IHPA

Independent Hospital Pricing Authority

# ICD-10-AM/ACHI/ACS Eleventh Edition

## Errata 1, 2 and 3

# ICD-10-AM Tabular List

**Page 30a**
**List of three character categories**

**Add** block heading

## CHAPTER 20
## EXTERNAL CAUSES OF MORBIDITY AND MORTALITY (U50–U73, V00–Y98)

**...**
**Legal intervention and operations of war (Y35–Y36)**
Y35 Legal intervention
Y36 Operations of war
**Exposure to or contact with allergens (Y37)**
Y37 Exposure to or contact with allergens
….

**Page 60**

**Add** Code also instruction

D68.3 Haemorrhagic disorder due to circulating anticoagulants

∇ 0303

Haemorrhage during long term use of anticoagulants
Hyperheparinaemia
Increase in:
• anti‑VIIIa
• anti‑IXa
• anti‑Xa
• anti‑XIa
• antithrombin

*Code also, if applicable:*
• nontraumatic haematoma of skin and subcutaneous tissue (L98.8)
• nontraumatic haematoma of soft tissue (M79.8-)

*Use additional external cause code (Chapter 20) to identify any administered anticoagulant*.

*Excludes:* abnormal coagulation profile (R79.83)
long term use of anticoagulants without haemorrhagic disorder (Z92.1)

**Page 86**

**Amend** code titles

**E66** **Obesity and overweight**

….
For patients under 18 years of age, assign fifth character 0.

✪ 0 body mass index [BMI] not elsewhere classified

✪ 1 body mass index [BMI] ≥ 30 kg/m$^2$ to ≤ 34.99 kg/m$^2$
Obese class I

✪ 2 body mass index [BMI] ≥35 kg/m$^2$ to ≤ 39.99 kg/m$^2$
Obese class II

✪ 3 body mass index [BMI] ≥40 kg/m
Clinically severe obesity
Extreme obesity
Obese class III

**Page 154**

**Amend** note

**H54** Visual impairment including binocular or monocular blindness

***Note:*** The following table gives a classification of severity of visual impairment recommended by the Resolution of the International Council of Ophthalmology (2002) and the Recommendations of the WHO Consultation on 'Development of Standards for Characterisation of Vision Loss and Visual Functioning' (Sept 2003). For characterising visual impairment for codes H54.0–H54.3, visual acuity should be measured with both eyes open with presenting correction if any. For characterising visual impairment for codes H54.4–H54.6, visual acuity should be measured monocularly with presenting correction if any.
If the extent of the visual field is taken into account, patients with a visual field of the better eye no greater than 10 in radius around central fixation should be placed under category 3. For monocular blindness (H54.4), this degree of field loss would apply to the affected eye.

**Page 184**

**Add** *Inclusion* terms

J17.2* Pneumonia in mycoses
Pneumonia in:
• candidiasis (B37.1†)
• coccidioidomycosis (B38.0–B38.2†)
• histoplasmosis (B39.-†)
• pneumocystosis (B48.5†)

**Page 340–1**

**Add** *Exclusion* term and note

**R40** Somnolence, stupor and coma
∇1905

Note: For classification purposes, where there are multiple GCS scores documented in an episode of care, code assignment should be based on the lowest GCS score, that is, the most severe level of consciousness impairment.

R40.0 Somnolence
Decreased (level of) consciousness (nontraumatic)
Drowsiness
GCS score 13–15

R40.1 Stupor
GCS score 9–12
Semicoma

***Excludes:*** due to trauma (S06.0-)
stupor:
- catatonic (F20.2)
- depressive (F31–F33)
- dissociative (F44.2)
- manic (F30.2)

that with any head injury classifiable to Chapter 19 (S06.01–S06.05)

R40.2 Coma
GCS score ≤ 8
Loss of consciousness (nontraumatic) NOS
Unconsciousness NOS

***Excludes:*** coma:
- diabetic (E10–E14)
- hepatic (K72.-)
- hypoglycaemic (nondiabetic) (E15)
- neonatal (P91.5)
- that with any head injury classifiable to Chapter 19 (S06.01–S06.05)
- uraemic (N19)

syncope (R55)

**Page 400**

**Amend** *Use additional instruction*

T78.0 Anaphylaxis and anaphylactic shock due to adverse food reaction
∇2115

*Use additional external cause code (Y37.01-Y37.5, Y37.8, Y37.9) to identify allergen, if known.*

**Page 413**

**Add** block

## CHAPTER 20
# EXTERNAL CAUSES OF MORBIDITY AND MORTALITY (U50–U73, V00–Y98)

…
**X60–X84 Intentional self-harm**
**X85–Y09 Assault**
**Y10–Y34 Event of undetermined intent**
**Y35–Y36 Legal intervention and operations of war**
**Y37 Allergens**
**Y40–Y84 Complications of medical and surgical care**
….

**Page 453**

**Amend** *Includes* note

X47.2 Accidental poisoning by and exposure to carbon monoxide from other domestic fuels

***Includes:*** that due to carbon monoxide from:
- charcoal
- coal
- coke (in domestic stove, portable grill, barbeque or fireplace (free standing))
- kerosene or ~~of~~ paraffin
- wood

**Page 455**

**Amend** *Includes* note

X67.2 Intentional self-poisoning by and exposure to carbon monoxide from other domestic fuels

***Includes:*** that due to carbon monoxide from:
- charcoal
- coal
- coke (in domestic stove, portable grill, barbeque or fireplace (free standing))
- kerosene or ~~of~~ paraffin
- wood

**Page 458**

**Amend** *Includes* note

X88.2 Assault by poisoning and exposure to carbon monoxide from other domestic fuels
*See subdivisions page 457*

***Includes:*** that due to carbon monoxide from:
- charcoal
- coal
- coke (in domestic stove, portable grill, barbeque or fireplace (free standing))
- kerosene or~~of~~ paraffin
- wood

**Page 461**

**Amend** *Includes* note

Y17.2 Poisoning by and exposure to carbon monoxide from other domestic fuels, undetermined intent

***Includes:*** that due to carbon monoxide from:
- charcoal
- coal
- coke (in domestic stove, portable grill, barbeque or fireplace (free standing))
- kerosene or~~of~~ paraffin
- wood

**Page 493**

**Add** *ACS number*

Z58.7 Exposure to tobacco smoke
∇0050, 2118

Passive (involuntary) smoking

***Includes:*** exposure to secondhand tobacco smoke (from):
- cigarette
- pipe
- waterpipe

***Excludes:*** mental and behavioural disorders due to the use of tobacco (F17.-)
newborn affected by maternal use of tobacco (P04.2)
personal history of tobacco use disorder (Z86.43)
tobacco use (Z72.0)

**Page 567**
**Appendix C: Unacceptable Principle Diagnosis Codes**

**Amend** and **remove** blocks

## APPENDIX C
# UNACCEPTABLE PRINCIPAL DIAGNOSIS CODES

…

U91 Syndrome not elsewhere classified
U92 Healthcare associated Staphylococcus aureus bacteraemia
V00–X59 Accidents
X60–~~Y92~~Y98 Other external causes of morbidity and mortality
Z06.50 Resistance to beta-lactam antibiotics, unspecified
Z06.51 Resistance to penicillin

**Page 574**
**Appendix D: Classification of Hospital Acquired Diagnoses (CHADx)**

**Add** and **remove** code T814 *Wound infection following a procedure*

## M CHADx 1
# POSTPROCEDURAL COMPLICATIONS

…

**1.9 Wound infection (excluding sepsis)**

| | |
|---|---|
| O860 | Infection of obstetric surgical wound |
| T814 | Wound infection following a procedure NEC |

**1.10 Complications of cardiac and vascular implants (excluding sepsis)**

| | |
|---|---|
| ~~T814~~ | ~~Wound infection following a procedure NEC~~ |
| T820 | Mechanical comp heart valve prosthesis |
| T821 | Mech comp cardiac electronic device |
| T822 | Mech comp coron art bypass valve gft |
| T823 | Mechanical comp oth vascular grafts |

**Page 576**
**Appendix D: Classification of Hospital Acquired Diagnoses (CHADx)**

**Delete** codes. **Add** codes (with new code numbers)

## M CHADx 1
# POSTPROCEDURAL COMPLICATIONS

….

**1.22 Postprocedural disorders: Musculoskeletal system**

| | |
|---|---|
| ~~M7674~~ | ~~Accid punct lacr cartilage dur proc~~ |
| ~~M7679~~ | ~~Accid punct lacr M/S org dur proc NEC~~ |
| M960 | Pseudarthrosis after fusion arthrodesis |
| M961 | Postlaminectomy syndrome NEC |
| M963 | Postlaminectomy kyphosis M966 Bone fx foll ins orthopaedic implant |
| M9671 | Accid punct lacr muscle during proc |
| M9672 | Accid punct lacr tendon dur proc |
| M9673 | Accid punct lacr ligament during proc |
| M9674 | Accid punct lacr cartilage dur proc |
| M9679 | Accid punct lacr M/S org dur proc NEC |
| M968 | Other intra/postop disrd M/S sys |
| M969 | Intra/postop disrd M/S system unsp |

**Page 582**
**Appendix D: Classification of Hospital Acquired Diagnoses (CHADx)**

**Amend** code titles

## M CHADx 3
# ACCIDENTAL INJURIES

….
**3.4 Injury due to assault** — *continued*

X9206 Aslt drown subm in bath tub pers unknown t vctm
X9207 Aslt drown subm in bath tub unknown mult pers
X9208 Aslt drown subm in bath tub oth spec pers
X9209 Aslt drown subm in bath tub unsp pers
X9280 ~~Aslt drown subm in other spec water sps/dp~~ Aslt drwn & submrs oth spec wtr sps/dp
X9281 ~~Aslt drown subm in other spec water parent~~ Aslt drwn & submrs oth spec wtr parent
X9282 ~~Aslt drown subm in other spec water other fm~~ Aslt drwn & submrs oth spec wtr oth fm
X9283 ~~Aslt drown subm in other spec water carer~~ Aslt drwn & submrs oth spec wtr carer
X9284 ~~Aslt drown subm in other spec water acq/frd~~ Aslt drwn submrs oth spec wtr acq/frd
X9285 ~~Aslt drown subm in other spec water ofc auth~~ Aslt drwn submrs oth spec wtr ofc auth
X9286 ~~Aslt drown subm in other spec water pers unknown t vctm~~ Aslt drwn spec wtr pers ? t vctm
X9287 ~~Aslt drown subm in other spec water unknown mult pers~~ Aslt drwn submrs spec wtr ? mult pers
X9288 ~~Aslt drown subm in other spec water oth spec pers~~ Aslt drwn oth spec wtr oth spec pers
X9289 ~~Aslt drown subm in other spec water unsp pers~~ Aslt drwn & submrs oth spec wtr ? Pers
X9290 ~~Aslt drown subm in unspec water sps/dp~~ Aslt drwn & submrs ? wtr sps/dp
X9291 ~~Aslt drown subm in unspec water parent~~ Aslt drwn & submrs ? wtr parent
X9292 ~~Aslt drown subm in unspec water other fm~~ Aslt drwn & submrs ? wtr oth fm
X9293 ~~Aslt drown subm in unspec water carer~~ Aslt drwn & submrs ? wtr carer
X9294 ~~Aslt drown subm in unspec water acq/frd~~ Aslt drwn & submrs ? wtr acq/frd
X9295 ~~Aslt drown subm in unspec water ofc auth~~ Aslt drwn & submrs ? wtr ofc auth
X9296 ~~Aslt drown subm in unspec water pers unknown t vctm~~ Aslt drwn submrs ? wtr pers ? t vctm
X9297 ~~Aslt drown subm in unspec water unknown mult pers~~ Aslt drwn & submrs ? wtr ? mult pers
X9298 ~~Aslt drown subm in unspec water oth spec pers~~ Aslt drwn & submrs ? wtr oth spec pers
X9299 ~~Aslt drown subm in unspec water unsp pers~~ Aslt drwn & submrs ? wtr ? Pers

# ICD-10-AM Alphabetic Index

**Page 16**

**Amend** term

**Adhesions, adhesive** (postinfective) K66.0
…
- peritoneum, peritoneal (male) K66.0
- - with intestinal obstruction K56.5
- - congenital Q43.32
- - female pelvic (postpartal) (to uterus) N73.6
- - - affecting
- - - - labour ~~and~~ or delivery O65.5
- - - - pregnancy O34.8
- - - postprocedural N99.4
…

**Page 57**

**Delete** codes. **Add** cross reference

**Carcinoma in situ** (M8010/2) — *continued*
…
- oxyphilic (M8290/2)
- pancreatobiliary-type (M8163/2) D01.5
- papillary (M8050/2) — *see also Neoplasm/in situ*
- - with invasion (infiltrating) — *see Carcinoma/papillary*
- - follicular variant (M8340/2) D09.3
- - intraductal (noninfiltrating) (M8503/2)
- - - breast D05.1
- - - specified site NEC — *see Neoplasm/in situ*
- - - unspecified site D05.1
- - transitional cell (M8130/2) D09.0
- - urothelial ~~(M8130/2) D09.0~~ — *see Carcinoma in situ/urothelial/papillary*
- pilomatrix (M8110/2) — *see Neoplasm/skin/in situ*
- pituitary (M8272/2) D09.3
...
- urothelial (M8120/2)
- - papillary (M8130/2) D09.0
- - - low grade (M8130/2) D09.0
- - - - invasive (M8130/3) — *see also Neoplasm/bladder/malignant*
- - - noninvasive (M8130/2) D09.0
- - - of low malignant potential (M8130/1) D41.4
- - specified site — *see Neoplasm/in situ*
- - unspecified site D09.1

**Page 113**

**Add and delete** terms, codes and cross reference

**Disorder** (of) — *see also Disease*
…
- cognitive (mild) (moderate) F06.7 ~~NEC R41.8~~
- - due to or secondary to
- - - age (age-associated) R41.8
- - - general medical condition F06.7
~~- - mild (organic) F06.7~~
- - severe — *see Dementia*
- colon K63.9

**Page 116**

**Add** terms, code and cross reference

**Disorder** (of) — *see also Disease*
…
- nervous system G98
- - autonomic (peripheral) G90.9
- - - specified NEC G90.8
- - central G96.9
- - - specified NEC G96.8
- - parasympathetic G90.9
- - specified NEC G98
- - sympathetic G90.9
- - vegetative G90.9
- neurocognitive (mild) (moderate) F06.7
- - severe — *see Dementia*
- neurohypophysis NEC E23.3

**Page 172**

**Add and delete** terms, codes and cross references

**Hepatitis** – *continued*
…
- viral, virus (without hepatic coma) B19.9
- - with hepatic coma B19.0
- - acute NEC B17.9
- - - specified NEC B17.8
- - - type
- - - - A B15.9
- - - - - with hepatic coma B15.0
- - - - B B16.9
- - - - - with delta-agent coinfection (hepatitis D) (without hepatic coma) B16.1
- - - - - - and hepatic coma B16.0
- - - - - hepatic coma (without delta-agent coinfection) B16.2
- - - - C B17.1
- - - - D ~~(coinfection)~~ (acute delta coinfection with chronic hepatitis B~~with delta-agent~~) (without hepatic coma) ~~B16.1~~B17.0
- - - - - with hepatic coma B16.0
- - - - E B17.2
- - chronic NEC B18.9
- - - specified NEC B18.8
- - - type
- - - - B B18.1
- - - - - with delta-agent (hepatitis D) B18.0
- - - - C B18.2
- - - - D (chronic hepatitis B with delta-agent) B18.0
- - - - E B18.8
- - congenital P35.3
…

**Page 185**

**Delete** nonessential modifier

**Hypotension** (arterial) ~~(chronic)~~ (constitutional) I95.9
- chronic I95.8

**Page 188**

**Add** terms and code

**Impaired, impairment** (function)
…
- myocardium, myocardial *(see also Insufficiency/myocardial)* I50.9
- neurocognitive NEC R41.8
- rectal sphincter R19.89

**Page 217**

**Amend** code

**Lateroversion**
- cervix
- - affecting
- - - fetus or newborn P03.8
- - - labour or delivery O65.5
- - - pregnancy ~~O34.5~~ O34.4
- - congenital Q51.84
- uterus, uterine (cervix) (postinfectional) (postpartal, old) N85.4
- - affecting
- - - fetus or newborn P03.8
- - - labour or delivery O65.5
- - - pregnancy O34.5
- - congenital Q51.83

**Lathyrism T62.2**

**Page 258**

**Delete** subterms and codes

| | Malignant | | | | |
|---|---|---|---|---|---|
| | Primary | Secondary | In situ | Benign | Uncertain or unknown behaviour |
| **Neoplasm, neoplastic** – *continued* | | | | | |
| - hemisphere, cerebral | C71.0 | C79.3 | - | D33.0 | D43.0 |
| - hepatic | C22.9 | C78.7 | D01.5 | D13.4 | D37.6 |
| - - duct (bile) | C24.0 | C78.8 | D01.5 | D13.5 | D37.6 |
| - - flexure (colon) | C18.3 | C78.5 | D01.0 | D12.3 | D37.4 |
| ~~- - primary~~ | ~~C22.9~~ | ~~-~~ | ~~D01.5~~ | ~~D13.4~~ | ~~D37.6~~ |
| - hepatobiliary | C24.9 | C78.8 | D01.5 | D13.9 | D37.6 |

**Page 261**

**Delete** subterms and codes

| | Malignant | | | | |
|---|---|---|---|---|---|
| | Primary | Secondary | In situ | Benign | Uncertain or unknown behaviour |
| **Neoplasm, neoplastic** – *continued* | | | | | |
| - liver | C22.9 | C78.7 | D01.5 | D13.4 | D37.6 |
| ~~- - primary~~ | ~~C22.9~~ | ~~-~~ | ~~D01.5~~ | ~~D13.4~~ | ~~D37.6~~ |

**Page 310**

**Add** terms and code

**Pregnancy** (single) (uterine) — continued
- complicated by — continued
…..
- - excessive
- - - fetal growth O36.6
- - - - with disproportion O33.5
- - - weight gain NEC O26.0
- - exhaustion O26.88
- - face presentation O32.3
- - failure, fetal head, to enter pelvic brim O32.4
- - false labour — see Labour/false
- - fatigue O26.88
- - fatty (metamorphosis) liver O26.6
- - fetal (suspected)
…
- - - disproportion due to fetal deformity O33.7
- - - distress O36.3
- - - excessive growth O36.6
- - - - with disproportion O33.5
- - - growth retardation O36.5
- - - hereditary disease O35.2
…

# ACHI Tabular List

**Page 29**

**Amend** code

42705-00 Extraction of crystalline lens with implantation of trans-trabecular drainage device

Extraction of crystalline lens with implantation of microstents

***Note:*** Performed for glaucoma in conjunction with cataract surgery

*Code first:*
• type of cataract extraction (see block **[200]**)

**Page 65**

**Amend** Code also when performed

**524** **Laryngectomy**

*Code also when performed:*
• radical neck dissection (~~31435-00~~ 96245-01 **[806]**)
• tracheostomy:
  • percutaneous (41880-00 **[536]**)
  • permanent (41881-01 **[536]**)

**Page 242**

**Amend** *exclusion term*

90665-01 Debridement of skin and subcutaneous tissue, not elsewhere classified

***Excludes:*** debridement of:
• burn (30017-02 **[1627]**)
• open fracture site (90580-00 **[1566]**)
• soft tissue (30023 **[1566]**)
that:
• by maggot debridement therapy (MDT) (96210-00 **[1604]**)
~~• with repair (suture) of wound of skin and~~
~~Subcutaneous tissue [1635]~~

**Page 243**

**Add** *Code also instruction*

**1635 Repair of wound of skin and subcutaneous tissue**

∇ 1217

Repair of laceration of skin and subcutaneous tissue

***Includes:*** use of:
- clips
- suture
- tissue adhesive resin (tissue glue)

*Code also when performed:*
- debridement of skin and subcutaneous tissue, not elsewhere classified (90665-01 **[1628]**)

***Excludes:*** that of:
- breast (90720-00 **[1759]**)
- ear (30052-00 **[304]**)
- eyelid (30052-01 **[236]**)
- lip (30052-02 **[406]**)
- nose (30052-03 **[380]**)

**Page 280**

**Amend** Excludes note

**1859 Digestive system diagnostic tests, measures or investigations**

11810-00 Measurement of gastro-oesophageal reflux involving ≥ 24 hour pH monitoring

***Includes:*** analysis
interpretation
report

***Excludes:*** that with ≥ ≤ 24 hour pH monitoring – omit code

# ACHI Alphabetic Index

**Page 29**

**Amend** code

**Block**
…
- transversus abdominis plane (TAP)
- - for
- - - analgesia, postprocedural 92517-01~~0~~ **[1912]**

**Page 48**

**Delete** subterm and cross reference

**Cystectomy** — *see also Excision/cyst*
- gallbladder — *see Cholecystectomy*
- ovary (para-ovarian)
- - ~~with hysterectomy — *see Hysterectomy*~~
- - bilateral
- - - laparoscopic 35638-05 **[1244]**
- - - via laparotomy 35717-00 **[1244]**
- - unilateral
- - - laparoscopic 35638-04 **[1244]**
- - - via laparotomy 35713-04 **[1244]**
- urinary
- - partial (open) 37000-01 **[1102]**
- - - via laparoscopy 37000-00 **[1102]**
- - total (radical) 37014-00 **[1102]**

**Page 84**

**Delete** subterm and cross reference

**Excision** — *see also Removal*
…
- osteophyte
- - ankle
- - - arthroscopic (closed) 49703-01 **[1531]**
- - joint structure NEC 90574-00 **[1561]**
- ovary — *see Oophorectomy*
- - with excision of fallopian tube — *see Salpingo-oophorectomy*
- - - ~~and hysterectomy — *see Hysterectomy*~~
- palate
- - bony (hard) (soft) 90141-02 **[403]**

**Page 149**

**Delete** subterms, nonessential modifiers and codes. **Add** subterms, nonessential modifiers and codes

**Myringotomy** ~~(unilateral) 41626-00 **[309]**~~
~~- with~~
~~- - aspiration 41626-00 **[309]**~~
~~- - - and intubation (grommet) 41632-02 **[308]**~~
~~- - drainage of abscess 41626-00 **[309]**~~
~~- - - and intubation (grommet) 41632-02 **[308]**~~
~~- - insertion of tube (grommet) 41632-02 **[308]**~~
- bilateral 41626-01 **[309]**
- - with
- - - aspiration 41626-01 **[309]**
- - - - and intubation (grommet) 41632-03 **[308]**
- - - drainage of abscess 41626-01 **[309]**
- - - - and intubation (grommet) 41632-03 **[308]**
- - - insertion of tube (grommet) 41632-03 **[308]**
- unilateral 41626-00 **[309]**
- - with
- - - aspiration 41626-00 **[309]**
- - - - and intubation (grommet) 41632-02 **[308]**
- - - drainage of abscess 41626-00 **[309]**
- - - - and intubation (grommet) 41632-02 **[308]**
- - - insertion of tube (grommet) 41632-02 **[308]**

**Page 156**

**Delete** subterm and cross reference

**Oophorectomy**
- with excision of fallopian tube — *see Salpingo-oophorectomy*
~~- - and hysterectomy — *see Hysterectomy*~~
- bilateral
- - laparoscopic (total) 35638-03 **[1243]**
- - via laparotomy (total) 35717-01 **[1243]**
…

**Page 233**

**Delete** subterm and cross reference

**Salpingectomy**
- by electrodestruction — *see Electrodestruction/fallopian tube*
- for reversal of sterilisation — *see Anastomosis/fallopian tube*
- with oophorectomy — *see Salpingo-oophorectomy*
~~- - and hysterectomy — *see Hysterectomy*~~
- bilateral
- - laparoscopic (total) 35638-10 **[1251]**

**Page 233**

**Delete** subterm and cross reference

**Salpingo-oophorectomy**
~~- with hysterectomy — *see Hysterectomy*~~
- bilateral
- - laparoscopic 35638-12 **[1252]**
- - via laparotomy 35717-04 **[1252]**

**Page 264**

**Amend** cross reference

**Vasovasostomy**
- bilateral 37619-01 **[1185]**
- - microsurgical 37616-01 **[1185]**
- unilateral 37619-00 **[1185]**
- - microsurgical 37616-00 **[1185]**

**Veneer** — *see* ~~*Facings*~~*Restoration*

**Venesection**
- therapeutic 13757-00 **[725]**

…

# Australian Coding Standards (ACS)

**Page 4**

**Update** wording within standard

*See also supplementary document for ACS 0002 Additional Diagnoses remediated version without tracked changes.*

## 0002 ADDITIONAL DIAGNOSES

An additional diagnosis is defined as:

"A condition or complaint either coexisting with the principal diagnosis or arising during the episode of admitted patient care, episode of residential care or attendance at a health care establishment, as represented by a code" (Australian Institute of Health and Welfare, 2018).

Codes assigned for additional diagnoses are a substantial component of the Admitted Patient Care National Minimum Data Set (APC NMDS). "The purpose of the APC NMDS is to collect information about care provided to admitted patients in Australian hospitals" (Australian Institute of Health and Welfare, 2018).

The national morbidity data collection is not intended to describe the current disease status of the inpatient population, but rather the conditions that are significant in terms of treatment required, investigations needed and resources used in each episode of care.

For classification purposes, additional diagnoses should be interpreted as conditions that significantly affect patient management in terms of requiring any of the following criteria:

- commencement, alteration or adjustment of therapeutic treatment
- diagnostic procedures
- increased clinical care

These three criteria are not mutually exclusive. Conditions must meet one or more of these criteria.

Many of the above activities are performed by clinicians in the form of clinical consultation. For the purposes of classification, a clinical consultation refers to documentation provided by the:

- treating clinician/team who is primarily responsible for managing a patient's condition during the episode of care
- specialist who provides advice/opinion, to the referring clinician/team, regarding a patient's management
- nurses, midwives and allied health professionals who are engaged in a patient's management within their scope of practice.

Documentation of a consultation does not have to be a formal consultation report. Documentation of assessment of a condition in the progress notes or elsewhere (eg a care plan) is sufficient. Telephone or electronic consultation with clear documentation of the information exchange is also regarded as a clinical consultation.

~~Note that a condition may be documented by the treating clinician/team due to its 'clinical significance', however, for classification purposes some conditions are normally not coded as additional diagnoses in certain circumstances.~~

### COMMENCEMENT, ALTERATION OR ADJUSTMENT OF THERAPEUTIC TREATMENT

- Do not assign an additional diagnosis code for a condition that ~~is transient and~~ can be treated successfully with administration of medication without the need for ~~further~~ clinical consultation, investigation or a plan of care (eg Mylanta for heartburn; paracetamol for headache; Sominex for insomnia; zinc oxide cream for nappy rash; Sudocream for groin excoriation) (see Examples 1, 2 ~~&~~, 3, 17 & 19).

~~An additional diagnosis code can be assigned if a condition requires **further** assessment (ie the condition is no longer considered transient) by a clinician **and**~~

- ~~a diagnostic or therapeutic intervention is undertaken, or~~
- ~~a care plan is prescribed following clinical consultation~~

~~For example, CT scan of the brain performed to investigate the cause of the headache; altered medication dosage for heartburn; neurological observations ordered following fall; strict fluid balance for fluid overload (see Examples 4 & 15)~~

- Do not assign an additional diagnosis code for a pre-existing condition requiring administration of ongoing medication. This includes where the ongoing medication is adjusted due to the management of another condition (eg reducing dosage of diuretics due to acute kidney injury (AKI) in patients with congestive heart failure (CCF); adjustment of the dose of antihypertensive medication due to hypotension) (see Examples 5 & 6).

  An additional diagnosis code can be assigned for a pre-existing condition if a change in the pre-existing condition requires an amendment to its treatment plan (eg increase in diuretics dosage due to exacerbation of congestive heart failure (CCF)) (see Examples 7 & 9)

- Do not assign an additional diagnosis code for a pre-existing condition that results in minor adjustment to the diagnostic work-up or the care plan (eg ordering a non-contrast CT scan instead of a contrast CT scan; a V/Q scan instead of a CTPA for a suspected pulmonary embolism in patients with chronic kidney disease; selection of non-hepatotoxic agents in patients with chronic liver disease) (see Example 8).

  An additional diagnosis code can be assigned for a pre-existing condition if it results in a major variation to the care plan for another condition (eg a procedure is delayed/cancelled due to a pre-existing condition; patient needs admission to the Intensive Care Unit following surgery that would normally be managed in the surgical ward postoperatively). See also ACS 0011 *Intervention not performed or cancelled* (see Example 10)

- ~~Do not assign an additional diagnosis code for a condition that is treated with nurse-initiated medications, or nurse-initiated interventions **alone** (eg applying zinc oxide cream for nappy rash; applying Sudocream for groin excoriation; providing a heat pack for neck pain; giving juice or fruit for hypoglycaemia) (see Examples 11, 17 & 19).~~

  ~~An additional diagnosis code can be assigned for the above scenario if a condition is subsequently assessed by a clinician/team, and diagnostic or therapeutic intervention(s) performed, or a care plan is commenced for a condition (see Example 12).~~

**EXAMPLE 1:**

Patient was admitted for induction of labour due to reduced fetal movements. In the progress notes, the midwife noted "patient complained of having headaches which resolved with paracetamol. Blood pressure was 135/90 and later 130/80. CTG has been performed awaiting review by clinician. No other concerns voiced". No investigations were performed for the headache. The patient progressed to delivery later that day.

Principal diagnosis: Delivery

Additional diagnosis: Maternal care for decreased fetal movements

In this example, the headache is not a ~~transient~~ condition that significantly affected patient management in this episode of care. ~~and~~The headache was treated successfully with administration of medication (paracetamol) without the need for ~~further investigations~~clinical consultation, or a care plan; therefore, it does not meet the criteria in ACS 0002.

**EXAMPLE 2:**

Patient was admitted with acute alcohol intoxication. Patient was assessed by a drug and alcohol clinician and alcohol dependence was diagnosed. In the progress notes: "Phenergan 25 mg was given for insomnia". The medication chart noted 'Phenergan 25 mg PRN nocte'. No ~~further investigations~~ clinical consultation was~~ere~~ undertaken for insomnia during the episode of care.

Principal diagnosis: Acute alcohol intoxication

Additional diagnosis: Alcohol dependence syndrome

In this example, insomnia is not a ~~transient~~ condition that significantly affected patient management in this episode of care. ~~and~~The insomnia was treated successfully with administration of medication (Phenergan) without the need for ~~further investigations~~clinical consultation, or a care plan; therefore, it does not meet the criteria in ACS 0002.

**EXAMPLE 3:**

Patient was admitted for pneumonia. In the progress notes: "patient had PRN gastrogel for reflux with good effect". No other documentation to indicate that a diagnostic procedure was ordered or a change of treatment was commenced for reflux.

Principal diagnosis: Pneumonia

In this example, the reflux is not a ~~transient~~ condition that significantly affected patient management in this episode of care. ~~and~~The reflux was treated successfully with administration of medication (Gastrogel) without the need for ~~further investigations~~clinical consultation, or a care plan; therefore, it does not meet the criteria in ACS 0002.

…

**EXAMPLE 5:**

Patient with a past history of atrial fibrillation (AF) on aspirin therapy, was admitted with aspirin induced duodenal ulcers. Aspirin was withheld during the episode of care, and the patient was commenced on medication to treat the ulcers.

Principal diagnosis: Duodenal ulcer

Additional diagnosis: Adverse effect from aspirin

In this example, the pre-existing AF does not meet the criteria in ACS 0002 as withholding the aspirin was part of the ~~treatment~~care plan for the duodenal ulcer, not for management of the AF.

**EXAMPLE 6:**

An elderly patient with hypertension was admitted with postural hypotension, in the context of poor oral intake and dehydration. Patient received rehydration with IV fluids, and his regular antihypertensive medication (perindopril) was withheld due to the postural hypotension.

Principal diagnosis: Postural hypotension

Additional diagnosis: Dehydration

In this example, the pre-existing hypertension does not meet the criteria in ACS 0002, as withholding the perindopril is part of the ~~treatment~~care plan for postural hypotension; the change is not for management of the hypertension. Assign U82.3 *Hypertension* for the hypertension (see ACS 0003 *Supplementary codes for chronic conditions*).

…

**EXAMPLE 11:**

Patient was admitted for febrile neutropenia and reduced oral intake secondary to chemotherapy for left breast cancer. Patient was advised by a nurse to drink more fluids as slightly hypotensive.

| | |
|---|---|
| Principal diagnosis: | Neutropenia |
| Additional diagnosis: | Drug-induced fever |
| | Adverse effect from chemotherapy |
| | Breast cancer |
| | Morphology code for breast cancer |

In this example, the hypotension was not a ~~significant~~ condition that significantly affected patient management in the episode of care.~~, as t~~The patient was only advised to drink more fluids. There was no diagnostic or therapeutic treatment/intervention undertaken, and no care plan was prescribed.~~; t~~Therefore, it does not meet the criteria in ACS 0002. Assign codes for the breast cancer as per the guidelines in ACS 0236 *Neoplasm coding and sequencing*.

**EXAMPLE 12:**

An 84-year-old female was admitted after a fall. CT scan of head, neck and chest revealed multiple fracture of ribs (4-7) on the left side of chest, which were treated conservatively. Her past medical history included ischaemic heart disease, hypertension, chronic obstructive pulmonary disease (COPD) and falls. On arrival, the patient was examined by the ~~ward~~registered nurse, who diagnosed and documented a stage I pressure injury (PI) on the left heel. A wound care treatment plan was commenced.

| | |
|---|---|
| Principal diagnosis: | Fractures of multiple ribs |
| Additional diagnosis: | External cause of injury |
| | Place of occurrence |
| | Activity |
| | Pressure injury, stage I, heel |

In this example, the pressure injury meets the criteria in ACS 0002 in the episode of care.~~, as t~~The PI was assessed and diagnosed by a registered nurse, and a treatment plan was commenced specifically for the condition. ~~(which~~Assessment and diagnosis of the PI is within the scope of nursing practice~~)~~.

Assign U82.3 *Hypertension* for the hypertension, U82.1 *Ischaemic heart disease* for the ischaemic heart disease and U83.2 *Chronic obstructive pulmonary disease* for the COPD (see ACS 0003 *Supplementary codes for chronic conditions*).

…

## INCREASED CLINICAL CARE

**Conditions are not significant** in an episode of care when clinical care provided for a condition is **routine** in nature. Examples of routine clinical care include:

- general nursing care, such as administration of medications, dietary check, recording of fluid balance (intake and output), management of incontinence (eg urinary and bowel), pressure area prevention and skin care, assisting with activities of daily living and mobilisation (see Example 17)
- assessment of vital signs (including pulse, blood pressure, temperature and oxygen saturation), blood glucose levels (BGLs), electrolyte balance, haemoglobin levels and routine functional tests (eg liver and kidney function) (see Example 13)

- assessment of pre-existing conditions without a documented care plan specifically for these conditions (eg routine preoperative anaesthetist assessment, routine allied health assessment such as physiotherapy assessment of Parkinson's disease, with no documented care plan or treatment commenced)
- pre and postoperative management, such as withholding medications prior to an intervention, checking drain/catheters, monitoring and management of pain levels and bowel function, deep venous thrombosis and pressure injury prophylaxis (see Example 19)

**Conditions are significant** in an episode of care when clinical care provided for a condition is beyond routine (ie **increased clinical care**). Examples of increased clinical care include:

- providing care for a condition that is in excess of the routine care that would normally be provided by medical officer/nursing/allied health for that condition (eg documented evidence that the patient with dementia requires increased observation due to fluctuation in behaviour, cognition and physical condition)
- receiving clinical consultation for a condition with documentation of:
    - a clinical assessment, and
    - a diagnosis~~tic statement~~, ~~or~~ and
    - a care plan for the condition (eg patient referral to an oncologist for cancer assessment with documentation of advice received; wound specialist/nurse assessment of pressure injury with documentation of staging of pressure injury and care plan).

  Note that a care plan may include an adjustment to, or continuation of, the current treatment plan, or transfer to another facility with documentation of the reason(s) for transfer (see Examples 12, 21 & 22)
- performance of a therapeutic treatment/intervention for a condition (see also ACS 0002 *Additional diagnoses/Commencement, alteration or adjustment of therapeutic treatment*)~~(eg dialysis for end-stage renal failure, pharmacotherapy for multiple sclerosis)~~ (see Examples 4, 5, 6 & 7)
- pre and postoperative management in excess of routine care (see also ACS 1904 *Procedural complications*) (see Examples 18 & 20)

**EXAMPLE 17:**

An 86-year-old man was admitted with community acquired pneumonia. Patient had a long history of urinary incontinence. During the admission, his incontinence pads were changed regularly and zinc oxide cream applied daily to his skin, by the nurse.

Principal diagnosis: Pneumonia

In this example, the ~~management of the patient's~~ urinary incontinence is not a condition that significantly affected patient management in this episode of care. ~~and~~Daily topical application of zinc oxide cream ~~skin~~ is ~~routine~~ general nursing care for this condition; therefore, it does not meet the criteria in ACS 0002.

…

**Page 6**

**Add** wording to scenario

## 0002 ADDITIONAL DIAGNOSES

…

**EXAMPLE 7:**
A 64-year-old man was admitted with a two day history of central chest pain on a background of advanced pulmonary fibrosis and hypertension. On arrival in the Emergency Department, he had a GCS of 15/15, oxygen saturation of 80% and blood pressure of 185/90. Metoprolol and amlodipine (not his normal medication) were administered for hypertension. He underwent a coronary angiogram and a diagnosis of angina secondary to coronary artery disease was made. During the admission, the patient's low oxygen saturation (documented as due to the pre-existing pulmonary fibrosis) required increased oxygen supplement and Ordine was commenced for shortness of breath. Home oxygen extension was arranged and a Hudson mask was provided on discharge.

| | |
|---|---|
| Principal diagnosis: | Angina pectoris, unspecified |
| Additional diagnosis: | Coronary artery disease |
| | Pulmonary fibrosis |
| | Hypertension |

In this example, the pre-existing pulmonary fibrosis and hypertension both meet the criteria in ACS 0002 as therapeutic treatment was given for the hypertension and a care plan (commenced Ordine, home oxygen extension with Hudson mask) commenced for the pulmonary fibrosis.

**Page 7**

**Delete** wording in scenario

## 0002 ADDITIONAL DIAGNOSES

…

**EXAMPLE 10:**
A patient was admitted for elective left total hip replacement for osteoarthritis. Prior to the operation, the anaesthetic team requested an Intensivist to assess the patient. Consultation noted "known to have severe OSA, on CPAP for four months. CCF with left ventricle ejection fraction (LVEF) of 40%. Risk of developing cardiac or respiratory complications is very high, needs ICU admission post-operation and troponin test. Postoperative hypotension is very likely given biventricular failure". Patient was transferred to ICU after surgery and extubated on the second day. She was treated with BiPAP, Lasix ~~for fluid overload~~, and chest physiotherapy in addition to other routine post-operative management.

| | |
|---|---|
| Principal diagnosis: | Osteoarthritis |
| Additional diagnosis: | Congestive heart failure |
| | Obstructive sleep apnoea |

In this example, the pre-existing congestive heart failure and obstructive sleep apnoea both meet the criteria in ACS 0002 in the episode of care, as these conditions resulted in a major variation to the care plan following the Intensivist consultation ('needs ICU admission after hip replacement')

**Page 11**

**Amend** code title in scenario

## 0002 ADDITIONAL DIAGNOSIS

…

**EXAMPLE 22:**
A 55-year-old man presented with lower respiratory infection ~~on background of~~exacerbating his chronic obstructive pulmonary disease. He was commenced on Bactrim BD and physiotherapy performed. On the second day of the admission, the patient complained of having chest tightness since arrival to the hospital. He described the pain as constant, but not radiating. Nurse consulted the treating clinician over the phone and documented "team doctor advised over the phone to administer PRN GTN 300mcg. ECG was performed. Patient states that pain was not relieved with PRN oral GTN, so was given further GTN 300mcg as per team instruction. Patient remains saturating well and telemetry is in situ". Patient responded well to the treatment and was discharged home.

Principal diagnosis: Chronic obstructive pulmonary disease with acute lower respiratory infection
Additional diagnosis: Chest pain
In this example, the chest pain meets the criteria in ACS 0002 in the episode of care, as clinical consultation was undertaken specifically for the condition (***Note:*** Telephone consultation with clear documentation of the information exchange is regarded as clinical consultation).

**Page 44**

**Amend** wording

## 0019 INTERVENTION ABANDONED, INTERRUPTED OR NOT COMPLETED

An intervention may be abandoned, interrupted or not completed due to unanticipated circumstances. This means the intervention may not progress beyond administration of anaesthesia, initial incision or inspection/exploration.

If an intervention was abandoned, interrupted or not completed assign:

- a code for the condition requiring the intervention (principal diagnosis)
- Z53.3 *Procedure abandoned after initiation*, as an additional diagnosis
- a code for the condition or complication responsible for the abandonment of the intervention, as an additional diagnosis, if ~~applicable~~known
- ACHI codes as applicable, coded to the extent of the intervention performed

…

**Page 52**

**Amend** codes

# 0030 ORGAN, TISSUE AND CELL PROCUREMENT AND TRANSPLANTATION

| ALLOGENEIC ORGAN/TISSUE/CELL PROCUREMENT AND TRANSPLANTATION TABLE | | | | | |
|---|---|---|---|---|---|
| **ORGAN/ TISSUE** | **ALLOGENEIC HARVEST DIAGNOSIS CODE** | **PROCUREMENT EPISODE PROCEDURE CODE** | | **TRANSPLANTATION EPISODE PROCEDURE CODE** | |
| Blood (components) via apheresis | Z51.81 | Block **[1892]** | *Apheresis* | Block **[802]** | *Bone marrow/stem cell transplantation* |
| ….. | | | | | |
| Liver | Z52.6 | ~~Block [953]~~<br><br>96258-01 **[953]**<br><br>96258-02 **[953]**<br><br>96258-03 **[953]** | ~~*Excision procedures on liver*~~<br><br>*Laparoscopic procurement of liver for transplantation, living donor*<br><br>*Procurement of liver for transplantation, living donor*<br><br>*Procurement of liver for transplantation, cadaver* | 90317-00 **[954]** | *Transplantation of liver* |

…

**Page 83**

**Delete** wording in scenario

## 0233 MORPHOLOGY

…

**EXAMPLE 2:**

Patient was admitted for a TRUS (transrectal ultrasound guided) biopsy of the prostate under local anaesthesia. Histopathology reported adenocarcinoma (M8140/3) and high grade glandular intraepithelial neoplasia (M8148/2) of the prostate.

Codes: C61 *Malignant neoplasm of prostate*
M8140/3 *Adenocarcinoma NOS*
~~37215-00 **[1163]** *Endoscopic biopsy of prostate*~~
37218-00 **[1163]** *Needle biopsy of prostate or seminal vesicle*

***Note:*** M8140/3 *Adenocarcinoma NOS* is more invasive than M8148/2 *Glandular intraepithelial neoplasia, high grade* and therefore the morphology for adenocarcinoma /3 is assigned.

**Page 84**

**Amend** code title in scenario

## 0234 CONTIGUOUS SITES

…

**EXAMPLE 3:**

Patient admitted with a mass in the tracheobronchial region. A biopsy was performed via a bronchoscopy under sedation, ASA 2. Histopathology report indicated squamous cell carcinoma (SCC).

Codes: C34.8 *Overlapping lesion of bronchus and lung*
M8070/3 *Squamous cell carcinoma NOS*
41898-04 **[544]** *Endoscopic [needle] biopsy of bronchus*
92515-29 **[1910]** ~~*General anaesthesia*~~*Sedation, ASA 29*

**Page 85**

**Amend** code title in scenario

# 0236 NEOPLASM CODING AND SEQUENCING

…

**PRIMARY NEOPLASM AS A CURRENT CONDITION**

A primary neoplasm is classified as a current condition if the episode of care is for:

- diagnosis or treatment of the primary neoplasm, in any of the following circumstances:
  - initial diagnosis of the primary neoplasm
  - treatment of complications of the primary neoplasm or neoplasm treatment
  - operative intervention to remove the primary neoplasm
  - medical care related to the primary neoplasm, including palliative care (see also ACS 2116 *Palliative care*)
  - recurrence of the primary neoplasm previously eradicated from the same organ or tissue (see also ACS 0237 *Recurrence of malignancy*).
- diagnosis or treatment of a secondary (metastatic) malignancy, regardless of when/if the primary site was previously resected. Assign an additional diagnosis code for the primary neoplasm if known, or C80.- *Malignant neoplasm without specification of site* if the site of the primary neoplasm is unknown or unspecified.
- treatment aimed at stopping progression of the neoplasm, such as:
  - pharmacotherapy or radiotherapy (see also ACS 0044 *Pharmacotherapy* and ACS 0229 *Radiotherapy*)
  - subsequent admissions for wider excision (even if there is no residual neoplasm identified on histopathology)
  - staged surgery for prophylactic removal of a related organ.

~~• treatment of another nonmalignant condition, when the malignancy is a comorbidity that has an affect on the episode of care as per ACS 0002 Additional diagnoses.~~

~~• dental clearance prior to radiotherapy. Assign a code for the condition requiring the procedure as per the criteria in ACS 0001 *Principal diagnosis.*~~

If the episode of care is for treatment of another nonmalignant condition, the malignancy may be classified as a current condition only if it meets the criteria for code assignment as per ACS 0002 *Additional diagnoses*.

If the episode of care is for dental clearance prior to radiotherapy, assign a code for the condition requiring the procedure as per the criteria in ACS 0001 Principal diagnosis.

If the episode is for follow-up care, the malignancy may be coded as current or as a past history, dependent on the circumstances surrounding the episode of care. (See also ACS 1204 *Plastic surgery*, ACS 2112 *Personal history* and ACS 2114 *Prophylactic surgery*.)

Where there are multiple metastatic sites, assign a code for each site in order to reflect the severity of the condition.

**Page 113**

**Add** wording

## 0534 SPECIFIC INTERVENTIONS RELATED TO MENTAL HEALTH CARE SERVICES

Specific intervention codes related to mental health care services are included in ACHI Chapter 19 Interventions not elsewhere classified in the following blocks:

…

For admitted episodes of care it is not mandatory to assign code(s) for mental health care interventions with the exception of electroconvulsive therapy and repetitive transcranial magnetic stimulation. However their use is encouraged in specialist mental health care facilities and units to better represent care provided to these patients. It should also be noted that these interventions are not exclusive to mental health and may be assigned outside of this context.

**Page 133**

**Amend** spelling in example

## 0925 HYPERTENSION AND RELATED CONDITIONS

**EXAMPLE 4:**

30 year old man presents with headaches, nausea, vomiting and lethargy approximately two weeks after a severe sore throat. He is otherwise healthy with no known previous illness and is taking no medication. Physical examination reveals facial oedema. Blood pressure is 180/110 mmHg. Investigations including kidney biopsy confirmed the diagnosis of postinfectious glomerulonephritis and hypertension secondary to acute kidney disease.

| | | |
|---|---|---|
| Codes: | N00.9 | *Acute nephritic syndrome, unspecified* |
| | I15.1 | *Hypertension secondary to other disorders* |

…

**Page 184**

**Add** wording

## 1506 FETAL PRESENTATION, DISPROPORTION AND ABNORMALITY OF MATERNAL PELVIC ORGANS

### CLASSIFICATION

…

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 (see exception below regarding uterine scar):

O64 *Labour and delivery affected by malposition and malpresentation of fetus,*
O65 *Labour and delivery affected by maternal pelvic abnormality,* **or**
O66 *Other factors affecting labour and delivery.*

**Page 185**

**Delete** term in scenario

## 1511 TERMINATION OF PREGNANCY (ABORTION)

…

**EXAMPLE 1:**
Patient admitted for suction D&C (GA) for termination of pregnancy at (13/40) ~~weeks~~ due to fetal anencephaly.

| | | |
|---|---|---|
| Codes: | O04.9 | *Medical abortion, complete or unspecified, without complication* |
| | O09.1 | *Duration of pregnancy 5–13 completed weeks* |
| | O35.0 | *Maternal care for (suspected) central nervous system malformation in fetus* |
| | 35640-03 **[1265]** | *Suction curettage of uterus* |
| | 92514-99 **[1910]** | *General anaesthesia, ASA 99* |

**Page 188**

**Revise** scenario

## 1521 CONDITIONS AND INJURIES IN PREGNANCY

…

**EXAMPLE 6:**
A pregnant patient with elevated blood pressure (no diagnosis of hypertension) was admitted by her obstetrician to the obstetric unit for hourly BP (blood pressure) monitoring by midwifery staff. She was assessed by the dermatologist and then treated with calamine lotion for heat rash during the admission. Her blood pressure returned to normal and her rash was no longer evident, therefore she was discharged home the following day.

Codes:
O99.8 *Other specified diseases and conditions in pregnancy, childbirth and the puerperium*
R03.0 *Elevated blood-pressure reading, without diagnosis of hypertension*
O99.7 *Diseases of the skin and subcutaneous tissue in pregnancy, childbirth and the puerperium*
L74.0 *Miliaria rubra*

**Page 237**

**Amend** code and code title

## 1911 BURNS

…

**EXAMPLE 1:**

Patient admitted with full thickness burns to the inner aspect of the right forearm (2% BSA) and partial thickness of the left hand (6% BSA). Burns were due to boiling water from a coffee plunger, at work.

| | | |
|---|---|---|
| Codes: | T22.312 | *Full thickness burn of shoulder and upper limb, except wrist and hand, forearm and elbow* |
| | T23.2 | *Partial thickness [blisters, epidermal loss] burn of wrist and hand* |
| | T31.00 | *Burns involving less than 10% of body surface, with less than 10 % or unspecified full thickness burns* |
| | X10.0 | *Contact with hot drink* |
| | Y92.9 | *Unspecified place of occurrence* |
| | U73.09 | *While working for income, unspecified* |

…

**Page 277**

**Delete** index entry

# C

…
**Chemotherapy** 0044, ***58***
- for HIV/AIDS (human immunodeficiency virus/acquired immune deficiency syndrome) 0102, ***65***

**Page 284**

**Delete** index entry and add cross reference

# N

**Neoplasm(s)** 0236, ***84***
- chemotherapy 0044, ***58*** *— see Neoplasm(s), pharmacotherapy*
- contiguous sites 0234, ***83***

…
- pharmacotherapy 0044, ***58***

**Page 286**

**Add** index entry

…

**Septicaemia** 0110, ***73***

- clinical 0109, ***73***

- culture negative 0109, ***73***

- with neutropenia 0109, ***73***

**Sequela(e)** 0001, ***1***, 0008, ***18***

- cerebrovascular accident (CVA) 0604, ***115***

- injuries/poisonings/toxic effects/external causes 1912, **i**

- postprocedural 1904, ***223***

**Severe sepsis** 0110, ***73***