Subject: Eleventh Edition FAQs Part 1: ACS 0010 Clinical documentation and general abstraction guidelines - Clinician queries

Q:

Does the documentation within an episode of care require updating/amendment following a clinician response to a documentation query?

A:

Many questions were received regarding the revision of ACS 0010 *Clinical documentation and general abstraction guidelines* in relation to whether or not the documentation contained within the episode of care requires updating/amendment following a clinician's response to a documentation query. Specifically, "Does it mean that the doctor has to fix the medical record or is the coding query response sufficient"…for completeness of the episode of care. There is no mention of 'updating the clinical documentation' within an episode of care to reflect the clinician's response to a documentation query in ACS 0010, nor in other introductory sections of the ACS.

The query response is acceptable as an update to the episode of care and to inform accurate clinical coding, as long as the guidelines for generating appropriate queries to clinicians are followed.

This content has been adapted and disaggregated from the Eleventh Edition Frequently Asked Questions – Amended, issued 28 June 2019 for implementation 1 July 2019 (updated for 1 October 2019).

Subject: Eleventh Edition FAQs Part 1: ACS 0010 *Clinical documentation and general abstraction guidelines* – Abstraction from outside the episode of care

Q:

When should information located outside the episode of care be used to add further specificity?

A:

There have been a number of questions regarding using information from outside the episode of care to add further detail/specificity to documented conditions.

ACS 0010 *Clinical documentation and general abstraction guidelines* under the section *Roles and responsibilities in the documentation and abstraction* process states:

> Information from the health care record outside of that directly relating to the current episode of care can help to inform code assignment. For example:
>
> - past episodes of care (at current or other health facility)
> - referral letters and other correspondence
> - emergency notes
> - outpatient notes
>
> Such sources can be used to:
>
> - clarify documentation contained within the current episode of care
> - gain further specificity on documentation contained within the current episode of care
> - determine the reason for admission (eg reviewing outpatient notes and referral letters).

A Clinical Coder should only be looking outside of the current episode of care (eg past episodes, referral letters, emergency and/or outpatient notes) only when conditions documented in the current episode of care require further clarification or specificity, or where the reason for admission is required (eg from outpatient notes or referral letters).

For example, a patient is re-admitted for an intervention on their broken wrist, after presenting to the Emergency Department the day before. The use of the radiology report from the Emergency Department visit to gather specificity on the fracture detail is acceptable.

Another example, is where a patient is admitted for day only chemotherapy for ‘breast cancer’, but has no documentation of the morphology in this episode of care. It is acceptable to use the histopathology result from a previous episode to gather specificity regarding the morphology.

It is not intended that conditions which are not documented in the current episode of care be classified after finding them documented in a previous episode(s) of care.

For example, if there is documentation of a patient being a ‘smoker’ or ‘ex-smoker’ in the current episode of care (with no further detail), but a previous episode of care contained documentation that the patient had chronic obstructive pulmonary disease (COPD) due to harmful use of tobacco, the code for harmful use of tobacco and COPD cannot be assigned in the current episode of care.

In another example, the current episode of care contains documentation that the patient is a Type 2 diabetic without any complications/manifestations listed. Documentation in a previous episode(s) indicates that the patient has complications/manifestations with their Type 2 Diabetes. In this instance it is not acceptable to use the documentation from a previous episode of care to assign the codes for the complications/manifestations in the current episode of care.

Classification instructions in specialty standards (eg ACS 0236 *Neoplasm coding and sequencing* and ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia)* are meant to provide classification guidance to ensure clarity, specificity of the condition(s) and above all consistency when performing the clinical coding function. The guidance provided in the ACS is not intended to classify for severity of a condition. Where severity is required, this is depicted in ICD-10-AM itself (eg stages of pressure injury, stages of chronic kidney disease).

ACS 0010 was revised with the intent to minimise coder burden where there is ambiguous or poor documentation in the current episode of care. Tracking back through episodes of care to establish manifestations of diabetes or metastatic sites of a neoplasm is not expected unless it is for the reasons highlighted above

This content has been adapted and disaggregated from the Eleventh Edition Frequently Asked Questions – Amended, issued 28 June 2019 for implementation 1 July 2019 (updated for 1 October 2019).

Subject: Eleventh Edition FAQs Part 1: Allergens and anaphylaxis

Q:

When assigning codes for anaphylactic reactions, should codes for the individual components of the reaction also be assigned?

A:

Research indicates that anaphylaxis and anaphylactic shock are part of a continuum. Anaphylaxis is a serious and potentially life-threatening reaction to a trigger such as an allergy. The clinical manifestations of mild anaphylaxis may rapidly progress to a more severe anaphylaxis and lead to upper airway obstruction, respiratory failure, and circulatory shock (that is, anaphylactic shock).

ACS 0001 *Principal diagnosis/Codes for symptoms, signs and ill-defined conditions* states:

> Codes for symptoms, signs and ill-defined conditions from Chapter 18 *Symptoms signs and abnormal clinical and laboratory findings* are not to be used as principal diagnosis when a related definitive diagnosis has been established.

Therefore, the individual components of the anaphylactic reaction (ie bronchospasm) would not be classified in addition to the anaphylaxis.

This content has been adapted and disaggregated from the Eleventh Edition Frequently Asked Questions – Amended, issued 28 June 2019 for implementation 1 July 2019 (updated for 1 October 2019).

Subject: Eleventh Edition FAQs Part 1: Neoplasms

Q:

When a diagnosis is a complication of the neoplasm, or a complication of neoplasm treatment, does the neoplasm itself need to meet ACS 0002 to be assigned?

A:

ACS 0236 *Neoplasm coding and sequencing* provides the following instructions for clinical coding:

> A primary neoplasm is classified as a current condition if the episode of care is for:
>
> - diagnosis or treatment of the primary neoplasm, in any of the following circumstances:
> - initial diagnosis of the primary neoplasm
> - treatment of complications of the primary neoplasm or neoplasm treatment
>
> …

For example, if a patient is admitted for treatment/management of a complication of chemotherapy, ACS 0236 instructs that the neoplasm must also be coded as a current condition. As ACS 0236 is a specialty standard, its instruction overrides ACS 0002 in this instance.

This content has been adapted and disaggregated from the Eleventh Edition Frequently Asked Questions – Amended, issued 28 June 2019 for implementation 1 July 2019 (updated for 1 October 2019).

Subject: Eleventh Edition FAQs Part 1: Ophthalmology – cataract with glaucoma intervention

Q:

When coding cataract extraction with insertion of iStent, why is an additional ACHI code assigned for cataract extraction?

A:

ACS 0701 *Cataract* was developed based on DRG logic which has since been superseded. It is acknowledged that consideration be given to a revision/deletion of ACS 0701 in a future edition of the Australian Coding Standards. Updated DRG logic has rendered the sequencing of cataract and glaucoma codes inconsequential.

ACHI code 42705-00 **[200]** *Extraction of crystalline lens with implantation of trans-trabecular drainage device* is a combination code due to the fact that an iStent has not yet been approved by the Therapeutic Goods Administration (TGA) and cannot yet be performed in Australia without a cataract intervention. It is for this reason the code 42705-00 **[200]** is located in the block for cataract interventions (Block **[200]** *Extraction of crystalline lens)* and not in block **[191]** *Procedures for glaucoma*.

The rationale for the *Code first* note is to capture the full clinical concept regarding the cataract intervention (i.e. the mechanism of extraction).

In Eleventh Edition Errata 1 a *Code first* instruction was added at 42705-00 **[200]** to ensure:

- the type of cataract extraction is captured; and
- the cataract is sequenced ahead of the glaucoma procedure (and the insertion of lens).

As an ICD convention or instructional note overrides an ACS, the classification instruction in ACS 0701 *Cataract* which states '*If treatment for glaucoma and cataract is received during the same operation, sequence the glaucoma before the cataract for the diagnosis and the procedure codes.'* will not be applied for iStent cases.

This content has been adapted and disaggregated from the Eleventh Edition Frequently Asked Questions – Amended, issued 28 June 2019 for implementation 1 July 2019 (updated for 1 October 2019).

Subject: Eleventh Edition FAQs Part 1: Sequencing of complications following abortion, ectopic or molar pregnancy

Q:

Are there sequencing instructions for assigning Chapter 15 codes in obstetrics episodes?

A:

There is no sequencing instruction for Chapter 15 *Pregnancy, childbirth and the puerperium* codes within a code string, unless directed by an Instructional note/term in the Tabular List or an Australian Coding Standard.

ACS 1544 *Complications following abortion and ectopic and molar pregnancy* states:

> Codes from category O08 *Complications following abortion and ectopic and molar pregnancy* are assigned when a patient is admitted with a complication of an abortion, but the abortion was treated, performed or complete (eg complete spontaneous abortion) prior to the episode of care (ie the 'complication' is the focus of care; also referred to as the 'subsequent episode'):
>
> - Assign a code from category O08 *Complications following abortion and ectopic and molar pregnancy*
> - Assign a code from another chapter, where it adds specificity
> - Sequence codes as per the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*.

Example 5 in ACS 1544 demonstrates when the Chapter 15 code would be assigned as an additional diagnosis not a principal diagnosis (ie it was not the reason for admission).

This content has been adapted and disaggregated from the Eleventh Edition Frequently Asked Questions – Amended, issued 28 June 2019 for implementation 1 July 2019 (updated for 1 October 2019).

Subject: Eleventh Edition FAQs Part 1: Delivery and assisted delivery

Q:

If a patient delivers enroute with a McRobert's manoeuvre performed by paramedics and then spontaneously delivers the placenta in the admitted episode of care, is the principal diagnosis coded to O83 or O80?

A:

ACS 1505 *Delivery and assisted delivery codes* states:

> For classification purposes, once an assistance procedure is performed during the delivery episode of care (eg McRoberts manoeuvre, version, breech extraction), the delivery is **not classified as spontaneous**.
>
> …
>
> Delivery is not complete until after expulsion of the placenta, excluding any retained portion(s), expelled or requiring removal post delivery.

For the scenario above, the delivery was not completed until the patient was in the health care facility, therefore the location where the McRoberts manoeuvre was performed is irrelevant.

This content has been adapted and disaggregated from the Eleventh Edition Frequently Asked Questions – Amended, issued 28 June 2019 for implementation 1 July 2019 (updated for 1 October 2019).

Subject: Eleventh Edition FAQs Part 1: Wound Management – Vacuum assisted closure (VAC) dressings

Q:

How many times should a VAC dressing be assigned in an episode of care?

A:

From Eleventh Edition onwards, VAC dressings should be coded once per episode, unless a subsequent VAC dressing(s) is undertaken in theatre under cerebral anaesthesia. In such cases the additional VAC dressing(s) would be coded as many times as performed under cerebral anaesthesia.

Q:

Where a VAC dressing is performed with debridement, do we code debridement with a VAC dressing, or just the VAC dressing?

A:

Coders should assign both ACHI codes for debridement with a VAC dressing as there is no *Excludes* note at 90665-01 **[1628]** *Debridement of skin and subcutaneous tissue, not elsewhere classified* to instruct otherwise.

Q:

Where a debridement occurs with a repair, do we code both debridement and repair of the wound?

A:

For Eleventh Edition, both codes for the repair (suture) of the skin and subcutaneous tissue at Block **[1635]** and the debridement at block **[1628]** should be assigned.

Eleventh Edition Errata 1 removed an *Excludes* note and included a *Code also* note at the category level at block **[1635]** *Repair of wound and subcutaneous tissue* to code also the debridement 90665-01 **[1628]**.

This content has been adapted and disaggregated from the Eleventh Edition Frequently Asked Questions – Amended, issued 28 June 2019 for implementation 1 July 2019 (updated for 1 October 2019).

Subject: Eleventh Edition FAQs Part 1: Diabetes mellitus and pressure injuries

Q:

Do the guidelines in ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* for 'complications' of diabetes mellitus, apply to pressure injury in a patient with diabetes mellitus?

A:

ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia/General classification rules for DM and IH* Rule 3 states:

> The classification includes conditions (often termed 'complications') which occur commonly with DM or IH. These conditions may or may not have been a direct consequence of the metabolic disturbance and are indexed under *Diabetes, with* or *Hyperglycaemia/intermediate/with*. Always refer to these index entries to classify DM or IH (see examples 2-7).

ACS 1221 *Pressure injury* states that synonymous terms for pressure injury include pressure ulcer, decubitus ulcer, pressure area, plaster ulcer and bedsore.

However, none of the synonyms for pressure injury listed in ACS 1221 are entries in the Alphabetic Index under *Diabetes, with.*

Therefore, the guidelines in ACS 0401 for 'complications' of diabetes mellitus do not apply to pressure injury in a patient with diabetes mellitus, unless the criteria for diabetic foot are met (See also ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia/6. Diabetic foot*).

For Eleventh Edition there was also an *Excludes* note added at E1-.69 *Diabetes mellitus with other specified complication* excluding pressure ulcer not meeting the criteria for diabetic foot (L89.-).

This content has been adapted and disaggregated from the Eleventh Edition Frequently Asked Questions – Amended, issued 28 June 2019 for implementation 1 July 2019 (updated for 1 October 2019).

Subject: Eleventh Edition FAQs Part 1: Ongoing anticoagulation therapy

Q:

In episodes of ongoing anticoagulation therapy, when should a code for Z95.2 *Presence of prosthetic heart valve* be assigned? When should the underlying disease code (eg atrial fibrillation) be assigned?

A:

As per ACS 0002 *Additional diagnoses* do not assign an additional diagnosis code for a pre-existing condition requiring administration of ongoing medication. This includes where the ongoing medication is adjusted due to the management of another condition.

An additional diagnosis code can be assigned for a pre-existing condition if a change in the pre-existing condition requires an amendment to its treatment plan.

Assign additional diagnosis codes for a personal or family history of diseases and disorders, or statuses (eg artificial opening, organ transplantation, presence of functional implants, graft or other device, dependence on enabling machines or devices) classified to categories Z80–Z99 *Persons with potential health hazards related to family and personal history and certain conditions influencing health status*, when they are relevant to a condition being managed or an intervention being performed in the current episode of care.

In ACS 0303 *Abnormal coagulation profile due to anticoagulants* Example 3 the intervention of bridging Clexane was required due to the presence of the heart valve replacement, therefore it is relevant to the episode of care.

In ACS 0303 *Abnormal coagulation profile due to anticoagulants* Example 4 the adjustment of the medication was to manage the overwarfarinisation, and not management of the atrial fibrillation.

This content has been adapted and disaggregated from the Eleventh Edition Frequently Asked Questions – Amended, issued 28 June 2019 for implementation 1 July 2019 (updated for 1 October 2019).

IHPA

Subject: Eleventh Edition FAQs Part 2: Wound management

Q:

Can 96255-00 **[1601]** *Wound management NEC* be assigned for management of wounds on the ward (ie not in theatre) when performed by a medical officer, a specialist nurse, or allied health staff (eg podiatrist); or is this code only assigned for wound management performed in theatre under cerebral anaesthesia?

A:

The code 96255-00 **[1601]** *Wound management NEC* is only assigned where it meets the criteria in ACS 0042 *Procedures normally not coded*, that is if:

- cerebral anaesthesia is required in order for the procedure to be performed (see ACS 0031 *Anaesthesia*)
- it is the principal reason for admission in same-day episodes of care. This includes patients who are admitted the day before or discharged on the day after a procedure because a same-day admission is not possible or practicable for them (eg elderly patients, those who live in remote locations)
- another specialty standard directs they should be assigned. In such cases, the specialty standard overrides this list and the stated code is assigned.

Examples in the Eleventh Edition education material that are in contradiction to this standard, have been corrected for implementation 1 October 2019.

Subject: Eleventh Edition FAQs Part 2: Lactation consultation in newborn episode

Q:

Can the new allied health code for lactation consultant be used on a newborn/neonate episode when the lactation consultant sees the neonate and documents in the progress notes, or is it for use in the obstetric (mothers) episode of care only?

A:

The new intervention code 95550-16 **[1916]** *Allied health intervention, lactation consultant* is intended for use on the mother's episode of care, not on the newborn's episode of care (male or female). This is confirmed by the presence of the clinical (sex) edit on this code which prohibits its assignment on the episode of care of a male.

Where a newborn is reviewed for feeding problems by a lactation consultant (eg review of tongue tie), coders should assign a diagnosis code to indicate the neonatal condition causing the breastfeeding (attachment) difficulty, if applicable or a code from category P92 *Feeding problems of newborn*.

Subject: Eleventh Edition FAQs Part 2: Nontraumatic haematoma

Q:

Can a nontraumatic haematoma be assigned where documentation specifies ‘spontaneous’ or ‘due to an unknown cause’? When a haematoma is documented as due to anticoagulants, should the essential modifier of ‘nontraumatic’ be followed?

A:

A spontaneous haematoma can be assumed to be ‘nontraumatic’ and the essential modifier ‘nontraumatic’ followed to assign a code for a spontaneous haematoma.

Similarly, where a haematoma is documented as due to anticoagulants, it can be assumed to be ‘nontraumatic’ and the essential modifier ‘nontraumatic’ followed to assign a code for a spontaneous haematoma. This is supported by the *Code also, if applicable* instruction:

D68.3 *Haemorrhagic disorder due to circulating anticoagulants*

…

Code also, if applicable:

- nontraumatic haematoma of skin and subcutaneous tissue (L98.8)
- nontraumatic haematoma of soft tissue (M79.8-)

However, where a haematoma is documented as due to an unknown cause, without further qualification, a code for a traumatic haematoma is assigned following the alphabetic index where ‘traumatic’ is a nonessential modifier:

Haematoma (skin surface intact) (traumatic) *(see also Contusion)* T14.08

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

Subject: Eleventh Edition FAQs Part 2: Use of U91 Syndrome code

Q:

When classifying a syndrome classifiable to a single ICD-10-AM code, should U91 *Syndrome, not elsewhere classified* also be assigned?

A:

Where a syndrome is classified to a single code, U91 *Syndrome, not elsewhere classified* is not assigned.

For example, Brugada syndrome is classified to I49.8 *Other specified cardiac arrhythmias.*

The criteria for code assignment of U91 *Syndrome, not elsewhere classified* is specified in ACS 0005 *Syndromes*:

> Where there is no single ICD-10-AM code to classify all the elements of a syndrome, assign:
>
> - codes for the manifestations that are relevant for the patient, and meet the criteria in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*
>
> and
>
> - U91 *Syndrome, not elsewhere classified*, as an additional diagnosis to flag that the manifestations are related to a syndrome.

U91 *Syndrome, not elsewhere classified* is intended to identify rare syndromes that are not classifiable to a single code in ICD-10-AM.