent with that in ICD-10 (and its modifications) and applies to all of the codes in the category and so should be assigned when its addition provides further specificity. For example when the external cause is specified as:

Food – also assign W79 *Inhalation and ingestion of food causing obstruction of respiratory tract*

or

Vomit – also assign W78 *Inhalation of gastric contents*.

Where aspiration pneumonia is documented and there is no indication of what was aspirated, do not assign an external cause code, as it will not provide any additional information.

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for implementation 01 July 2014.

Coding Rules

Published 15 March 2014

Ref No: Q2649 | Published On: 15-Mar-2014 | Status: Updated | Updated On: 15-Jun-2022

Confusion or delirium with dementia

Q:

What codes are assigned for confusion, acute confusion, confusional state and acute confusional state?

A:

Confusion NOS and delirium NOS are classified separately in ICD-10-AM.

Confusion NOS is a symptom of dementia and therefore where both of these conditions are documented, only a code for the dementia is assigned.

A code for delirium is only assigned when this condition is documented **or** when acute confusional state is specifically documented, in accordance with the ICD-10-AM Alphabetic Index:

State (of)

…

- confusional (psychogenic) F44.88

- - acute or subacute (*see also Delirium*) F05.9

A code for confusion, acute confusion, confusional state or acute confusional state is only assigned when the condition meets the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*.

Where:

- **confusion NOS** or **acute confusion** are documented, assign R41.0 *Disorientation, unspecified*
- **acute confusional state** is documented, assign F05.9 *Delirium, unspecified* (as a default — see also lead term *Delirium*)
- **confusional state** is documented, take care before assigning F44.88 *Other specified dissociative [conversion] disorders.*

  Do not assign F44.88 unless documentation within the health care record indicates that the patient has a dissociative [conversion] disorder. Where documentation is inadequate, seek advice from the treating clinician to determine if the patient has confusion, acute confusional state (ie delirium) or a true dissociative [conversion] disorder.

Where **acute confusional state/delirium** is specifically documented:

- as **due to another medical condition**, assign F05.8 *Other delirium* in addition to the medical condition
- in a patient who **also has dementia**, assign F05.1 *Delirium superimposed on dementia*
- in a patient who **also has dementia and** documentation states that the acute confusional state/delirium is due to a general medical condition, assign F05.8 *Other delirium* in addition to the general medical condition (other than dementia)

Follow the ICD-10-AM Alphabetic Index:

State (of)

…

- confusional (psychogenic) F44.88

- - acute or subacute (*see also Delirium*) F05.9

- - - with senility or dementia F05.1

Delirium, delirious (acute or subacute) (not alcohol- or drug-induced) F05.9

…

- due to (secondary to)

…

- - general medical condition F05.8

…

- mixed origin (dementia and other) F05.8

…

- superimposed on dementia F05.1

Note: The documentation does not have to specify 'superimposed on dementia'. The term 'superimposed' implies delirium **with** dementia.

If the documentation in the health care record is unclear as to whether the patient has confusion or delirium, seek advice from the treating clinician.

Amendments may be considered for a future edition.

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

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for implementation 01 April 2014.

Ref No: Q2786 | Published On: 15-Mar-2014 | Status: Updated | Updated On: 15-Jun-2019

Intraoperative floppy iris syndrome (IFIS)

Q:

What is the correct code to assign for intraoperative floppy iris syndrome?

A:

Intraoperative floppy iris syndrome (IFIS) is mainly encountered during cataract surgery and is characterised by a flaccid iris, the tendency for the iris to prolapse out of the incision and progressive intraoperative pupillary constriction. This triad of conditions although found during surgery is commonly related to alpha1 adrenergic antagonist prescribed for relief of lower urinary tract symptoms of benign prostatic hypertrophy (Friedman, 2009).

Other drugs associated with IFIS include saw palmetto, finasteride, antipsychotic drugs, angiotensin antagonists, and some beta-blockers with particular alpha-blocking properties.

Therefore, IFIS should be classified as an adverse effect of drug therapy and the following codes assigned:

H21.8 *Other specified disorders of iris and ciliary body*

H57.0 *Anomalies of pupillary function*

following the Alphabetic Index:

Prolapse, prolapsed

- iris (traumatic)

- - nontraumatic H21.8

Anomaly, anomalous (congenital) (unspecified type)

- pupil

- - function H57.0

and

U91 *Syndrome, not elsewhere classified*.

If a causal link is documented add:

Y40–Y59 *Drugs, medicaments and biological substances causing adverse effects in therapeutic use*

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

OR

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

Indexing improvements may 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.

Bibliography:

Friedman, AH. (2009). Tamsulosin and the Intraoperative Floppy Iris Syndrome. Journal of American Medical Association: 301(19):2044-2045. doi:10.1001/jama.2009.704.

Liaboe, L., Baker, M. & Oetting, T. (2013). Floppy Iris Syndrome. EyeRounds.org.Retrieved from: http://webeye.ophth.uiowa.edu/eyeforum/cases/169-IFIS.htm

Published 15 March 2014,
for implementation 01 April 2014.

Ref No: Q2683 | Published On: 15-Mar-2014 | Status: Updated | Updated On: 15-Jun-2022

Incisional inguinal hernia

Q:

How do you code an incisional inguinal hernia?

A:

Clinical advice indicates that incisional inguinal hernia is not a clinical concept. If this terminology is documented in the clinical record, clarification should be sought from the treating clinician.

If clinical clarification cannot be obtained, the following advice should be followed:

- Where incisional inguinal hernia is documented and there has been a previous inguinal hernia repair, it is a recurrent inguinal hernia and should be coded to K40 *Inguinal hernia* with a fifth character of 1 *recurrent*.
- Incisional hernias occur secondary to previous surgery, but NOT secondary to previous hernia surgery. Where incisional inguinal hernia is documented and there is no evidence in the clinical record that there was a previous inguinal hernia repair, assign a code from the range K43.0–K43.2.

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

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Ref No: Q2799 | Published On: 15-Mar-2014 | Status: Updated | Updated On: 15-Jun-2022

CADASIL

Q:

What is the correct code to assign for cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy (CADASIL)?

A:

Cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy (CADASIL) is a hereditary condition caused by a mutation in the NOTCH3 gene on chromosome 19q12. Accumulation of the pathologic NOTCH3 receptor protein in small and medium-sized cerebral arteries is responsible for thickening and fibrosis of the walls of these arteries resulting in cerebral infarctions. CADASIL is characterized by the clinical tetrad of dementia, psychiatric disturbances, migraine, and recurrent strokes. All components may not be present and the severity of associated symptoms and mode of presentation are highly variable. The most frequent presentation is recurrent ischaemic cerebrovascular episodes (transient ischemic attacks or cerebral infarctions) (Behrouz R, 2013).

There is no specific code for CADASIL in ICD-10-AM.

Clinical advice indicates that I67.3 *Progressive vascular leukoencephalopathy* is the most appropriate for CADASIL in ICD-10-AM.

Assign I67.3 *Progressive vascular leukoencephalopathy* following the index pathway:

Leukoencephalopathy *(see also Encephalopathy)*

- vascular, progressive I67.3

The manifestations of CADASIL, for example stroke or dementia, should be coded if they meet the criteria in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses.*

References:

Behrouz, R. (2013). CADASIL (Cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy) clinical presentation. Retrieved from: http://emedicine.medscape.com/article/1423170-clinical

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

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for implementation 01 April 2014.

Ref No: Q2803 | Published On: 15-Mar-2014 | Status: Current

Focal segmental glomerulosclerosis (FSGS)

Q:

What is the correct code to assign focal segmental glomerulosclerosis (FSGS)?

A:

Focal segmental glomerulosclerosis (FSGS) is a type of kidney disease that scars parts of the glomeruli, the filtering units of the kidney. The scarring occurs only in some of the glomeruli and only part of the individual glomerulus is damaged.

FSGS causes asymptomatic proteinuria or nephrotic syndrome with or without renal insufficiency.

The natural history of FSGS is variable and can range from oedema that is difficult to manage, to proteinuria that is refractory to corticosteroids and other immunosuppressive agents, to worsening hypertension and a progressive loss of renal function (Rao, S.T.K. 2013).

For documentation of FSGS assign an appropriate code from N00-N07, with a fourth character of .1 following the index pathway:

Sclerosis, sclerotic

- focal and segmental (glomerular) — *code to N00–N07 with fourth character .1.*

The appropriate codes are:

N00.1 *Acute nephritic syndrome, focal and segmental glomerular lesions*

N01.1 *Rapidly progressive nephritic syndrome, focal and segmental glomerular lesions*

N02.1 *Recurrent and persistent haematuria, focal and segmental glomerular lesions*

N03.1 *Chronic nephritic syndrome, focal and segmental glomerular lesions*

N04.1 *Nephrotic syndrome, focal and segmental glomerular lesions*

N05.1 *Unspecified nephritic syndrome, focal and segmental glomerular lesions*

N06.1 *Isolated proteinuria with focal and segmental glomerular lesions*

N07.1 *Hereditary nephropathy, not elsewhere classified, focal and segmental glomerular lesions*

Clarification should be sought from the clinician if the documentation in the clinical record does not support assignment of an appropriate code as per the list above.

When clarification from the clinician is not possible, clinical advice indicates that

N03.1 *Chronic nephritic syndrome, focal and segmental glomerular lesions* is the most appropriate code.

Indexing improvements will be considered for this condition for a future edition of ICD-10-AM.

References:

Rao, S.T.K. (2013). Focal Segmental Glomerulosclerosis. Emedicine.medscape.com.

Retrieved from: http://emedicine.medscape.com/article/245915-overview

Published 15 March 2014,
for implementation 01 April 2014.

Ref No: Q2798 | Published On: 15-Mar-2014 | Status: Current

Threadlift procedure

Q:

How do you code threadlift procedure?

A:

Threadlift procedure (suture lift, stitch lift) is a minimally invasive, nonsurgical cosmetic procedure performed for facial rejuvenation. Threadlift procedure is performed alone or in combination with fat/filler injection. The procedure is performed under local anaesthesia, with or without intravenous sedation.

Specialised suture material is inserted subcutaneously through the hairline or behind the ear using a long needle, towards the area being lifted. The threads/sutures are then used to pull the skin backwards towards the hairline to produce lift.

As there is no specific ACHI code for threadlift procedure, assign:

90676-00 **[1660]** *Other procedures of skin and subcutaneous tissue* following the index pathway:

Procedure

- skin (subcutaneous tissue) NEC 90676-00 **[1660]**

When fat/filler injection is also performed, assign 90660-00 **[1602]** *Administration of agent into skin and subcutaneous tissue*.

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for implementation 01 April 2014.

Coding Rules

Published 15 December 2013

Ref No: Q2813 | Published On: 15-Dec-2013 | Status: Updated | Updated On: 01-Jul-2017

Donor Lymphocyte Infusion

Q:

Is a donor lymphocyte infusion considered a stem cell transplant or is it a transfusion of a blood product?

A:

Donor lymphocyte infusion (DLI) is the administration of donated lymphocytes to patients who have previously received stem cell transplantation and have either residual disease or relapse of their leukaemia, lymphoma or myeloma. The donor lymphocytes recognise the patient's cells as foreign and attack them, causing a condition called graft versus host disease (GvHD). The benefit of this immune response is that the donor cells also kill any leukaemia cells present.

DLI is classified as 13706-04 **[1893]** *Administration of leukocytes* by following the Alphabetic Index:

Administration

- type of agent

- - donor leukocytes 13706-04 **[1893]**

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 2014.

Ref No: Q2659 | Published On: 15-Dec-2013 | Status: Updated | Updated On: 15-Jun-2022

Skin Necrosis

Q:

Should skin necrosis be coded the same as gangrene? When there is documentation of necrotic ulcer should both R02 and L97.- be assigned and if yes, in what order?

A:

ICD-10-AM classifies skin necrosis without further specification to R02 *Gangrene NEC* as per ICD-10. The above query does not specifically mention the wound site, but as L97.- *Ulcer of lower limb* is cited, it is assumed that the query relates to a lower limb necrotic/gangrenous ulcer.

When an ulcer is described as necrotic, gangrenous or with areas of skin necrosis it is appropriate to assign a code for the ulcer (L97.- in the case of lower limb ulcers) and R02 (except for pressure areas where necrosis is inherent in the staging) even though L97.- excludes R02 *Gangrene* (ie skin necrosis).

Code sequencing is determined by following the principles in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses* (see also *Note at the beginning of Chapter 18 Symptoms, signs and abnormal clinical findings, not elsewhere classified*).

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

Published 15 December 2013,
for implementation 01 January 2014.

Ref No: Q2835 | Published On: 15-Dec-2013 | Status: Current

Type 2 diabetes mellitus with hypercholesterolaemia or hyperlipidaemia

Q:

When hypercholesterolaemia and hyperlipidaemia meet the criteria in ACS 0002 should E78.0 *Pure hypercholesterolaemia* or E78.5 *Hyperlipidaemia, unspecified* be assigned in addition to elevated fasting triglycerides (E78.1 *Pure hyperglyceridaemia*) or depressed HDLs (E78.6 *Lipoprotein deficiency*) in a Type 2 diabetes mellitus patient with features of insulin resistance?

A:

The codes at category E78 *Disorders of lipoprotein metabolism and other lipidaemias* are not mutually exclusive and there are no index entries to preclude the assignment of E78.0 *Pure hypercholesterolaemia* and E78.5 *Hyperlipidaemia, unspecified* in addition to E78.1 *Pure hyperglyceridaemia* and E78.6 *Lipoprotein deficiency*.

For type 2 diabetes mellitus with features of insulin resistance, assign E78.0 *Pure hypercholesterolaemia* or E78.5 *Hyperlipidaemia, unspecified* in addition to E78.1 *Pure hyperglyceridaemia* and E78.6 *Lipoprotein deficiency* if these conditions meet the criteria in ACS 0002 *Additional diagnoses*.

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Ref No: Q2822 | Published On: 15-Dec-2013 | Status: Updated | Updated On: 15-Jun-2022

Portal Vein Thrombosis

Q:

How do you code a single portal vein thrombus extending into additional vessels, for example – Abdo CT states that the thrombus has extended into the splenic vein at its junction with the portal vein and also into the superior mesenteric artery.

A:

Portal vein thrombosis (PVT) is defined as thrombosis of the portal vein and/or its tributaries, which include the splenic vein and the superior and inferior mesenteric veins. Splenic vein thrombosis may occur with a patent portal vein. Thrombosis of the mesenteric veins without involvement of the portal vein is uncommon.

For the scenario cited, documentation of portal vein thrombosis, assign I81 *Portal vein thrombosis*. Additional codes should not be assigned to identify the thrombosis of the splenic vein or superior mesenteric vessel as this is part of the PVT.

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

References:

Boyer, T. (2008). Management of Portal Vein Thrombosis. Gastroenterology and hepatology (N Y) October; 4(10): 699–700. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3104181/

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

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Ref No: Q2815 | Published On: 15-Dec-2013 | Status: Updated | Updated On: 15-Jun-2022

Use of Z30.1 *Insertion of contraceptive device*

Q:

Is it necessary to assign Z30.1 *Insertion of contraceptive device* in any episode where a patient has a subdermal contraceptive implant inserted in addition to another procedure?

A:

It is correct to assign Z30.1 *Insertion of contraceptive device*, in addition to the procedure code 14203-00 **[1906]** *Direct subdermal hormone implantation*, when a subdermal hormone implant is inserted for the purpose of contraception. Similarly, Z30.1 is always assigned for insertion of intrauterine contraceptive device, in addition to the procedure code, when the intention is for contraceptive management.

This is consistent with previously published advice regarding the assignment of a code from subcategory Z30.2 *Sterilisation intervention* (See Coding Rule *Diagnosis code for sterilisation when performed in conjunction with other procedures*).

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

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Coding Rules

Published 15 June 2013

Ref No: Q2788 | Published On: 15-Jun-2013 | Status: Updated | Updated On: 15-Jun-2022

Removal of urethral sling following male stress incontinence procedure

Q:

What is the correct code to use for removal of urethral sling following male stress incontinence procedure?

A:

There is no specific procedure code for removal of urethral sling following previous stress incontinence procedure for male patients. ACHI does not distinguish between removal and revision procedures for male stress incontinence. The appropriate code for removal of a urethral sling for a male stress incontinence procedure is 37044-03 **[1109]** *Revision of retropubic procedure for stress incontinence, male* following index pathways:

Revision (partial) (total)

- sling procedure (for stress incontinence)

- - female 35599-01 **[1110]**

- - male 37044-03 **[1109]**

Or

Sling procedure (for stress incontinence)

- female 35599-00 **[1110]**

- - revision 35599-01 **[1110]**

- male 37044-00 **[1109]**

- - revision 37044-03 **[1109]**

Amendments may be considered for a future edition.

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

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Ref No: Q2730 | Published On: 15-Jun-2013 | Status: Current

Fluid overload, ESKD (end-stage kidney disease) and pulmonary oedema

Q:

What should be assigned as the principal diagnosis for fluid overload with end-stage kidney disease (ESKD) with/without pulmonary oedema?

A:

Fluid overload results from diseases where there is compromised regulation of sodium and water such as renal failure, congestive heart failure (CHF) and liver failure. Fluid overload in a patient with ESKD may cause cardiopulmonary complications such as pulmonary oedema (PO) and CHF. Patients may present with a combination of multiple cardiac and/or liver diseases and/or non-compliance with treatment which may contribute to fluid overload.

The selection of principal diagnosis (PDx) for a patient admitted with fluid overload depends on what other conditions are documented and the circumstances of the admission. Coders should be guided by ACS 0001 *Principal diagnosis, Problems and underlying conditions* and ACS 0002 *Additional diagnoses, Problems and underlying conditions*. Each case should be reviewed based on documentation and coders should seek clarification from the clinician where there is uncertainty regarding the principal diagnosis.

References:

Galanes, S and Gulanick, M (2012), Fluid Volume Excess - Hypervolemia; Fluid Overload, Elsevier, accessed: 20 March 2013, available: http://www1.us.elsevierhealth.com/MERLIN/Gulanick/archive/Constructor/gulanick22.html.

Ronco, C, Rossa Costanzo, M, Bellomo, R and Maisel, AS (2010), Fluid Overload: Diagnosis and Management, S.Karger AG, Basel (Switzerland).

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for implementation 01 July 2013.

Ref No: Q2680 | Published On: 15-Jun-2013 | Status: Current

Sedation and ventilation

Q:

Should a sedation code be assigned when sedation is administered for initiation of ventilation?

A:

Sedation that is administered to achieve anaesthesia for initiation of intubation/ventilation should be coded as per ACS 0031 *Anaesthesia, point 2. Sedation*.

Q:

Should a sedation code be assigned when ongoing sedation is administered with ventilation?

A:

Ongoing sedation is administered with many procedures for patient's comfort, control of anxiety and pain relief and should not be coded.

Bibliography:

Hogarth, DK and Hall, J (2004), Management of sedation in mechanically ventilated patients, accessed: 23/4/2013, available: http://www.consensus-conference.org/data/upload/consensus/1/pdf/737.pdf.

Brush, DR and Kress, JP (2009), Sedation and analgesia for the mechanically ventilated patient, Clinics in Chest Medicine, Vol. 30, No. 1, pp. 131–141.

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for implementation 01 July 2013.

Ref No: Q2719 | Published On: 15-Jun-2013 | Status: Updated | Updated On: 15-Jun-2022

Management of tracheostomy

Q:

In what circumstances is it appropriate to assign the following ACHI code: 90179-06 **[568]** *Management of tracheostomy*?

A:

Tracheostomy management includes care such as suctioning and cleaning. Assign 90179-06 **[568]** *Management of tracheostomy* where management of the tracheostomy alone is provided during an episode of care.

Do not assign this code:

- where the tracheostomy is initiated during the episode of care (see block **[536]** *Tracheostomy*)
- where associated ventilatory support is being provided (see block **[569]** *Ventilatory support*)
- for replacement or removal of tracheostomy tubes (see block **[568]** *Airway management*)
- for revision of tracheostomy (41881-02 **[541]** *Revision of tracheostomy*)
- for closure of tracheostomy (41879-02 **[539]** *Closure of external fistula of trache*a).

Q:

In what circumstances it is appropriate to assign the following ICD-10-AM code:

Z43.0 *Attention to tracheostomy*?

A:

Where a patient is admitted with an in situ tracheostomy which receives attention or management during the episode; such as revision, closure, tube replacement, or cleaning, also assign Z43.0 *Attention to tracheostomy*. This code is not assigned where there is a malfunction or complication of the tracheostomy, as in the excludes note at Z43.0.

Q:

In what circumstances it is appropriate to assign the following ICD-10-AM code:

Z93.0 *Tracheostomy status*?

A:

Assign Z93.0 *Tracheostomy status* where a patient is admitted with an in situ tracheostomy and it is determined that the presence of the tracheostomy meets the criteria in ACS 0002 *Additional diagnoses*; however it does not fall within the bounds of the scenarios cited above.

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

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Ref No: Q2644 | Published On: 15-Jun-2013 | Status: Updated | Updated On: 15-Jun-2022

Anaemia secondary to angiodysplasia of the colon

Q:

What codes should be used if a patient is admitted for anaemia secondary to angiodysplasia of the colon?

A:

Clinical advice confirms that the diagnostic statement 'anaemia secondary to angiodysplasia of the colon' indicates a causal link, that is, there is bleeding from the site of the angiodysplasia resulting in the anaemia. Codes should be assigned as follows:

Anaemia - D50.0 *Iron deficiency anaemia secondary to blood loss (chronic)* or
D62 *Acute posthaemorrhagic anaemia* as appropriate, following an index pathway such as:

Anaemia/due to/haemorrhage (chronic)

Anaemia/secondary to/blood loss (chronic)

Haemorrhage, haemorrhagic/anaemia (chronic)

Angiodysplasia - K55.22 *Angiodysplasia of colon with haemorrhage* following the index pathway:

Angiodysplasia/with haemorrhage.

Q:

Can angiodysplasia of the colon without haemorrhage still result in anaemia?

A:

Angiodysplasia will only cause anaemia when it bleeds.

Q:

Does the haemorrhage from the angiodysplasia have to be an overt haemorrhage, or can it be very slow and slight as might be expected from a vascular lesion?

A:

The blood loss may be of varying degrees, from a low grade, chronic bleed, which may be indicated by a positive faecal occult test or melaena, through to an acute, profound bleed which is life threatening.

Q:

Does the haemorrhage have to be present in the episode in order to code the angiodysplasia as ‘with haemorrhage’?

A:

Bleeding from angiodysplasia is usually intermittent and therefore may not be apparent in the admission, however where indicated by the clinical documentation, eg. ‘angiodyplasia of colon with haemorrhage’ or ‘anaemia secondary to angiodysplasia of the colon’, the condition should be considered as being ‘due to’/’with’ haemorrhage.

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

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Coding Rules

Published 15 December 2012

Ref No: Q2782 | Published On: 15-Dec-2012 | Status: Updated | Updated On: 15-Jun-2022

CIN III as principal diagnosis and indication for LLETZ procedure

Q:

What should be assigned as principal diagnosis when CIN III is documented on a Pap smear as the indication for LLETZ procedure, however histopathology after the procedure reveals CIN II or CIN I?

A:

A Large Loop Excision of the Transformation Zone (LLETZ) procedure of the cervix is performed after an abnormal Pap smear to treat pre-cancerous cells (CIN II/CIN III or high grade squamous intraepithelial lesions (HSIL/HGSIL)). This procedure uses an electric current passed through a fine wire loop electrode to shave abnormal tissue from the transformation zone of the cervix. This tissue is then sent for pathological analysis.

Clinical advice confirms that a code for the higher grade lesion (CIN III) should be assigned as the principal diagnosis.

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

Bibliography:

Australian Government Department of Health and Ageing 2006, *National Cervical Screening Program resources - "An abnormal Pap smear result: What this means for you?"*, viewed: September 2012, <http://www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/EFAA19DECAA2111ACA2574EB007F73AF/$File/pap-smear.pdf.>.

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for implementation 01 January 2013.

Ref No: Q2687 | Published On: 15-Dec-2012 | Status: Updated | Updated On: 15-Jun-2022

Principal diagnosis for prophylactic PEG insertion prior to oropharyngeal radiation therapy

Q:

When a patient is admitted for prophylactic PEG insertion prior to undergoing oropharyngeal radiation therapy for a malignant neoplasm of the tonsil, would the principal diagnosis be a code for the neoplasm or Z51.4 *Preparatory care for subsequent treatment, not elsewhere classified*?

A:

Z51.4 *Preparatory care for subsequent treatment, not elsewhere classified* is a non-specific code and the above preparatory care interventions are considered part of the treatment of the condition (usually a neoplasm). Therefore, the data collection is better served by assigning a condition code with an intervention code specially describing the reason for admission.

Assign a code for the condition necessitating the insertion of the PEG as the principal diagnosis.

Amendments will be considered for a future edition.

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

Reference:

National Centre for Classification in Health (2010), *Coding Matters, The 10-AM Commandments*, Vol. 16, No. 4.

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Ref No: Q2647 | Published On: 15-Dec-2012 | Status: Updated | Updated On: 15-Jun-2022

Insertion of Steinman pin for traction

Q:

What is the correct procedure code to assign for closed reduction of shaft of femur with percutaneous insertion of Steinman pin to proximal tibia?

A:

Clinical advice confirms that insertion of a Steinman pin is to aid the application of the skeletal traction (the closed reduction) and is considered an external fixation device not internal fixation of the fracture.

The appropriate code to assign for closed reduction of shaft of femur with percutaneous insertion of Steinman pin to proximal tibia is 47516-01 **[1486]** *Closed reduction of fracture of femur* following index pathway:

Reduction

- fracture

- - femur (closed) NEC 47516-01 **[1486]**

The *Note* at Chapter 15 *Procedures on musculoskeletal system* provides the following definition:

> Closed reduction — *involves correction of a dislocation/fracture without operative exposure and includes additional external fixation*

Therefore, it is not necessary to assign an additional code for insertion of the Steinman pin.

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

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Diagnosis code for sterilisation when performed in conjunction with other procedures

Q:

When an elective sterilisation is performed at the same time as another procedure, eg. a caesarean section, is it necessary to assign a code from subcategory Z30.2 *Sterilisation intervention* as an additional diagnosis?

A:

It is correct to assign a code from subcategory Z30.2 *Sterilisation intervention* as an additional diagnosis code when a sterilisation procedure is performed electively in the same operative episode as another procedure, such as a caesarean section. Assignment of the procedure code alone does not indicate that the procedure has been performed electively, rather than for a medical reason.

This is consistent with international coding practice.

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

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Coding Rules

Published 15 June 2012

Ref No: Q2712 | Published On: 15-Jun-2012 | Status: Updated | Updated On: 15-Jun-2022

Ultrasound guided compression repair of pseudoaneurysm

Q:

Can you please clarify how to code ultrasound guided compression repair of a pseudoaneurysm?

A:

Ultrasound guided compression repair of a pseudoaneurysm meets the definition of a procedure as per ACS 0016 *General procedure guidelines*, as it:

- carries a procedural risk
- may carry an anaesthetic (sedation) risk
- requires specialised training

The correct code to assign for repair of cubital fossa pseudoaneurysm using ultrasound guided compression is 92205-00 **[1908]** *Noninvasive therapeutic intervention, not elsewhere classified*, following the pathway:

Procedure

- therapeutic NEC 92205-00 **[1908]**

Do not assign an ACHI code for the ultrasound component, in accordance with the guidelines in ACS 0042 *Procedures normally not coded* and ACS 0016 *General procedure guidelines*, as it is inherent in the compression procedure.

See also Coding Rule *CT guided core biopsy of the lung*.

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

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Ref No: Q2770 | Published On: 15-Jun-2012 | Status: Updated | Updated On: 15-Jun-2019

Alternating hemiplegia of childhood

Q:

What is the correct code to assign for alternating hemiplegia of childhood (AHC)?

A:

Alternating hemiplegia of childhood is a rare neurological disorder of uncertain aetiology, also referred to as AHC or alternating hemiplegia syndrome. Current research indicates that the disorder may be caused by a gene mutation. AHC is characterised by recurrent hemiplegic attacks that alternate in laterality, paroxysmal attacks including dystonic spells, oculomotor abnormalities or autonomic symptoms, global neurological impairment or neurologic findings such as ataxia, dystonia or choreoathetosis. Symptoms usually manifest before eighteen months of age and can be resolved by sleep. Where alternating hemiplegia of childhood is documented, assign G98 *Other disorders of nervous system, not elsewhere classifie*d, following the Alphabetic Index:

Disorder

- nervous system

- - specified NEC G98

and

U91 *Syndrome, not elsewhere classified.*

Refer to ACS 0005 *Syndromes* for guidelines with regards to coding manifestations.

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

References:

National Organisation for Rare Disorders, Inc. (NORD) (2012), *Rare Diseases database*, accessed: May 2012, available: http://www.rarediseases.org/rare-disease-information/rare-diseasesOrphanet (2012), *Orphanet: The portal for rare diseases and orphan drugs*, accessed: May 2012, available: http://www.orpha.net

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Ref No: Q2763 | Published On: 15-Jun-2012 | Status: Updated | Updated On: 15-Jun-2019

Banding of GAVE at gastroscopy

Q:

What procedure code should be assigned for gastroscopy with banding of the vascular lesions in a patient with gastric antral vascular ectasia (GAVE)? The only banding code available is for banding of gastric varices.

A:

GAVE, or watermelon stomach, is a form of gastrointestinal vascular malformation where oozing haemorrhages, resembling red watermelon stripes, are seen in the gastric antrum on endoscopy. Endoscopic band ligation (EBL), which is routinely used for the treatment of oesophageal and gastric varices, has also been found to be effective in controlling bleeding from nonvariceal gastrointestinal disorders such as GAVE.

The correct code to assign for EBL of GAVE lesions is 30476-03 **[874]** *Endoscopic banding of gastric varices*.

Although this code title specifies 'gastric varices' it is the same procedure as that used to treat GAVE.

Amendments may be considered for a future edition.

Bibliography:

National Centre for Classification in Health 2006, 'Gastric antral vascular ectasia (GAVE)', Coding Matters, vol.13, no.1, p.5

Selinger, C and Ang, Y 2008, 'Gastric Antral Vascular Extasia (GAVE): An update on clinical presentation, pathophysiology and treatment', Digestion, International Journal of Gastroenterology, vol.77, no.2, pp.131-137

Wells, C, Harrison, M, Gurudu, S, Crowell, M, Byrne, T, DePetris, G, and Sharma, V 2008, 'Treatment of gastric antral vascular ectasia (watermelon stomach) with endoscopic band ligation', Gastrointestinal Endoscopy, vol.68, no.2, pp.231–236

Zepeda-Gomez, S and Marcon, N 2008, 'Endoscopic band ligation for nonvariceal bleeding: A review', Canadian Journal of Gastroenterology, vol.22, no.9, pp.748-752

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Ref No: Q2756 | Published On: 15-Jun-2012 | Status: Updated | Updated On: 15-Jun-2022

Diabetes mellitus and unspecified proteinuria

Q:

Can E1-.22 **diabetes mellitus with established diabetic nephropathy* be assigned for diabetes mellitus and unspecified proteinuria?

A:

Please refer to the rules in ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia*.

E1-.22 **diabetes mellitus with established diabetic nephropathy* should not be assigned unless the proteinuria is described as 'fixed' or 'persistent'. The terms 'fixed' and 'persistent' are correctly listed as essential modifiers in the Alphabetic Index. There is no default code at the Index entry *Diabetes, with, proteinuria* as unspecified proteinuria is not linked with diabetes mellitus. Where there is no link the two conditions, diabetes mellitus and proteinuria, should be coded independently.

Diabetes, diabetic

- with

- - proteinuria

- - - with end-stage kidney disease (ESKD) *(see also Diabetes, with, chronic kidney disease)* E1-.22

- - - fixed E1-.22

- - - persistent E1-.22

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

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Ref No: Q2714 | Published On: 15-Jun-2012 | Status: Current

Coding of 'diabetic conditions'

Q:

What is the correct code assignment and sequence for a 'diabetic' condition?

In particular, what codes should be assigned for 'diabetic diarrhoea' and how should the codes be sequenced?

A:

Please refer to ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision. To code "diabetic" conditions refer to ACS 0401 *Diabetes mellitus and impaired glucose regulation*, which includes guidelines for coding 'diabetic' conditions, *Rule 2* states:

> "The terms 'diabetic', 'due to' or 'secondary to' infer a causal relationship between the DM and other conditions. Where such terms are used check the Alphabetic Index for appropriate codes indexed directly under *Diabetes, diabetic* or appropriate codes indexed under the lead term for the condition with a subterm *diabetic*..."

Therefore to code 'diabetic diarrhoea', follow the index pathway *Diabetes, diabetic, diarrhoea* to assign E1-.43 **Diabetes mellitus with diabetic autonomic neuropathy*. 'Diabetic diarrhoea' is an inclusion term at E1-.43 because it is a type of diarrhoea peculiar to diabetes and is symptomatic of diabetic neuropathy. K52.9 *Noninfective gastroenteritis and colitis, unspecified* may also be assigned as an additional code according to ACS 0401, *Rule 4b* following the index pathway:

Diarrhoea

- noninfectious K52.9

The codes should be sequenced according to ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*.

If a complication of diabetes mellitus is documented as 'diabetic' yet there are no appropriate index entries directly under *Diabetes, diabetic* then follow ACS 0401, *Rule 3* and *Rule 4a* to assign a diabetes mellitus code and *Rule 4b* and *Rule 6* to assign a code for the other condition.

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Coding Rules

Published 15 December 2011

Ref No: Q2721 | Published On: 15-Dec-2011 | Status: Updated | Updated On: 15-Jun-2019

Same-day admission for both radiotherapy and chemotherapy

Q:

What is the correct principal diagnosis to assign in a same day episode of care when both radiotherapy under general anaesthetic and intravenous pharmacotherapy is given for treatment of a neoplasm?

A:

For the scenario cited assign the principal diagnosis according to the guidelines in ACS 0001 *Principal diagnosis*, which states:

> *"**Two or more diagnoses that equally meet the definition for principal diagnosis***
> *When two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic work-up and/or therapy provided, and the Alphabetic Index, Tabular List or the standard does not provide sequencing direction, the clinician should be asked to indicate which diagnosis best meets the principal diagnosis definition.*
> *If no further information is available, code as the principal diagnosis the first mentioned diagnosis."*

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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Healthcare associated *Staphylococcus aureus* bloodstream infection (HA-SABSI)

Q:

Is a condition onset flag (COF) of 1 assigned in the first admitted episode of care where HA-SABSI is diagnosed and a COF of 2 assigned for any subsequent admitted episode of care relating to the previously diagnosed HA-SABSI?

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*.

Therefore, a condition onset flag of 1 is assigned in the episode of care where *Healthcare associated Staphylococcus aureus bloodstream infection* (HA-SABSI) first arose and a condition onset flag of 2 is assigned in any subsequent episode of care relating to the previously diagnosed HA-SABSI, as it arose before the current admitted patient episode of care.

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

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Coding Rules

Published 15 June 2011

Ref No: Q2640 | Published On: 15-Jun-2011 | Status: Updated | Updated On: 15-Jun-2022

Cause of death and ACS 0002 *Additional diagnoses*

Q:

A patient is planned for discharge after a two week admission for cellulitis of the toe with PVD. The clinical record noted that the patient had a history of ischaemic heart disease but it did not meet the criteria for code assignment as per ACS 0002 *Additional diagnoses*. On the planned day of discharge the patient is found dead in their bed. Myocardial infarction is subsequently listed on the death certificate as the cause of death. Should the myocardial infarction be coded for epidemiological purposes even though it does not meet the criteria for code assignment as per ACS 0002?

A:

In the scenario cited, the cause of death (myocardial infarction) should not be coded, as it does not meet the criteria for code assignment as per ACS 0002 *Additional diagnoses*, which states:

> *Additional diagnoses are conditions that significantly affect patient management in an episode of care in terms of requiring any of the following:*
>
> - *commencement, alteration or adjustment of therapeutic treatment*
> - *diagnostic interventions*
> - *increased clinical care.*

ACS 0002 does not mention collection of information for epidemiological purposes, but states that additional diagnoses are coded to collect information about the care provided in Australian hospitals for the Admitted Patient Care National Minimum Data Set (APC NMDS):

> *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.*

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 Rules

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Ref No: Q2620 | Published On: 15-Apr-2011 | Status: Updated | Updated On: 15-Jun-2022

Principal diagnosis for insertion of fiducial markers (use of Z51.4 *Preparatory care for subsequent treatment, not elsewhere classified*)

Q:

What is the correct principal diagnosis code to assign in an admission for insertion of fiducial markers? Should the principal diagnosis be the condition necessitating insertion of fiducial markers or Z51.4 *Preparatory care for subsequent treatment, not elsewhere classified*?

A:

Z51.4 *Preparatory care for subsequent treatment, not elsewhere classified* is a non-specific code and the above preparatory care interventions are considered part of the treatment of the condition (usually a neoplasm). Therefore, the data collection is better served by assigning a condition code with an intervention code specially describing the reason for admission.

Assign a code for the condition necessitating the insertion of fiducial markers as the principal diagnosis.

Amendments will be considered for a future edition.

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

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Hypertensive kidney disease with kidney failure (I12.0)

Q:

Is I12.0 *Hypertensive kidney disease with kidney failure* intended for use when hypertensive kidney disease is present with acute kidney failure?

A:

Clinical advice states that:

- Hypertension can be associated with all forms of renal disease. However, it is unlikely that sustained hypertension per se will arise from, and be the cause of, chronic kidney disease (CKD) if acute kidney failure/injury fully resolves.
- Clinically acute kidney failure/injury is a separate condition from chronic kidney disease (CKD), though it may result in CKD if it does not fully resolve.
- Hypertension can pre-date acute kidney failure/injury, of course, and may well outlast it.
- Hypertension can also persist, having arisen due to the acute kidney failure/injury, if the acute kidney failure/injury does not fully resolve.
- Many forms of acute kidney failure/injury are associated with hypertension.
- Rapidly progressive hypertension (and malignant hypertension) can cause acute kidney failure/injury and result in CKD (and/or permanent complete loss of renal function).

Lawrence McMahon, Professor of Nephrology, Monash University (personal communication, 16 September 2010).

So, clinically, while there is an association between acute kidney failure/injury and hypertension and unresolved acute kidney failure/injury may progress to CKD, there is no direct cause and effect relationship between acute kidney failure/injury and hypertensive kidney disease. Category I12 *Hypertensive kidney disease* does not include the concept of acute renal failure and specifies only those conditions where there is a causal relationship between certain kidney conditions and hypertension, specifically:

> *"any condition in N00-N07, N18.-, N19 or N26 due to hypertension arteriosclerosis of kidney arteriosclerotic nephritis (chronic)(interstitial) hypertensive nephropathy nephrosclerosis"*

This is further confirmed in ACS 1438 *Chronic kidney disease/Stages of chronic kidney disease (CKD)* where it states:

> *Under the definition of chronic kidney disease, 'kidney failure' in a chronic context, is not described until the kidneys have ceased to function, that is, failed. This is CKD stage 5, as measured by the estimated or measured glomerular filtration rate (eGFR/GFR) or the requirement for ongoing kidney replacement therapy, or by documentation of 'end-stage' kidney failure. Therefore, 'failure' status must be validated by documentation and/or eGFR/GFR level before assigning codes qualified by 'with kidney failure', for example, I12.0* Hypertensive kidney disease with kidney failure*.*

In summary, I12.0 *Hypertensive kidney disease with kidney failure* does not include the concept of acute renal failure, and can only be assigned with acute renal failure in instances where acute on chronic renal failure is documented.

Amendments may be considered for a future edition.

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

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Pelvic collection

Q:

What is the correct disease code for 'pelvic collection'?

A:

'Pelvic collection' is not a diagnosis but a sign of other conditions. For example, it may be a sign of pelvic inflammatory disease, or a sign of malignancy, or a sign of infection after procedures on pelvic organs (such as pus collection in the Pouch of Douglas after vaginal hysterectomy). The 'collection' itself may be of blood, peritoneal fluid, bowel contents, pus or an abscess. To assign the correct code(s) for 'pelvic collection' follow the guidelines below:

1. First seek further documentation/clinical advice to determine a diagnosis or to establish the nature of the sign (eg infection, abscess, blood), then code accordingly, for example:
   - pelvic inflammatory disease (N73.9 *Female pelvic inflammatory disease, unspecified*)
   - postprocedural abscess of peritoneum (T81.4 *Wound infection following a procedure, not elsewhere classified*).
2. In instances where the collection is stated as due to a procedure follow direction provided in ACS 1904 *Procedural Complications.*
3. If further documentation/clinical advice is not available, assign:
   R19.89 *Other specified symptoms and signs involving the digestive system and abdomen* following the Alphabetic Index:

Symptoms specified NEC

- involving

- - pelvis NEC R19.89

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 Rules

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Anaemia in chronic diseases

Q:

When can code D63* *Anaemia in chronic diseases* classified elsewhere be assigned?

A:

This code can only be assigned for the following indexed conditions:

Anaemia

- brickmaker's B76.9+ D63*
- Diphyllobothrium (Dibothriocephalus) B70.0+ D63*
- due to
- - myxoedema E03.9+ D63*
- Egyptian B76.9+ D63*
- hookworm B76.9+ D63*
- malarial *(see also Malaria)* B54+ D63*
- marsh *(see also Malaria)* B54+ D63*
- miner's B76.9+ D63*
- paludal *(see also Malaria)* B54+ D63*
- syphilitic (acquired) (late) A52.7+ D63*
- tropical B76.9+ D63*
- tuberculous A18.8+ D63*

Chlorosis

- Egyptian B76.9+ D63*
- miner's B76.9+ D63*

Syphilis, syphilitic (acquired)

- anaemia (late) A52.7+ D63*

Tuberculosis, tubercular, tuberculous (caseous) (degeneration) (gangrene) (necrosis)

- anaemia A18.8+ D63*

Follow coding guidelines relating to aetiology and manifestation (dagger and asterisk) convention in ACS 0001 *Principal diagnosis.*

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 Rules

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Candida urinary tract infection (UTI)

Q:

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

A:

The finding of *Candida* in urine is mostly insignificant and occurs as a result of contamination or asymptomatic colonisation. It is often associated with the use of urinary catheters or antimicrobial therapy and many cases resolve spontaneously. If there is documentation of *Candiduria* or a *Candidal UTI* that meets the criteria for code assignment as per ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses,* assign B37.4 *Candidiasis of other urogenital sites*.

Follow the ICD-10-AM Alphabetic Index:

Infection

- Candida — *see also Candidiasis*

Candidiasis, candidal

- urogenital site NEC B37.4

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

Bibliography

Doctor Fungus, Urinary Candidiasis. Retrieved 31 March, 2010. http://www.doctorfungus.org/mycoses/HUMAN/Candida/urinary.php

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Ref No: TN196 | Published On: 15-Jun-2010 | Status: Updated | Updated On: 15-Jun-2022 | Supersedes: TN393

Crush and compression fractures

Q:

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

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

A:

Both crush and compression fractures, without further specification, should be coded to *Fracture*, by site.

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

Fracture (circumstances unknown or unspecified) X59

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

Osteoporosis causes severe weakening of the bones and can cause fractures, particularly lumbar fractures.

If a fracture is documented as being associated with osteoporosis, then assign the appropriate code from category M80 *Osteoporosis with pathological fracture.*

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

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

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Poststreptococcal glomerulonephritis

Q:

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

A:

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

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

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

Glomerulonephritis *(see also Nephritis)*

- poststreptococcal NEC N05.9 and

Infection, infected

- *Streptococcus*, streptococcal NEC

- - Group

- - - A, as the cause of disease classified to other chapters B95.0

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

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

Bibliography

Emedicine, Bhimma, R., Acute Poststreptococcal Glomerulonephritis. Retrieved 8 December, 2009. http://emedicine.medscape.com/article/980685-overviewMedline Plus, Post-streptococcal glomerulonephritis (GN). Retrieved 8 December 2009. http://www.nlm.nih.gov/medlineplus/ency/article/000503.htm

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Intrathecal pump refill

Q:

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

A:

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

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

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

Admission

- adjustment (of) — *see Adjustment*

Adjustment — *continued*

- device (related to) NEC Z46.9

- - drug delivery or pump (CADD) (external) (implantable spinal) Z45.1

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Traumatic amputation

Q:

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

A:

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

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

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Coding Rules

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Aortic valve replacement - mechanical versus bioprosthetic

Q:

What is the correct code to assign for a valve replacement which is a combination of a bioprosthesis and a mechanical prosthesis, that is, a pig valve within a metal stent?

A:

The aortic valve described above should be assigned 38488-01 **[623]** *Replacement of aortic valve with bioprosthesis*. In porcine valves, the valve tissue is sewn to a metal wire stent, which acts as a frame, and is considered a bioprosthesis. Mechanical valves do not contain any tissue. Examples include the *caged-ball, tilting-disk and bileaflet* valves.

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Ref No: TN197 | Published On: 15-Mar-2010 | Status: Current

External cause code for adult walker with wheels

Q:

What is the correct external cause code for a fall on the same level while pushing an adult walker with wheels?

A:

ACS 2009 *Mode of pedestrian conveyance* states: “A pedestrian conveyance can be defined as ‘something that serves as a means of transportation’ and includes scooters, rollerskates, wheelchairs, skateboards, etc.”

An adult walker with wheels does not meet the above definition of a pedestrian conveyance. That is, it is not used as a means of transportation but rather as an aid to walking.

Therefore, the correct external cause code for a fall, on the same level, while pushing an adult walker with wheels, is either W18.8 *Other specified fall on same level* or the appropriate code from category W01 *Fall on same level from slipping, tripping and stumbling*, depending on the circumstances of the fall.

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Ref No: TN197 | Published On: 15-Mar-2010 | Status: Updated | Updated On: 15-Jun-2022

Brachytherapy planning

Q:

Is it acceptable to assign Z51.4 *Preparatory care for subsequent treatment* as the principal diagnosis when a patient is admitted for brachytherapy planning or should the principal diagnosis be the cancer?

A:

Z51.4 *Preparatory care for subsequent treatment, not elsewhere classified* is a non-specific code and the above preparatory care interventions are considered part of the treatment of the condition (usually a neoplasm). Therefore, the data collection is better served by assigning a condition code with an intervention code specially describing the reason for admission.

Assign a code for the condition necessitating the brachytherapy planning as the principal diagnosis.

Amendments will be considered for a future edition.

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

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Coding Rules

Published 15 December 2009

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Bipolar affective disorder

Q:

The ICD-10-AM Alphabetic Index contains index entries under *Disorder, bipolar, affective* for 'current episode' and 'most recent episode'. What do these terms mean when assigning a code for bipolar affective disorder?

A:

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

There should be documentation in the current episode of care of the 'current' or 'most recent' affective episode before selecting either of these terms from the index pathway:

Disorder

- bipolar

- - affective

If the 'episode' is not documented, and cannot be verified with the clinician, assign the default code F31.9 *Bipolar affective disorder, unspecified*. Coders should not assume that outpatient notes or other admission notes are indicative of the most recent affective state.

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

Q:

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

A:

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

> 'End-of-(battery) life is an indication for elective replacement of the pacemaker or defibrillator generator (device)... Admission for elective replacement of pacemaker or defibrillator is assigned code: Z45.0 *Adjustment and management of cardiac device* together with the appropriate procedure code(s).'

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

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Coding Rules

Published 15 June 2009

Ref No: TN200 | Published On: 15-Jun-2009 | Status: Current

Fall while water skiing

Q:

What is the correct external cause code to assign for fall causing injury (other than drowning/submersion injury) while water skiing?

A:

The correct external cause code to assign for fall from water skis causing injury (other than drowning/submersion injury) is W02.2 *Fall involving water ski* following the index pathway:

Fall, falling (accidental)

- involving

- - conveyance, pedestrian

- - - not in collision with pedestrian

- - - - ski(s)

- - - - - water W02.2

Water ski accidents may be classified as a pedestrian conveyance or water craft accident depending on the circumstances of the accident. However, clinical advice from the National Injury Surveillance Unit (NISU) confirmed that W02.2 *Fall involving water ski* describes this accident more specifically than the residual code V94.7 *Other and unspecified water transport accidents, water skis* and should, therefore, be assigned in this instance.

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for implementation 01 July 2009.

Ref No: TN200 | Published On: 15-Jun-2009 | Status: Updated | Updated On: 15-Jun-2022

Ischaemic fingers

Q:

Ischaemic fingers due to occlusion of blood vessel secondary to injecting crushed benzodiazepine tablets into the ulnar artery. What is the correct code assignment for the above scenario?

A:

The correct codes to assign for this scenario are:

T42.4 *Poisoning by benzodiazepines*

I77.8 *Other specified disorders of arteries and arterioles*

and the appropriate external cause of injury codes.

Assign a more specific code if the type of blood vessel occlusion is specified e.g. I74.2 *Embolism and thrombosis of arteries of upper extremities* for thrombosis of ulnar artery.

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

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Coding Rules

Published 15 March 2009

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Glaucoma with diabetes mellitus

Q:

For a diabetic patient with glaucoma NOS is it appropriate to assign E1-.39 **Diabetes mellitus with other specified ophthalmic complication* and H40.9 *Glaucoma, unspecified*?

A:

There is no index entry for '*Diabetes, with glaucoma*' in ICD-10-AM, therefore E1-.39 **Diabetes mellitus with other specified ophthalmic complication* should not be assigned in this scenario.

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Coding Rules

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Epstein-Barr Virus (EBV) hepatitis

Q:

How do you code Epstein-Barr Virus (EBV) hepatitis?

A:

The Epstein-Barr virus, also called *Human herpesvirus 4* (HHV-4), is a virus of the herpes family (which includes *Herpes simplex virus*) and is one of the most common viruses in humans. Most people become infected with EBV, which is often asymptomatic but commonly causes the clinical syndrome known as infectious mononucleosis or glandular fever.

Epstein-Barr virus infections can also be associated with hepatocellular hepatitis. The frequency of this association varies with age. It is estimated to be in 10% of young adults and 30% in the elderly where it presents itself as an anicteric viral hepatitis.

The correct codes to assign for EBV hepatitis are:

B17.8 *Other specified acute viral hepatitis*

B27.0 *Gammaherpesviral mononucleosis* by following the index pathways:

Hepatitis

- viral, virus

- - specified type (with or without coma) NEC B17.8 and

Epstein-Barr virus (gammaherpesviral mononucleosis) B27.0

It is incorrect to classify EBV infections to category B00 *Herpesviral [herpes simplex] infections*. Although Epstein-Barr virus is a herpesviral infection, it is not a Herpes simplex infection and the excludes note for gammaherpesviral mononucleosis in B00 directs coders to B27.0 *Gammaherpesviral mononucleosis*, where mononucleosis due to Epstein-Barr virus is classified.

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Lawee, David, Mild Infectious Mononucleosis presenting with transient mixed liver disease, The College of Family Physicians of Canada. Accessed 29 July 2008 http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1949255

Virology Down Under, Epstein-Barr Virus. Accessed 24 July 2008. http://www.uq.edu.au/vdu/VDUEBV.htm

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for implementation 01 January 2009.

Coding Rules

Published 15 September 2008

Ref No: TN203 | Published On: 15-Sep-2008 | Status: Updated | Updated On: 01-Jul-2017

Obstetrics/Gynaecology

Q:

Does anaemia and pre-existing anaemia need to meet ACS 0002 for the combined code to be assigned?

A:

For a code to be assigned from category O99.0- *Anaemia complicating pregnancy, childbirth and the puerperium*, the 'anaemia' firstly needs to meet ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*. However, as per the ICD-10-AM index:

Anaemia D64.9

- in pregnancy, childbirth or puerperium O99.00

- - affecting fetus or newborn P00.8

- - childbirth or puerperium NEC O99.03

- - - with mention of pre-existing anaemia O99.04

- - pregnancy O99.01

- - - with mention of pre-existing anaemia O99.02

- - puerperal, postpartum NEC O99.03

- - - with mention of pre-existing anaemia O99.04

Once it has been determined that anaemia requires coding in accordance with ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*, the 'pre-existing anaemia' component only needs to be 'mentioned' and therefore does not itself have to meet ACS 0001 or ACS 0002 for the appropriate fifth character code to be assigned.

Q:

Why wasn't 'postpartum' removed from 16564-00 *Postpartum evacuation of uterus by dilation and curettage* and 16564-01 *Postpartum evacuation of uterus by suction curettage* in block **[1345]** given that the diagnostic detail was removed from the other D&C codes?

A:

The term 'postpartum' could not be removed from the above codes in block **[1345]** as these are specific procedures which are performed in the postpartum period for retained products of conception and need to be distinguished from other evacuation of uterus codes in block **[1265]**.

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 Rules

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Seprafilm®

Q:

Is it necessary to assign a code for Seprafilm® inserted during a procedure?

A:

To reduce the occurrence of adhesions following surgery, surgeons can use adhesion barriers to separate tissue and organs while the body heals. Seprafilm® is a type of adhesion barrier composed of chemically modified sugars, some of which occur naturally in the human body. It is a clear film that sticks to the tissues to which it is applied and is slowly absorbed into the body over a period of seven days. It is placed at sites of tissue injury during surgery (commonly abdominal and pelvic surgery) to help prevent the formation of adhesions between tissues and organs.

The insertion of Seprafilm® is a prophylactic measure which is completely absorbed into the body and does not require removal. It is unnecessary to assign a code for this procedure.

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 2008.

Coding Rules

Published 15 September 2007

Ref No: TN207 | Published On: 15-Sep-2007 | Status: Updated | Updated On: 15-Jun-2022

Insulin pumps

Q:

What is the correct code to assign for insulin delivered via an insulin pump?

A:

An insulin pump is not implanted in the body. It is a small, pager-sized device you wear or carry. It is made up of a pump reservoir (like a regular syringe) filled with insulin, one or more small batteries, and a simple programmable interface. It is connected to the body via a thin tube, called an infusion set, which delivers small, constant amounts of insulin via a subcutaneous cannula attached to a small needle. In most cases patients insert and change the cannula/needle themselves, every 2–3 days, at home. The insulin pump is programmed (by the user) to administer a basal rate of insulin continuously throughout the day and night, depending on individual needs. Patients activate the pump to deliver a bolus dose of insulin during meals. Patients may also administer a bolus dose in response to high blood glucose levels. Insulin pumps contain ultra short acting insulin only. Patients may be admitted to hospital for fitting/commencement of an insulin pump or conversion to a new pump. Administration of insulin via an insulin pump is not normally coded as per ACS 0042 *Procedures normally not coded*:

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 *Pharmacotherapy* and ACS 1615 *Specific diseases and interventions related to the sick neonate*)

However, where insulin is administered via an insulin pump as the principal treatment in same-day episodes of care, assign:

96200-06 **[1920]** *Subcutaneous administration of pharmacological agent, insulin*

96209-06 **[1920]** *Loading of drug delivery device, insulin.*

If the patient's pump is loaded with insulin but they do not receive a dose during the episode of care, assign only:

96209-06 **[1920]** *Loading of drug delivery device, insulin*

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 Rules

Published 15 June 2007

Ref No: TN208 | Published On: 15-Jun-2007 | Status: Current

External Cause of Injury Code for capsicum spray administered by Police

Q:

What is the correct external cause code assignment for capsicum spray administered by Police?

A:

Oleoresin capsicum (OC) is an extract of pepper plants of the genus Capsicum. It is the principal active ingredient in capsicum spray and one of its other uses is as a pharmacological agent in anaesthetic and analgesic creams. An aerosol is used to disperse the liquid form of the OC extract into gas.

The correct code to assign, therefore, is Y35.2 *Legal intervention involving gas* (with an appropriate place of occurrence code.)

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Coding Rules

Published 15 December 2006

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Pain versus injury post trauma

Patients involved in trauma accidents such as motor vehicle accidents, fall from height, sports injury, etc may present at the emergency department with pain in certain areas of the body without any obvious injury. Should the principal diagnosis in these cases be pain or injury as it could be argued that pain signifies an underlying injury.

Classification

In the scenario cited, the underlying injury should be coded. It is important to classify the injury and the external cause code to reflect the admission.

Example: Patient admitted to accident and emergency (AE) post motor vehicle accident (MVA) complaining of neck and back pain. Investigations to exclude injuries reveal no abnormal findings and analgesics were given. The patient is discharged with a final diagnosis of neck and back pain.

Codes:

S19.9 *Unspecified injury of neck*

S39.9 *Unspecified injury of abdomen, lower back and pelvis*

Appropriate external cause, place of occurrence and activity codes

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

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Dog ears of breast

A dog ear of breast is an excessive redundant roll of skin which can be found at the corner of an incision in the axilla or underarm when too much skin is gathered at an angle. It can occur after mastectomy or reduction mammoplasty and is not a complication of the procedure. The condition may improve with time, or it can be surgically corrected by excision.

Classification

For episodes of care involving excision of dog ears of breast assign:

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

90676-00 **[1660]** *Other procedures on skin and subcutaneous tissue*

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Coding Rules

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Ref No: TN221 | Published On: 15-Mar-2004 | Status: Current

Storage of bone in the abdominal wall

An interesting new procedure is being performed in some hospitals. An initial operation is performed to excise a **bone flap** from the cranium, which is then preserved/stored in a subcutaneous pocket overlaying the abdomen. The purpose of the surgery is to alleviate the symptoms of severe post traumatic cerebral oedema. A second operation, performed days or weeks later, involves reopening the abdomen to retrieve the bone flap, followed by cranioplasty.

Classification

Documentation of this new procedure should be classified as 90952-00 **[987]** *Incision of abdominal wall* for the storage of bone in abdominal wall component of the procedure.

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