Independent Hospital Pricing Authority

National Coding Advice

Coding Rules and FAQs for ICD-10-AM/ACHI/ACS Eleventh Edition current at 1 April 2022

IHPA

National Coding Advice – Coding Rules and FAQs for ICD-10-AM/ACHI/ACS
Eleventh Edition current at 1 April 2022

Contents

Coding Rules

Published 15 March 2022

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

Administration of nebulised antineoplastic agent

Q:

What code is assigned for administration of 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* where antineoplastic agents are administered through inhalation by nebulised droplets or powder aerosols.

Follow the ACHI Alphabetic Index:

Pharmacotherapy (systemic effect)

- for

- - neoplasm and/or neoplasm related conditions — *code to block* **[1920]** *with extension -00*

- specified NEC 96205 **[1920]**

Amendments will be considered for a future edition.

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: Q3775 | Published On: 15-Mar-2022 | Status: Current

History of positive result on COVID-19 rapid antigen test

Q:

Is a previous positive rapid antigen test (RAT) result for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) conducted by a patient at home (ie outside the health facility) sufficient to assign U07.3 *Personal history of COVID-19*?

A:

Coding Rule, titled *Classification of post COVID-19 conditions*, advises to assign U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* as an additional diagnosis where clinical documentation indicates that the patient has previously confirmed coronavirus disease 2019 (COVID-19) that is no longer current.

Documentation of a positive result of a rapid antigen test for SARS-CoV-2, that has been conducted by the patient at home (ie outside of the health facility) is not by itself confirmation of a past COVID-19 diagnosis.

Assign U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* where clinical documentation indicates a previously confirmed COVID-19 diagnosis that is no longer current.

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: Q3766 | Published On: 15-Mar-2022 | Status: Current

Use of rapid antigen test results for COVID-19 emergency use code assignment

Q:

Are rapid antigen test results considered laboratory tests for the purposes of assigning emergency use codes for COVID-19?

A:

Rapid antigen tests (RATs) detect the presence of specific proteins of the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) virus. RATs are more accurate when used by individuals with symptoms or those who have been in contact with a coronavirus disease 2019 (COVID-19) patient. RATs are not as accurate if people are asymptomatic. False positive or false negative results may be provided (TGA 2021).

The World Health Organization (WHO) has advised:

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

Clinical advice has confirmed that RATs are not a laboratory test, but are being used as confirmation of a COVID-19 diagnosis.

Assign U07.1 *Emergency use of U07.1 [COVID-19, virus identified]* when there is documentation of COVID-19 confirmed by a positive **laboratory** test for SARS-CoV-2 (such as polymerase chain reaction (PCR) test).

Assign U07.2 *Emergency use of U07.2 [COVID-19, virus not identified]* when there is documentation of COVID-19 confirmed via a **non-laboratory** test (such as an x-ray or a RAT) or where laboratory testing is inconclusive, not available or unspecified.

Do not assign Z03.8 *Observation for other suspected diseases and conditions* or U06.0 *Emergency use of U06.0 [COVID-19, ruled out]* based on a negative SARS-CoV-2 RAT result. Assign these codes only when a laboratory test has been performed and the result rules out COVID-19.

This advice was provided to jurisdictions for dissemination on 13 January 2022 and confirmed existing advice regarding the assignment of COVID-19 emergency use codes and other associated codes.

Reference:

Therapeutic Goods Administration 2021, *How testing works for COVID-19*, viewed 11 January 2022, <https://www.tga.gov.au/how-testing-works-covid-19#presence-rat>.

World Health Organisation 2021, *Antigen-detection in the diagnosis of SARS-CoV-2 infection*, viewed 14 January 2022, <https://www.who.int/publications/i/item/antigen-detection-in-the-diagnosis-of-sars-cov-2infection-using-rapid-immunoassays>.

Ref No: Q3776 | Published On: 15-Mar-2022 | Status: Current

Vaccine-induced immune thrombotic thrombocytopenia syndrome

Q:

What code is assigned for vaccine-induced immune thrombotic thrombocytopenia syndrome (VITTS)?

A:

Thrombosis with thrombocytopenia syndrome (TTS) is a rare and specific syndrome. It occurs when a person has blood clots (thrombosis) as well as low platelet counts (thrombocytopenia). It is also referred to as 'vaccine-induced immune thrombotic thrombocytopenia' (VITT) syndrome (Healthdirect 2021).

Coding Rule titled *Code assignment and sequencing for COVID-19 vaccines causing adverse effects in therapeutic use,* advises to assign an appropriate chapter code and external cause codes for specified adverse effects (complications) of a COVID-19 vaccination.

Assign D69.5 *Secondary thrombocytopenia* for VITT syndrome (VITTS).

Follow the ICD-10-AM Alphabetic Index:

Thrombocytopenia, thrombocytopenic

- secondary D69.5

Assign U07.7 *Emergency use of U07.7 [COVID-19 vaccines causing adverse effects in therapeutic use]* in addition to external cause codes where clinical documentation indicates that a patient has experienced an adverse effect due to a COVID-19 vaccination.

Improvements to this area of the classification have been included in ICD-10-AM Twelfth Edition.

See also Coding Rule *COVID-19 vaccines causing adverse effects in therapeutic use*.

See also Coding Rule *Code assignment and sequencing for COVID-19 vaccines causing adverse effects in therapeutic use*.

References:

Healthdirect 2021, *Thrombosis with thrombocytopenia syndrome (TTS)*, viewed 25 January 2022, <https://www.healthdirect.gov.au/thrombosis-with-thrombocytopenia-syndrome-tts>.

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: Current

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 total arthroplasty of hip*.

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

Follow the ACHI Alphabetic Index:

Revision

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

- - hip (total) 49324-00 **[1492]**

- - knee (total) 49527-00 **[1524]**

Amendments will be considered for a future edition.

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: Q3659 | Published On: 15-Dec-2021 | Status: Current

Gonioscopy-Assisted Transluminal Trabeculotomy (GATT) and AB-interno canaloplasty (ABiC)

Q:

What codes are assigned for Gonioscopy-Assisted Transluminal Trabeculotomy (GATT) and AB-interno canaloplasty (ABiC)?

A:

Gonioscopy-Assisted Transluminal Trabeculotomy (GATT) and AB-interno canaloplasty (ABiC) are both forms of minimally invasive glaucoma surgery (MIGS). They are performed for treatment of glaucoma in combination with procedures for the treatment of cataract.

GATT is performed via micro-incisions in the cornea, after which, the trabecular meshwork is cut. An advantage of the GATT approach is that there is less scar tissue and subsequent surgeries have a significantly higher rate of success (Glaucoma Associates of Texas 2021).

ABiC uses an illuminated microcatheter technology called iTrack to viscodilate the Schlemm channels of the eye in order to improve aqueous outflow without a stent or shunt. Instead of changing or bypassing the natural drainage pathways of aqueous humour, ABiC is designed to restore the natural outflow pathway by addressing all drainage channels (Webeyeclinic 2018).

Assign 90075-00 **[191]** *Other procedures for glaucoma* when GATT or ABiC is performed.

Follow the ACHI Alphabetic Index:

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

See also Coding Rule *Insertion of minimally invasive glaucoma surgery (MIGS) device without concurrent cataract extraction.*

Improvements to ACHI are proposed for Twelfth Edition.

References:

Glaucoma Associates of Texas 2021, *GATT procedure: Gonioscopy-Assisted Transluminal Trabeculotomy*, viewed 15 September 2021, <https://www.glaucomaassociates.com/gonioscopy-assisted-transluminal-trabeculotomy/>.

Webeyeclinic 2018, ABiC Glaucoma Procedure, viewed 15 September 2021, <https://www.webeyeclinic.com/glaucoma/abic-glaucoma-procedure>

Ref No: Q3516 | Published On: 15-Dec-2021 | Status: Current

Lynch syndrome

Q:

What codes are assigned for same-day endoscopy for Lynch syndrome?

A:

Lynch syndrome is a genetic disorder that causes an increased risk of developing cancers. The most common cancer in people with Lynch syndrome is colorectal (large bowel) cancer. However, having Lynch syndrome does not necessarily result in developing cancer. The most common check-up is a colonoscopy to examine large intestinal tract (Cancer Australia n.d.; Centers for Disease Control and Prevention 2020).

Where Lynch syndrome is documented as the indication for same-day screening endoscopy apply the guidelines in ACS 0052 *Same-day endoscopy - Surveillance*:

- Assign Z12.1 *Special screening examination for neoplasm of intestinal tract* as principal diagnosis if no cancer is detected or has ever been detected. ACS 0052 states:

  Assign as principal diagnosis:

  - *an appropriate code from categories Z11, Z12 and Z13 Special screening examination for… if screening for a disease pre-cursor (risk factor) or other factor and no disease is detected or has ever been detected*

  Follow the ICD-10-AM Alphabetic Index:

  Screening
  - Lynch syndrome Z12.1

- Assign a code from category C18 *Malignant neoplasm of colon*, or C19 *Malignant neoplasm of rectosigmoid junction*, where a malignant neoplasm is detected.

Do not follow the ICD-10-AM Alphabetic Index at the lead terms *Lynch syndrome* or *Syndrome/Lynch* unless a malignant neoplasm has been detected.

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

References:
Cancer Australia, n.d, *Lynch Syndrome*, viewed 01 December 2021, <https://www.canceraustralia.gov.au/affected-cancer/lynch-syndrome>.

Centers for Disease Control and Prevention 2020, *Lynch Syndrome*, viewed 01 December 2021, <https://www.cdc.gov/genomics/disease/colorectal_cancer/lynch.htm>.

Ref No: Q3753 | Published On: 15-Dec-2021 | Status: Current

Monoclonal antibodies for treatment of COVID-19

Q:

What codes are assigned when monoclonal antibodies are 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 the published *National Coding Advice*.

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*

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: Q3757 | Published On: 15-Dec-2021 | Status: Current

Testing for evidence of a previous SARS-CoV-2 infection

Q:

What code should be assigned where a patient is tested for evidence of a previous SARS-CoV-2 infection?

A:

Coding Rule *Application of U06.0 Emergency use of U06.0 [COVID-19, ruled out]* confirms that health care facilities may test admitted patients for SARS-CoV-2 infection where COVID-19 is a differential diagnosis or there is a decision to rule out COVID-19 for other reasons.

Where a patient is tested with an intention to look for evidence of previous COVID-19 infection, rather than an acute/current COVID-19 infection, do not assign U06.0.

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

See also Coding Rule *Classification of post COVID-19 conditions*.

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: Q3639 | Published On: 15-Sep-2021 | Status: Current

Autoimmune autonomic ganglionopathy

Q:

What code is assigned for autoimmune autonomic ganglionopathy?

A:

Autoimmune autonomic ganglionopathy (AAG) is a type of autonomic neuropathy in which the body's own immune system attacks the receptor of the ganglia (part of the peripheral autonomic nerve fiber) (WHO 2020).

AAG manifestations vary from person to person. Symptoms may include severe orthostatic hypotension, fainting, constipation, fixed and dilated pupils, urinary retention, and dry mouth and eyes (GARD 2021).

The correct code to assign for AAG is G90.8 *Other disorders of autonomic nervous system.*

Follow the ICD-10-AM Alphabetic Index:

Disorder (of)

- autonomic nervous system

- - specified NEC G90.8

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

- Reference

Genetic and Rare Diseases centre (GARD) (2021), *Autoimmune autonomic ganglionopathy*, viewed 7 May 2021, <https://rarediseases.info.nih.gov/diseases/11917/autoimmune-autonomic-ganglionopathy>.

World Health Organization (WHO) (2020), ICD-11 Mortality and Morbidity Statistics (MMS), viewed 7 May 2021, <https://icd.who.int/browse11/l-m/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f1029892421>.

Ref No: Q3742 | Published On: 15-Sep-2021 | Status: Current

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

Q:

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

A:

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

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

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

Ref No: Q3499 | Published On: 15-Sep-2021 | Status: Current

Epileptic psychosis with delirium

Q:

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

A:

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

Follow the ICD-10-AM Alphabetic Index:

Epilepsy, epileptic, epilepsia

- psychosis

- - with delirium F05.8

or

Psychosis

- epileptic

- - with delirium F05.8

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

Use additional code to identify underlying disease.

Amendments will be considered for a future edition.

Ref No: Q3718 | Published On: 15-Sep-2021 | Status: Current

Fever as an adverse effect of COVID-19 vaccination

Q:

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

A:

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

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

Follow the ICD-10-AM Alphabetic Index:

Fever

- drug-induced R50.2

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

Ref No: Q3726 | Published On: 15-Sep-2021 | Status: Current

Monoclonal macroglobulinaemia

Q:

What morphology code is assigned for monoclonal macroglobulinaemia?

A:

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

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

Macroglobulinaemia (idiopathic) (primary)
- monoclonal (essential) D47.2

Assign the following topography and morphology codes for monoclonal macroglobulinaemia:

D47.2 *Monoclonal gammopathy of undetermined significance (MGUS)*
M9765/1 *Monoclonal gammopathy of undetermined significance*

This has been corrected for Twelfth Edition.

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: Current

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

Note that ACS 1506 *Fetal presentation, disproportion and abnormality of maternal pelvic organs* and the cited indexing were amended in Eleventh Edition Errata 3.

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>.

Ref No: Q3638 | Published On: 15-Jun-2021 | Status: Current

Telangiectasia of the intestine and rectum

Q:

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

A:

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

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

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

Follow the ICD-10-AM Alphabetic Index:

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

- with haemorrhage K55.22

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

References and Bibliographies

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

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

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

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

Coding Rules

Published 16 March 2021

Ref No: Q3624 | Published On: 16-Mar-2021 | Status: Current

Characteristics of left ventricular failure

Q:

What is the correct code assignment 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 I50.9

See also Coding Rule *Congestive cardiac failure (CCF) and left ventricular failure (LVF)*.

Amendments will be considered for a future edition.

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: TN1551 | Published On: 16-Mar-2021 | Status: Current

COVID-19 vaccines causing adverse effects in therapeutic use

Effective from 1 January 2021

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

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

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

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

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

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

L50.0 *Allergic urticaria*

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

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

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

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

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

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

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

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

See also Coding Rule *Allergens and anaphylaxis.*

Reference:

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

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

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

Published 16 March 2021,
for implementation 01 January 2021.

Ref No: Q3625 | Published On: 16-Mar-2021 | Status: Current

Delirium superimposed on specified and unspecified dementia

Q:

What codes are assigned for a diagnosis of specified dementia (ie vascular) with delirium?

What codes are assigned for unspecified 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, if known.

For example, for vascular dementia not otherwise specified (NOS) assign F01.9 *Vascular dementia, unspecified*.

Follow the ICD-10-AM Alphabetic Index:

Dementia

- vascular (of) F01.9

Where dementia with delirium is documented but the type of dementia is not specified, do not assign F03 *Unspecified dementia*, as it does not add specificity.

Published 16 March 2021,
for implementation 01 April 2021.

Ref No: Q3490 | Published On: 16-Mar-2021 | Status: Current | Supersedes: TN1505

Glaucoma drainage device insertion and cataract extraction

Q:

What is the sequencing for cataract and glaucoma diagnosis codes?

For intervention codes, is it necessary to follow the *Code first* instruction in the ACHI Tabular List at 42705-00 **[200]** *Extraction of crystalline lens with implantation of trans-trabecular drainage device* and assign a code for cataract extraction, even if the type of cataract extraction is not documented?

A:

Diagnosis codes for cataract and glaucoma are sequenced in accordance with the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*.

For intervention codes, the *Code first* instruction must be followed and a code for extraction of crystalline lens must be assigned first with 42705-00 **[200]** *Extraction of crystalline lens with implantation of trans-trabecular drainage device*. Where the type of cataract extraction is not documented, assign 42698-05 **[200]** *Other extraction of crystalline lens*.

Follow the ACHI Alphabetic Index:

Extraction

- lens (crystalline) NEC 42698-05 **[200]**

An update in this area of classification is being progressed for Twelfth Edition.

Published 16 March 2021,
for implementation 01 April 2021.

Ref No: Q3612 | Published On: 16-Mar-2021 | Status: Current

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 (Z80–Z99)* states:

> Assign additional diagnosis codes for a personal or family history of diseases and disorders, or statuses (eg…) classified to categories Z80–Z99, when they are relevant to a condition being managed or an intervention being performed in the current episode of care.

Where there is documentation of long term use of prescribed medicinal cannabis that meets criteria in ACS 0002 *Additional diagnoses/Family and personal history and certain conditions influencing health status (Z80–Z99)*, assign Z92.28 *Personal history of long term (current) use of other medicaments, other medicaments*.

Follow the ICD-10-AM Alphabetic Index:

Long

- term use (current) of

- - medicaments NEC Z92.28

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>.

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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>.

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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*

O03.5 *Spontaneous abortion, complete or unspecified, complicated by genital tract and pelvic infection*

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*.

Note that the classification of sepsis is under review for ICD-10-AM/ACS Twelfth Edition.

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.

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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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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.

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Coding Rules

Published 18 December 2020

Ref No: Q3579 | Published On: 18-Dec-2020 | Status: Current

Clarification of nursing scope of practice and use of nursing documentation to inform code assignment

The Australian Coding Standards (ACS) How to use this document states:

> …
>
> *The term 'clinician' is used throughout the ACS and refers to the treating medical officer but may refer to other clinicians such as allied health professional, midwives, and nurses. Generally, medical officer documentation is the primary source for clinical coders to use for classification purposes. The following example indicates that clinical coders can also use documentation from other clinicians if the documented information is appropriate to the clinician's scope of practice.*
>
> ***EXAMPLE 1:***
>
> - *Malnutrition documented by a dietitian*
> - *Pressure injuries documented by a wound specialist (Clinical Nurse Specialist) or a registered nurse*
> - *Post partum haemorrhage documented by a midwife*
> - *Dysphagia documented by a speech pathologist*

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.

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Clarification of ACS 0236 *Neoplasm coding and sequencing*

Q:

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

A:

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

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

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

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

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

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

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

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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.

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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.

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Ref No: Q3522 | Published On: 18-Dec-2020 | Status: Current

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

Q:

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

A:

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

For example:

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

  Follow the ICD-10-AM Alphabetic Index:

  Sepsis (generalised)

  - Gram-negative (organism)

  - - specified NEC A41.58

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

  Follow the ICD-10-AM Alphabetic Index:

  Bacteraemia *(see also Infection/by type)*

  Infection, infected (opportunistic)

  - Klebsiella (K.) pneumoniae NEC A49.8

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

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

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

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Multisystem inflammatory syndrome associated with COVID-19

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

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

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

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

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

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

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

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

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

References:

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

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

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

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

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Classification of post COVID-19 conditions

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

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

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

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

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

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

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

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

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

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

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

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

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

Codes: J12.8 *Other viral pneumonia*

Z50.9 *Rehabilitation*

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

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

Codes: J18.9 *Pneumonia, unspecified*

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

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

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

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

Reference:

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

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

Q:

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

A:

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

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

Follow the ACHI Alphabetic Index:

Procedure

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

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

References:

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

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

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Oral pharmacotherapy for neoplasm and neoplasm (treatment) related conditions

Q:

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

A:

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

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

Follow the ACHI Alphabetic Index:

Pharmacotherapy (systemic effect)

- oral 96203 **[1920]**

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

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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/OrphrynglArwy.

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: Q3527 | Published On: 18-Dec-2020 | Status: Current

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 the relevant code from category F64 *Gender identity disorders.*

Amendments maybe considered for a future edition.

References:

Healthdirect Australia 2019, Gender confirmation surgery, Healthdirect Australia, viewed 2 March 2020, https://www.healthdirect.gov.au/gender-confirmation-surgery.

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Terms synonymous with adhesiolysis

Q:

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

A:

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

Adhesiolysis — *see also Division/adhesions*

Division (freeing)

- adhesions

Freeing

- adhesions — *see Division/adhesions*

Lysis — *see also Division*

- adhesions — *see Division/adhesions*

Release

- adhesions

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

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

Amendments will be considered for a future edition.

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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 following delivery of placenta) NEC O72.1

- - delayed or secondary 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*

Place of occurrence code

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

Complication(s) (from) (of)

- caesarean section wound (puerperal) NEC O90.8
- obstetric
- - surgical wound (puerperal) NEC O90.8

Section II External Causes of Injury:

Complication(s) (delayed) (medical or surgical procedure) (of or following)

- surgical operation
- - specified NEC Y83.8

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.*

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
	PrimarySecondary
Neoplasm, neoplastic	
- pericardium.....	C38.0C79.88

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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Ref No: Q3610 | Published On: 18-Dec-2020 | Status: Current

Vena cava thrombus or pulmonary embolism due to central or peripheral vascular catheter

Q:

What codes are assigned for vena cava thrombus or pulmonary embolism due to central or peripheral vascular catheter?

A:

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 the Alphabetic Index. Assign an additional code to provide specificity of the condition, not the anatomical site.

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

Follow the ICD-10-AM Alphabetic Index:

Complication(s) (from) (of)

- vascular

- - device, implant or graft

- - - embolism T82.82

- - - thrombosis T82.82

Also assign external cause codes.

T82.82 contains sufficient specificity regarding the complicating condition (ie embolism or thrombosis). Do not assign an additional code from Chapter 9 *Diseases of the circulatory system* to specify the site of the embolism or thrombosis.

Note, however, that embolism or thrombosis following a procedure (eg insertion of a device) are medical conditions that commonly occur postoperatively. Where there is no causal link documented between these conditions and insertion of a device, do not assign T82.82. Follow the guidelines in ACS 1904 *Procedural complications/Intraoperative/postoperative medical conditions*.

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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

- in pregnancy, childbirth or puerperium (intrahepatic) 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 (*Code also specific liver disorder, if known*) 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:

Pregnancy (single) (uterine)

- complicated by

- - conditions in

- - - K00–K93 O99.6

- - diseases of

- - - digestive system (conditions in K00–K66, K80–K93) NEC O99.6

Cholestasis NEC K83.1

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.

Amendments will be considered for a future edition.

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 Inde*terminate 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 *Complications of prosthetic devices, implants and grafts.* Assign an additional code to provide specificity of the condition.

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

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

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Coding Rules

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Eleventh Edition ACS 1904 *Procedural complications* – due to/related to prosthetic devices, implants or grafts

This Coding Rule supersedes the published Coding Rule of the same name, implemented 1 July 2019, to correct the following errors:

- Incorrect principal diagnosis assigned in Example 3
- Incorrect code assignment in Example 5

Procedural complications may be classified to either the body system chapters or block T80–T88 *Complications of surgical and medical care, not elsewhere classified*.

Where a complication is related to a prosthetic device, implant or graft, assign an appropriate code from T82–T85 *Complications of prosthetic devices, implants and grafts*, unless otherwise directed by the Alphabetic Index or not supported by an *Includes* note.

Where a condition is not related to a prosthetic device, implant or graft and:

- it is related to a body system, assign an appropriate code from the body system chapter
- the complication is not related to a body system, assign an appropriate code from T80–T81 or T86–T88

ACS 1904 *Procedural complications/Overview/dot point three*, supports the use of codes in T82–T85 for complications specific to prosthetic devices, implants and grafts including mechanical complication, infection, pain, thrombosis, haemorrhage, mesh erosion and so on.

A causal relationship does not need to be documented to assign a procedural complication when a condition is classified to block T82–T85 unless there is a specific Coding Rule or ACS that indicates otherwise (eg complications related to coronary artery bypass graft).

Example 1: Patient with a history of endovascular aneurysm repair (EVAR) of an abdominal aortic aneurysm (AAA) with a bifurcated endoprosthesis, was readmitted due to intermittent abdominal pain and progressive dyspnoea. Computed tomography (CT) angiogram of the aorta confirmed endoleaks following EVAR.

Assign:

T82.3 *Mechanical complication of other vascular grafts*

External cause codes

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

Leak, leakage

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

- - arterial graft NEC T82.3

Example 2: Patient was admitted for a ruptured anterior cruciate ligament (ACL) graft for which the patient underwent revision of a left knee ACL reconstruction.

Assign:

T84.4 *Mechanical complication of other internal orthopaedic devices, implants and grafts*

External cause codes

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

Complication(s) (from) (of)

- orthopaedic

- - device, implant or graft *(see also Complication(s)/by site and type)* T84.9

- - - mechanical NEC T84.4

Example 3: A 59-year-old woman was admitted with loss of mobility, and pain in her left leg stump. She had a below knee amputation (BKA) of her left lower limb in 2010. She only intermittently wore her prosthesis over the amputated site, because of persistent touch-evoked pain. Physical examination revealed erythema on the stump with cellulitis. She was diagnosed with cellulitis of the amputation stump due to an ill-fitting prosthetic limb.

Assign:

T88.8 *Other specified complications of surgical and medical care, not elsewhere classified*

L03.13 *Cellulitis of lower limb*

Y84.8 *Other medical procedures*

Place of occurrence code

Z89.5 *Acquired absence of leg at or below knee*

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

Complication(s)

- orthopaedic

- - external device or appliance T88.8

Cellulitis (diffuse) (with lymphangitis)

- limb

- - lower L03.13

Absence

- extremity (acquired)

- - lower

- - - below knee (unilateral) Z89.5

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

Complication(s) (delayed) (medical or surgical procedure) (of or following)

- procedures other than surgical operation NEC (see also Complication(s)/by type of procedure)

- - specified Y84.8

Example 4: Urethral trauma/injury sustained from displacement of an indwelling catheter.

Assign:

T83.0 *Mechanical complication of urinary (indwelling) catheter*

External cause codes

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

Displacement, displaced

- device, implant or graft (see also Complication(s)/by site and type/mechanical)
- - catheter NEC
- - - urinary (indwelling) T83.0

It is not necessary to assign an additional code from Chapter 19 (eg S37.3- *Injury of urethra*) to indicate the site of the post-operative complication. The purpose of S codes in Chapter 19 *Injury, poisoning and certain other consequences of external causes* is to classify injures due to trauma (ie an injury not related to an intervention).

If urethral trauma/injury occurs during removal (accidental or intentional) of an indwelling catheter (IDC) by a patient, ACS 1904 is not applicable as the trauma/injury is not a complication of the device (catheter).

Where the urethral trauma/injury meets the criteria in ACS 0002 *Additional diagnoses*, assign:

S37.3- *Injury of urethra*

X58 *Exposure to other specified factors*

Place of occurrence and activity codes

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

Injury

- urethra (sphincter) S37.30
- - membranous S37.31
- - penile S37.32
- - prostatic S37.33
- - specified part NEC S37.38

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

Exposure (to)

- factor(s)
- - specified NEC X58

Example 5: Ureteral stricture due to a procedure.

Ureteral stricture occurring after insertion of prosthetic devices, implants or grafts is classified as a complication of prosthetic devices, implants or grafts.

Assign:

T83.84 *Stenosis following insertion of genitourinary prosthetic devices, implants and grafts*

External cause codes

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

Complication(s) (from) (of)

- genitourinary NEC (see also Complication(s)/by site and type)
- - device, implant or graft
- - - stricture (stenosis) T83.84

Ureteral stricture due to a procedure with no involvement of prosthetic devices, implants or grafts is classified to an appropriate code from the end of body system chapter.

Assign:

N99.89 *Other intraoperative and postprocedural disorder of genitourinary system*

N13.5 *Kinking and stricture of ureter without hydronephrosis*

External cause codes

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

Complication(s) (from) (of)

- genitourinary NEC *(see also Complication(s)/by site and type*)
- - intraoperative or postprocedural
- - - specified NEC N99.89

Stricture

- ureter (postprocedural) N13.5

N13.5 is assigned as an additional diagnosis to provide further specificity of the condition (ie ureteral stricture).

Example 6: Lymphocele following cannulation of the femoral vein.

Assign:

T82.89 *Other specified complications of cardiac and vascular prosthetic devices, implants and grafts*

I97.83 *Postprocedural lymphocele, lymphoedema and chylothorax*

External cause codes

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

Complication(s) (from) (of)

- vascular

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

- - - infusion catheter

- - - - specified NEC T82.89

Lymphocele I89.8

- postprocedural I97.83

I97.83 is assigned to provide further specificity of the condition (ie postprocedural lymphocele) (Note: there are no *Excludes* notes to prevent assignment of T82.89 and I97.83 together). However, it is not necessary to assign I89.8 *Other specified noninfective disorders of lymphatic vessels and lymph nodes* as it does not provide further specificity of the condition.

This content has been adapted and disaggregated from the Clarification on the application of ACS 1904 *Procedural complications* issued 28 June 2019 for implementation 1 July 2019 (updated for 1 October 2020)

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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, should codes for the symptoms or manifestations of the reaction also be 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 criteria in ACS 0002*

- 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.

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Ref No: Q3422 | Published On: 21-Sep-2020 | Status: Current

Catamenial anaphylaxis

Q:

What code is assigned for catamenial anaphylaxis?

A:

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

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

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

Follow the ICD-10-AM Alphabetic Index:

Disease, diseased

- pelvis, pelvic

- - female

- - - specified N94.8

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

Follow the ICD-10-AM Alphabetic Index:

Anaphylaxis

- due to

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

Also assign external cause and place of occurrence codes.

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

Amendments will be considered for a future edition.

References:

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

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

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

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Ref No: Q3457 | Published On: 21-Sep-2020 | Status: Current

Transoral endoscopic (hemi) thyroidectomy vestibular approach

Q:

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

A:

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

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

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

Follow the ACHI Alphabetic Index:

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

Thyroidectomy

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

Amendments will be considered in a future edition.

References:

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

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Ref No: Q3479 | Published On: 21-Sep-2020 | Status: Current

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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Ref No: Q3489 | Published On: 21-Sep-2020 | Status: Current

Spinal cord compression secondary to neoplasm

Q:

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

A:

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

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

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

G99.2* *Myelopathy in diseases classified elsewhere*

G95.2 *Cord compression, unspecified*

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

Follow the ICD-10-AM Alphabetic Index:

Myelopathy

- in (due to)

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

Compression

- spinal (cord) G95.2

References:

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

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

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for implementation 01 October 2020.

Ref No: Q3492 | Published On: 21-Sep-2020 | Status: Current

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 *Venom of other arthropods* first, followed by

T78.2 *Anaphylaxis and anaphylactic shock, unspecified*

Y37.61 *Allergy to bees*

Place of occurrence code

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

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 if applicable, to identify reaction such as:*
>
> *…*
>
> - anaphylaxis and anaphylactic shock (T78.2)

The *Instructional* note at T78.2:

> *Use additional external cause code (Y37.-) to identify allergen, if known.*

Amendments will be considered for a future edition.

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Ref No: Q3504 | Published On: 21-Sep-2020 | Status: Current

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 Rules Q3479 *Lower respiratory tract infection (LRTI) with presence of chronic obstructive pulmonary disease (COPD)* and Q3505 *COPD exacerbation and influenza*.

Amendments will be considered for a future edition.

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Ref No: Q3505 | Published On: 21-Sep-2020 | Status: Current

COPD exacerbation and influenza

Q:

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

A:

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

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

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

ACS 0015 *Combination codes* states:

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

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

Follow the ICD-10-AM Alphabetic Index:

Disease, diseased

- lung

- - obstructive (chronic)

- - - with (acute)

- - - - exacerbation NEC

- - - - - infective J44.0

Influenza

- virus

- - identified (respiratory manifestations) (seasonal) NEC *(see also Influenza/A/H5N1)* J10.1

- - not identified (respiratory manifestations) NEC J11.1

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

Amendments will be considered for a future edition.

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Ref No: 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: Q3547 | Published On: 21-Sep-2020 | Status: Current

Newborn of a diabetic mother

Q:

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

A:

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

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

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

  Follow the ICD-10-AM Alphabetic Index:

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

  - in pregnancy, childbirth or puerperium

  - - affecting fetus or newborn P70.1

  - - arising in pregnancy

  - - - affecting fetus or newborn P70.0

  - - gestational

  - - - affecting fetus or newborn P70.0

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

  Follow the ICD-10-AM Alphabetic Index:

  Observation (for)

  - newborn

  - - for suspected condition

  - - - specified condition NEC Z03.79

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

Amendments will be considered for a future edition.

References:

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

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

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Ref No: Q3528 | Published On: 21-Sep-2020 | Status: Current

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

Q:

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

A:

The Conventions used in the Alphabetic Index of Interventions state:

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

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

Replacement

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

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

Follow the ACHI Alphabetic Index:

Replacement

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

Amendments will be considered for a future edition.

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Ref No: Q3615 | Published On: 21-Sep-2020 | Status: Current

Tight perineum as indication for episiotomy

Q:

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

A:

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

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

Follow the ICD-10-AM Alphabetic Index:

Rigid, rigidity

- perineum or vulva

- - affecting

- - - labour or delivery O65.5

Amendments will be considered for a future edition.

References:

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

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

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Ref No: Q3614 | Published On: 21-Sep-2020 | Status: Current

Venous hypertension

Q:

What code is assigned for peripheral venous hypertension?

A:

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

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

Follow the ICD-10-AM Alphabetic Index:

Increase, increased

- venous pressure I87.8

Amendments will be considered for a future edition.

References:

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

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

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

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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: Current

Excision of mesh following vaginal or urethral erosion

Q:

What codes are assigned for excision of mesh following vaginal or urethral erosion?

A:

Assign the following codes for excision of mesh due to vaginal erosion:

35557-00 **[1282]** *Excision of lesion of vagina*

92116-00 **[1900]** *Removal of other device from genital tract*

Follow the ACHI Alphabetic Index:

Excision — *see also Removal*

- lesion(s)

- - vagina 35557-00 **[1282]**

Removal — *see also Excision*

- device

- - genitourinary tract NEC 92116-00 **[1900]**

Mesh erosion involving the urethra is a more 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.

Amendments will be considered for a future edition.

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Ref No: Q3570 | Published On: 21-Sep-2020 | Status: Current

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

Phantom limb pain

Q:

What code is assigned for phantom limb pain?

A:

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

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

Follow the ICD-10-AM Alphabetic Index:

Phantom limb syndrome (without pain) G54.7

- with pain G54.6

Amendments will be considered for a future edition.

References:

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

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

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

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for implementation 01 October 2020.

Ref No: Q3558 | Published On: 21-Sep-2020 | Status: Current

Haemorrhoid procedure using LigaSure™ device

Q:

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

A:

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

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

Follow the ACHI Alphabetic Index:

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

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

Amendments will be considered for a future edition.

References:

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

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

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Ref No: Q3555 | 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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Ref No: Q3553 | Published On: 21-Sep-2020 | Status: Current

Admission for correction of stretched earlobe(s)

Q:

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

A:

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

H61.1 *Noninfective disorders of pinna*

W45.0 *Body piercing*

Place of occurrence and activity codes

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

Deformity

- ear (acquired) H61.1

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

Piercing

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

Amendments will be considered for a future edition.

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Ref No: Q3548 | Published On: 21-Sep-2020 | Status: Current

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 of 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 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.

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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/.

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Covered endovascular reconstruction of the aortic bifurcation (CERAB)

Q:

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

A:

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

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

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

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

Follow the ACHI Alphabetic Index:

Insertion

- stent

- - artery

- - - aorta (transluminal)

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

Amendments will be considered for a future edition.

References:

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

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for implementation 01 July 2020.

Ref No: Q3447 | Published On: 22-Jun-2020 | Status: Current

Debulking of free flap

Q:

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

A:

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

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

Follow the ACHI Alphabetic Index:

Revision

- flap

- - free

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

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

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

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

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

Amendments will be considered for a future edition.

References:

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

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

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Ref No: Q3518 | Published On: 22-Jun-2020 | Status: Current

Fetal intracardiac injection for termination of pregnancy

Q:

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

A:

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

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

Follow the ACHI Alphabetic Index:

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

Amendments will be considered for a future edition.

References:

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

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

Published 22 June 2020,
for implementation 01 July 2020.

Ref No: Q3531 | Published On: 22-Jun-2020 | Status: 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 (that were properly administered) to code range T88.2–T88.59 and is reflected in the ICD-10-AM Alphabetic Index:

Anaesthesia, anaesthetic

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

Complication(s)

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

…

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

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

Follow the ICD-10-AM Alphabetic Index:

Complication(s)

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

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

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

Amendments will be made for a future edition.

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Ref No: Q3530 | Published On: 22-Jun-2020 | Status: Current

Latarjet procedure

Q:

What codes are assigned for Latarjet procedure?

A:

Latarjet procedure, also known as Latarjet-Patte procedure, is a surgical option for treatment of recurrent shoulder dislocation, congenital deformity or trauma in the presence of glenoid bone loss (Hurley et al. 2019). This procedure can be performed both open and arthroscopically. The Latarjet procedure involves transferring part of the coracoid process and the adjacent tendon to the anterior glenoid rim to improve stability (Hurley et al. 2019).

Where Latarjet procedure is performed by an open approach, assign:

48930-00 **[1404]** *Stabilisation of shoulder*

48242-00 **[1569]** *Bone graft with internal fixation, not elsewhere classified*

Where Latarjet procedure is performed arthroscopically, assign:

48957-00 **[1404]** *Arthroscopic stabilisation of shoulder*

48242-00 **[1569]** *Bone graft with internal fixation, not elsewhere classified*

Follow the ACHI Alphabetic Index:

Stabilisation

- joint (see also Arthrodesis)
- - shoulder 48930-00 **[1404]**
- - - arthroscopic 48957-00 **[1404]**

Graft (repair)

- bone
- - with
- - - internal fixation NEC 48242-00 **[1569]**

Amendments will be considered for a future edition.

References:

Hurley, E.T., Lim Fat, D., Farrington, S.K. & Mullett, H. 2019, 'Open versus arthroscopic Latarjet procedure for anterior shoulder instability: a systematic review and meta-analysis', *American Journal of Sports Medicine*, vol. 47, no. 5, pp. 1248–1253. https://doi.org/10.1177%2F0363546518759540.

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for implementation 01 July 2020.

Ref No: Q3459 | Published On: 22-Jun-2020 | Status: Current

Lipoedema

Q:

What code is assigned for lipoedema?

A:

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

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

Assign R60.0 *Localised oedema*.

Follow the ICD-10-AM Alphabetic Index:

Lipoedema — *see Oedema*

Oedema, oedematous

- localised R60.0

Amendments will be considered for a future edition.

References:

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

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

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

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

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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.

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Ref No: Q3480 | Published On: 22-Jun-2020 | Status: Current

Median arcuate ligament syndrome

Q:

What code is assigned for median arcuate ligament syndrome?

A:

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

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

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

Follow the ICD-10-AM Alphabetic Index:

Syndrome

- coeliac artery compression I77.4

Amendments will be considered for a future edition.

References:

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

Published 22 June 2020,
for implementation 01 July 2020.

Ref No: 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.

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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/.

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for implementation 01 July 2020.

Ref No: Q3468 | Published On: 22-Jun-2020 | Status: Current

Removal of adnexa with vaginal hysterectomy

Q:

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

A:

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

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

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

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

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

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

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

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

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

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

Amendments will be considered for a future edition.

References:

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

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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.

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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.

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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.

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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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Coding Rules

Published 20 March 2020

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Periodic limb movement disorder

Q:

What code is assigned for periodic limb movement disorder?

A:

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

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

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

Follow the ICD 10 AM Alphabetic Index:

Disorder (of)

…

- sleep

…

- - specified NEC G47.8

or

Parasomnia G47.8

Amendments will be considered for a future edition.

References:

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

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

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

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for implementation 01 April 2020.

Ref No: Q3486 | Published On: 20-Mar-2020 | Status: Current

Insertion of Fetal Pillow®

Q:

What code is assigned for insertion of Fetal Pillow®?

A:

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

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

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

Amendments will be considered for a future edition.

References:

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

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

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for implementation 01 April 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.

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for implementation 01 April 2020.

Ref No: Q3437 | Published On: 20-Mar-2020 | Status: Current

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

Q:

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

A:

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

The *Note* at B95–B97 states:

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

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

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

J69.0 *Pneumonitis due to food or vomit*

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

Follow the ICD-10-AM Alphabetic Index:

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

- aspiration J69.0

Infection, infected (opportunistic)

- Pseudomonas, pseudomonad NEC

- - as cause of disease classified elsewhere B96.5

Amendments will be considered for a future edition.

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Ref No: Q3426 | Published On: 20-Mar-2020 | Status: Current

Large or grade 3 tonsils

Q:

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

A:

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

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

Follow the ICD-10-AM Alphabetic Index:

Enlargement, enlarged — *see also Hypertrophy*

- tonsils J35.1

- - with adenoids J35.3

or

Hypertrophy

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

- - with adenoids J35.3

Amendments may be considered for a future edition.

References:

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

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

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Ref No: Q3432 | Published On: 20-Mar-2020 | Status: Current

Assignment of F17.3 with Z72.0

Q:

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

A:

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

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

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

Follow the ICD-10-AM Alphabetic Index:

Tobacco (nicotine)

- withdrawal state F17.3

Amendments will be considered for a future edition.

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Ref No: Q3463 | Published On: 20-Mar-2020 | Status: Current

Detorsion of ovary

Q:

What code is assigned for detorsion of the ovary?

A:

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

Assign a code for repair of the ovary:

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

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

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

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

Follow the ACHI Alphabetic Index:

Repair

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

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Ref No: Q3461 | Published On: 20-Mar-2020 | Status: Current

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 D89.8 *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 D89.8

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.

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/.

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Ref No: Q3494 | Published On: 20-Mar-2020 | Status: Current

Body lift procedure

Q:

What code is assigned for body lift procedure?

A:

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

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

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

Follow the ACHI Alphabetic Index:

Brachioplasty — *see Lipectomy/arm*

Lipectomy

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

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

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

Amendments will be considered for a future edition.

References:

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

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

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for implementation 01 April 2020.

Ref No: P462 | Published On: 20-Mar-2020 | Status: Current

Clarification of code assignment for procedures assisting delivery

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

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

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

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

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

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

Example 1

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

O83 *Other assisted single delivery*

Z37.0 *Single live birth*

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

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

Follow the ACHI Alphabetic Index:

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

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

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

  Note: *Spontaneous delivery may include:*

  •*administration of Syntocinon in third stage labour*

  •*controlled cord traction (CCT)*

  •*epidural injection/infusion*

  •*episiotomy with repair*

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

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

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

Example 2

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

O80 *Single spontaneous delivery*

Z37.0 *Single live birth*

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

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

Follow the ACHI Alphabetic Index:

Delivery (spontaneous) (vertex) **90467-00 [1336]**

- assistance procedure (McRobert's manoeuvre) NEC *(see also specific interventions)*

…

- - fetal monitoring — *see Monitoring/fetal*

Monitoring

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

Example 3

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

O80 *Single spontaneous delivery*

Z37.0 *Single live birth*

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

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

Follow the ACHI Alphabetic Index:

Delivery (spontaneous) (vertex) **90467-00 [1336]**

- assistance procedure (McRobert's manoeuvre) NEC *(see also specific interventions)*
- - episiotomy 90472-00 **[1343]**

Example 4

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

O83 *Other assisted single delivery*

O73.0 *Retained placenta*

Z37.0 *Single live birth*

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

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

Follow the ACHI Alphabetic Index:

Delivery (spontaneous) (vertex)
- assisted 90477-01 **[1343]**

…
- placenta NEC
- - postpartum — *see Removal/placenta*

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

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Ref No: Q3458 | Published On: 20-Mar-2020 | Status: Current

Encephaloduroarteriosynangiosis (EDAS)

Q:

What code is assigned for encephaloduroarteriosynangiosis (EDAS)?

A:

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

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

Follow the ACHI Alphabetic Index:

Bypass

- extracranial to intracranial

- - with graft

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

References:

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

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

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Ref No: 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.

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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.

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Ref No: Q3429 | Published On: 20-Mar-2020 | Status: Current

Malignant and metastatic melanotic neuroectodermal tumour

Q:

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

A:

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

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

Coded nomenclature of morphology of neoplasms

M9363/0 Melanotic neuroectodermal tumour

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

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

Topography code(s) from blocks:

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

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

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

Amendments will be considered for a future edition.

References:

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

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Ref No: Q3433 | Published On: 20-Mar-2020 | Status: Current

Mesorectal lymph nodes

Q:

What code is assigned for metastatic mesorectal lymph nodes?

A:

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

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

Follow the ICD-10-AM Alphabetic Index:

Neoplasm, neoplastic

- lymph, lymphatic

- - gland (secondary)

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

References:

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

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

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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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Ref No: Q3449 | Published On: 20-Mar-2020 | Status: Current

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

Q:

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

A:

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

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

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

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

Follow the ICD-10-AM Alphabetic Index:

Abnormal, abnormality, abnormalities

- specimen

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

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

References:

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

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

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Ref No: Q3438 | Published On: 20-Mar-2020 | Status: Current

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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Ref No: Q3474 | Published On: 20-Mar-2020 | Status: Current

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

Q:

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

A:

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

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

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

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

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

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

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

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Ref No: Q3482 | Published On: 20-Mar-2020 | Status: Current

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:

> *Clinical documentation of accurate diagnoses is the responsibility of the clinician.*
>
> *…*
>
> *Before classifying any documented clinical concept, the clinical coder must verify 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.*
>
> *…*
>
> *Do not use test result value, descriptions, medication charts, symbols and abbreviations in isolation to inform code assignment.*
>
> *…*

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 Q3384 ‘BMI from calculated EMR fields’ published on 15 March 2019.

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Trapeziectomy with abductor pollicis longus (APL) suspensionplasty

Q:

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

A:

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

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

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

Follow the ACHI Alphabetic Index:

Arthroplasty

- wrist

- - carpal bone

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

Amendments will be considered for a future edition.

References:

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

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

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

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

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Ref No: Q3454 | Published On: 20-Mar-2020 | Status: Current

Utilisation of multiple machine perfusion units for organ transplantation

Q:

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

A:

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

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

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

Amendments will be considered for a future edition.

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Coding Rules

Published 07 February 2020

Ref No: TN1530 | Published On: 07-Feb-2020 | Status: Updated | Updated On: 27-Mar-2020

Subject: Coronavirus disease 2019 (COVID-19)

Effective from 1 January 2020; Updated 27 March 2020

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

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

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

The World Health Organization (WHO) has advised:

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

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

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

CLASSIFICATION

Laboratory confirmed cases

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

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

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

and

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

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

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

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

Clinically diagnosed or probable COVID-19

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

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

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

and

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

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

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

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

COVID-19 complicating pregnancy

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

Suspected COVID-19, ruled out

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

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

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

or

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

and

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

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

Transfer with suspected COVID-19

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

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

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

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

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

References:

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

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

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

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Coding Rules

Published 16 December 2019

Ref No: Q3439 | Published On: 16-Dec-2019 | Status: Current

Subject: Post tonsillectomy haemorrhage

Q:

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

A:

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

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

ACS 1904 *Procedural complications* states:

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

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

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

Haemorrhage, haemorrhagic

- postprocedural T81.0

Code also external cause and place of occurrence codes.

References:

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

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for implementation 01 January 2020.

Ref No: Q3411 | Published On: 16-Dec-2019 | Status: Current

Subject: 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 *Laparoscopic/arthroscopic/endoscopic surgery.*

See also Q3390 ‘Endoscopic vacuum-assisted closure (EVAC) of gastrointestinal defect’ published on 15 March 2019.

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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for implementation 01 January 2020.

Ref No: Q3444 | Published On: 16-Dec-2019 | Status: Current

Subject: 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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for implementation 01 January 2020.

Ref No: Q3430 | Published On: 16-Dec-2019 | Status: Current

Subject: 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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Subject: 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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Ref No: Q3427 | Published On: 16-Dec-2019 | Status: Current

Subject: 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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Ref No: TN1511 | Published On: 16-Dec-2019 | Status: Current

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

Effective from 25 September 2019

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

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

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

CLASSIFICATION

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

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

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

Bibliography:

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

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

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

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

Published 16 December 2019,
for implementation 01 January 2020.

Ref No: Q3483 | Published On: 16-Dec-2019 | Status: Current

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

Q:

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

A:

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

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

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

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

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

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

References:

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

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

Published 16 December 2019,
for implementation 01 January 2020.

Ref No: Q3475 | Published On: 16-Dec-2019 | Status: Current

Subject: Closed reduction of fracture of the acetabulum

Q:

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

A:

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

Reduction

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

- - acetabulum

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

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

Repair

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

Amendments may be considered for a future edition.

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Ref No: Q3456 | Published On: 16-Dec-2019 | Status: Current

Subject: 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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for implementation 01 January 2020.

Ref No: Q3451 | Published On: 16-Dec-2019 | Status: Current

Subject: ACHI code for percutaneous cholecystostomy

Q:

What code is assigned for percutaneous cholecystostomy if ‘trocar’ is not documented in the clinical record?

A:

Cholecystostomy involves placement of a drainage catheter in the gallbladder to prevent the gallbladder from becoming too swollen (Stanford Children’s Hospital n.d.). Percutaneous cholecystostomy (PC) is an alternative treatment to cholecystectomy, which allows immediate decompression and drainage of the inflamed gallbladder in some high-risk surgery patients such as the critically ill or patients with multiple comorbidities (Pablo Juan 2015).

Seldinger and trocar are two widely used percutaneous drainage techniques for catheter placement into vascular and nonvascular anatomical spaces (Hilal et al. 2017).

The indexing at *Cholecystostomy/trocar* is incorrect. Assign 90348-00 **[961]** *Percutaneous aspiration of gallbladder* for percutaneous cholecystostomy, including where trocar or Seldinger technique is documented. Follow the ACHI Alphabetic Index:

Aspiration

- gallbladder

- - percutaneous (closed) (needle) 90348-00 **[961]**

The ACHI Alphabetic Index at *Cholecystostomy/trocar* will be amended in Eleventh Edition Errata 4.

References:

Hilal, G.T., Mustafa, O., Rusen, A., Fahrettin, K., Fatma, A.E.O., Baki, H. Utku, M.Y. 2017, ‘Comparison of seldinger and trocar techniques in the percutaneous treatment of hyatid cysts’, Word Journal of Radiology, vol. 9, no. 11, viewed 11 November 2019, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5714805/

Pablo, A.B. Juan, J.D.P. 2015, ‘Ultrasound guided percutaneous cholecystostomy in acute cholecystitis: case vignette and review of the technique’, Journal of Ultrasound, vol. 18, no. 4, viewed 11 November 2019, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4630280/

Standford Children’s Hospital, What is a cholecystostomy? Standford Children’s Hospital, viewed 11 November 2019, https://www.stanfordchildrens.org/en/topic/default?id=cholecystostomy-22-cholecystostomy

Published 16 December 2019,
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Coding Rules

Published 28 June 2019

Ref No: TN1504 | Published On: 28-Jun-2019 | Status: Updated | Updated On: 21-Sep-2020

Subject: Eleventh Edition ACS 1904 *Procedural complications* – additional code to add specificity

Note: The scenario in Example 12 of this coding rule has been amended to specify a causal relationship between the intervention and the postprocedural pain, and how care for the pain was beyond routine postoperative pain.

When classifying procedural complications, a number of general coding conventions utilised in ICD-10-AM need to be highlighted, in particular, multiple condition coding which states:

"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)."

The instruction in the ACS regarding 'an additional code from Chapters 1 to 19 may be assigned where it provides further specificity', is intended to provide further specificity of the condition, not an anatomical site.

For postoperative complications, the majority of complications occur around the area that has been operated on, therefore it is unnecessary to add an additional code to identify the site of the complication.

It should also be noted that ICD-10-AM does not have diagnostic codes/entities independently reflecting the detail of an anatomical site, therefore it is not possible to identify every single possible site for all diseases/injuries. While some ICD-10-AM codes specify the anatomical site, they are generally located in the specific chapters/categories to which they relate (mainly in Chapter 13 *Diseases of the musculoskeletal system and connective tissue* and Chapter 19 *Injury, poisoning and certain other consequences of external causes*). These codes should not be used to provide further specificity of the anatomical site when the nature of diseases/injuries are completely different.

Example 10:

28-year-old lady admitted for a bilateral breast augmentation with insertion of saline prostheses performed under general anaesthetic (GA). In the postoperative period, the patient developed a haematoma around her right breast wound site as documented by the plastic surgeon. The area was marked and monitored closely for the next 12 hours. An ultrasound of the breast confirmed a superficial haematoma not amenable to drainage.

Note: code T85.83 and classification guidelines below have been updated since original publication

Assign:

Z41.1 *Other plastic surgery for unacceptable cosmetic appearance*

T85.83 *Haemorrhage and haematoma following insertion of other prosthetic devices, implants and grafts*

with appropriate external cause codes.

Follow the Alphabetic Index:

Haematoma (skin surface intact) (traumatic) *(see also Contusion*)

- postprocedural T81.0

Then follow the *Excludes* note at T81.0 *Haemorrhage and haematoma complicating a procedure, not elsewhere classified* to assign T85.83.

It is unnecessary to assign N64.8 *Other specified disorders of breast* to capture the site of the haematoma.

Example 11:

Haematoma in the subdural region of the brain post craniotomy and excision of a brain lesion.

Assign:

T81.0 *Haemorrhage and haematoma complicating a procedure, not elsewhere classified*

with appropriate external cause codes.

Follow the Alphabetic Index:

Haematoma (skin surface intact) (traumatic) (*see also Contusion*)

- postprocedural T81.0

It is unnecessary to assign an additional code from Chapter 19 (eg S06.5 *Traumatic subdural haemorrhage*) to indicate the site of the post-operative complication. The purpose of S codes in Chapter 19 *Injury, poisoning and certain other consequences of external causes* is to classify injuries due to trauma (ie an injury not related to an intervention).

Example 12:

Patient admitted with an old medial meniscal tear of the left knee and underwent arthroscopic meniscal debridement under general anaesthetic (GA). In the postoperative period, the patient complained of extreme left knee pain, confirmed by the clinician as secondary to the arthroscopic debridement. The pain management team was requested to review the patient, and an increase in pain medication dosage was prescribed and administered. Discharge home was delayed due to ongoing knee pain. Discharged home on day 4 postoperatively once the pain was well controlled and patient was able to mobilise.

Assign:

M23.23 *Derangement of meniscus due to old tear or injury, medial collateral ligament or other and unspecified medial meniscus*

T81.83 *Pain following a procedure, not elsewhere classif*ied

with appropriate external cause codes.

Follow the Alphabetic Index:

Complication(s) (from) (of)

- postprocedural

- - pain NEC T81.83

It is unnecessary to assign M25.56 *Pain in joint, lower leg* to capture the site of the pain.

If the pain being assessed/treated is not at the site of the operation, such as shoulder pain following laparoscopic cholecystectomy and the clinician confirms that the shoulder pain is due to laparoscopy, and it meets ACS 0002 *Additional diagnoses*, an additional code for the shoulder pain (M25.51) can be added to provide further specificity.

Example 13:

Patient admitted to hospital for a laparoscopic cholecystectomy performed under general anaesthetic (GA). During the procedure the duodenum was accidentally lacerated and then repaired. Histopathology report: Gallbladder – chronic cholecystitis and cholelithiasis.

Assign:

K80.10 *Calculus of gallbladder with other cholecystitis, without mention of obstruction*

K91.63 *Accidental puncture and laceration of intestine during a procedure*

with appropriate external cause codes.

Follow the Alphabetic Index:

Complication(s) (from) (of)

- accidental puncture or laceration during procedure

- - digestive system organ or structure

- - - intestine (large) (rectum) (small) K91.63

It is unnecessary to assign an additional code from Chapter 19 *Injury, poisoning and certain other consequences of external causes* (eg S36.41 *Injury of duodenum*) to provide further specificity of the site.

Example 14:

Accidental laceration of digital nerve of hand during a procedure

Assign:

G97.34 *Accidental puncture and laceration of peripheral nerve during a procedure*

with appropriate external cause codes.

Follow the Alphabetic Index:

Complication(s) (from) (of)

- accidental puncture or laceration during procedure

- - nervous system organ or structure

- - - peripheral nerve G97.34

It is unnecessary to assign S64.4 *Injury of digital nerve of other finger* or S64.3 *Injury of digital nerve of thumb* to provide site specificity.

Example 15:

A patient admitted to hospital with stiffness of right total knee replacement (TKR) for manipulation under anaesthesia (MUA) performed under general anaesthetic (GA) without any complications

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*

with appropriate external cause codes.

Follow the 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

The additional code M25.66 is assigned to provide further specificity of the condition not the site (ie stiffness of the joint).

This content has been adapted and disaggregated from the Clarification on the application of ACS 1904 Procedural complications issued 28 June 2019 for implementation 1 July 2019 (updated for 1 October 2019).

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Subject: Eleventh Edition ACS 1904 *Procedural complications* – care beyond intraoperative/postoperative care

Some conditions that develop postoperatively are considered as natural or expected events and are not necessarily complications of clinical care (ie they are not considered significant as per the criteria in ACS 0002 *Additional diagnoses*).

These conditions are only assigned as procedural complications when there is documentation of care or management that is significantly beyond routine care.

Care beyond routine may include:

- consultation/treatment by a clinician resulting in a change of management
- application of vacuum dressing or other specialised dressing/device, which was not previously required, to replace a conventional dressing
- unexpected or unplanned return to theatre
- commencement of antibiotics
- treatment that delays discharge

Example 16:

This 58 year old lady with bilateral ovarian cysts underwent bilateral oophorectomy and division of omental adhesions under a general anaesthetic (GA) without any complications. Persistent wound ooze from the abdominal site noted on day 2 postoperatively by wound management team. The dressing from the abdominal wound was removed and a vacuum dressing was applied. Patient remained in hospital until ooze settled down. The patient was discharged home on day 4 as significant ooze was no longer present. Patient instructed to present to the Emergency Department if she has any concerns. Histopathology report – mucinous cystadenoma of ovaries.

Assign:

D27 *Benign neoplasm of ovary*

M8470/0 *Mucinous cystadenoma NOS*

K66.0 *Peritoneal adhesions*

T81.89 *Other complications following a procedure, not elsewhere classified*

with appropriate external cause codes.

Follow the Alphabetic Index:

Complication(s) (from) (of)

- postprocedural

- - specified NEC T81.89

This content has been adapted and disaggregated from the Clarification on the application of ACS 1904 Procedural complications issued 28 June 2019 for implementation 1 July 2019 (updated for 1 October 2019).

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Subject: Eleventh Edition ACS 1904 *Procedural complications* – assigned to body system chapters

Procedural complications may be classified to either the body system chapters or block *Complications of surgical and medical care, not elsewhere classified* (T80–T88), and the following rules apply:

- 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
    - the complication is not related to a body system, assign an appropriate code from T80–T81 or T86–T88

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

Example 7:

Patient was admitted with persistent oedema of the right arm 2 years after radical mastectomy and chest wall radiotherapy for adenocarcinoma of the right breast. Examination revealed extensive, predominantly pitting, oedema of the right forearm and upper arm and an ultrasound (US) of the right upper limb confirmed the diagnosis of lymphoedema. She was given physiotherapy for the lymphoedema and a prescription of a compression garment.

Assign:

I97.2 *Postmastectomy lymphoedema syndrome*

with appropriate external cause codes.

Follow the Alphabetic Index:

Lymphoedema

- postmastectomy I97.2

In some instances the Alphabetic Index does not link the 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 an intraoperative or postoperative complication. For example:

Adhesions, adhesive (postinfective)

- postprocedural

- - peritoneal

- - - pelvic N99.4

Example 8:

Patient with adenocarcinoma of the prostate underwent a radical prostatectomy under general anaesthetic (GA). During the postoperative period the patient complained of pain and swelling at the operative site. A computed tomography (CT) scan of the abdomen and pelvis was performed which confirmed the presence of a lymphocele which was considered secondary to prostatectomy. The surgical team decided to manage this conservatively over the next 24 hours.

Assign:

C61 *Malignant neoplasm of prostate*

M8140/3 *Adenocarcinoma NOS*

I97.83 *Postprocedural lymphocele, lymphoedema and chylothorax*

with appropriate external cause codes.

Follow the Alphabetic Index:

Lymphocele

- postprocedural I97.83

This content has been adapted and disaggregated from the Clarification on the application of ACS 1904 *Procedural complications* issued 28 June 2019 for implementation 1 July 2019 (updated for 1 October 2019).

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Subject: Eleventh Edition ACS 1904 *Procedural complications* – classified to T80–T81 or T86–T88 (Chapter 19)

When 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 9: A 70-year-old man with a history of acute myocardial infarction underwent coronary artery bypass graft (CABG) with a left saphenous vein autograft. He was readmitted 10 days after surgery as an infection developed at the saphenous donor site and a skin graft was applied to the donor site.

Assign:

T81.4 *Wound infection following a procedure, not elsewhere classified*

Y83.2 *Surgical operation with anastomosis, bypass or graft*

Place of occurrence as appropriate

Follow the Alphabetic Index:

Complication(s) (from) (of)

- postprocedural

- - wound infection T81.4

Skin infections that develop at a vein donor site are considered a post procedural skin infection rather than a complication of the CABG site (ie the heart). Y83.2 is assigned as an external cause code to describe the type of procedure causing a complication, ie CABG.

This content has been adapted and disaggregated from the Clarification on the application of ACS 1904 *Procedural complications* issued 28 June 2019 for implementation 1 July 2019 (updated for 1 October 2019).

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Coding Rules

Published 15 March 2019

Ref No: Q3377 | Published On: 15-Mar-2019 | Status: Current

Subject: Internal fixation of an unstable fracture without documentation of reduction

Q:

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

A:

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

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

Amendments may be considered for a future edition.

References:

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

Published 15 March 2019,
for implementation 01 April 2019.

Ref No: Q3406 | Published On: 15-Mar-2019 | Status: Updated | Updated On: 16-Dec-2019

Subject: 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:

As per the guidelines in ACS 0044 *Pharmacotherapy*/ACHI classification:

> *When a patient receives pharmacotherapy for a neoplasm or neoplasm (treatment) related condition multiple times during an episode of care, and the same ACHI code applies, assign the ACHI code once only.*

Therefore, where chemotherapy (ie pharmacotherapy for a neoplasm or neoplasm (treatment) related condition) is assigned 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*

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Subject: 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: Q3312 | Published On: 15-Mar-2019 | Status: Current

Subject: Hashimoto's encephalopathy

Q:

What codes are assigned for Hashimoto's encephalopathy?

A:

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

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

Follow the Alphabetic Index:

Encephalopathy (acute) G93.4

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

Amendments may be considered for a future edition.

References:

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

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

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Ref No: Q3314 | Published On: 15-Mar-2019 | Status: Current

Subject: Fat grafting by injection

Q:

What code is assigned for fat grafting by injection?

A:

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

For fat grafting by injection, assign:

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

Follow the Alphabetic Index:

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

- specified site

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

Amendments may be considered for a future edition.

References:

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

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

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Ref No: Q3332 | Published On: 15-Mar-2019 | Status: Current

Subject: *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*

Where *E. coli* bacteraemia is also documented, assign:

A49.8 *Other bacterial infections of unspecified site.*

Follow the Alphabetical Index:

Infection, infected

- urinary (tract) NEC N39.0

- Escherichia (E.) coli NEC

- - as cause of disease classified elsewhere B96.2

Bacteraemia *(see also Infection/by type)*

Infection, infected

- Escherichia (E.) coli NEC A49.8

Note: The *Excludes* notes at A49 and B95-B96 does not apply as the *E. Coli* infection in this scenario relates to two different clinical concepts (i.e. UTI and bacteraemia).

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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Ref No: Q3335 | Published On: 15-Mar-2019 | Status: Current

Subject: 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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Ref No: Q3337 | Published On: 15-Mar-2019 | Status: Current

Subject: 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 nerve root compression 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]**

Amendments will be considered for a future edition.

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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Ref No: Q3344 | Published On: 15-Mar-2019 | Status: Current

Subject: 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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Ref No: Q3354 | Published On: 15-Mar-2019 | Status: Current

Subject: Follicular Lymphoma grade 1–2

Q:

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

A:

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

ACS 0233 *Morphology* states:

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

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

M9695/3 *Follicular lymphoma,* grade 1

M9691/3 *Follicular lymphoma*, grade 2

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

C82.0 *Follicular lymphoma grade 1*

M9695/3 *Follicular lymphoma, grade 1*

Follow the ICD-10-AM Alphabetic Index:

Lymphoma

- follicular

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

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

Reference:

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

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Ref No: Q3356 | Published On: 15-Mar-2019 | Status: Current

Subject: CNS Lymphoma

Q:

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

A:

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

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

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

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

Follow the ICD-10-AM Alphabetic Index:

Lymphoma (malignant)

- B-cell

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

- - - primary

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

- - - - - unspecified site C72.9

Amendments may be considered for a future edition.

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Ref No: Q3361 | Published On: 15-Mar-2019 | Status: Current

Subject: 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: Q3366 | Published On: 15-Mar-2019 | Status: Current

Subject: Aborted stroke

Q:

What code is assigned for aborted stroke?

A:

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

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

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

I63.9 *Cerebral infarction, unspecified*.

Follow the Alphabetic Index:

Stroke (apoplectic) (brain) (paralytic)

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

Infarct, infarction (of)

- cerebral I63.9

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

References:

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

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Ref No: Q3369 | Published On: 15-Mar-2019 | Status: Current

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

Q:

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

A:

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

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

Follow the ACHI Alphabetic Index:

Reduction

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

- - zygoma, zygomatic arch (malar)

- - - open

- - - - with fixation

- - - - - internal

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

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

Amendments may be considered for a future edition.

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Ref No: Q3370 | Published On: 15-Mar-2019 | Status: Current

Subject: Notchplasty without knee reconstruction

Q:

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

A:

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

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

Follow the Alphabetic Index:

Ostectomy NEC

- femur

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

Amendments maybe considered for a future edition.

References:

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

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

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Ref No: Q3371 | Published On: 15-Mar-2019 | Status: Current

Subject: 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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Ref No: Q3374 | Published On: 15-Mar-2019 | Status: Current

Subject: 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)
- Y59.8 *Other specified vaccines and biological substances causing adverse effects in therapeutic use.*

  Follow the 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:

Allergy, allergic (reaction)

- drug, medicament and biological (any) (correct medicinal substance properly administered) (external) (internal) T88.7

Assign external cause and place of occurrence codes as listed above.

Amendments may be considered for a future edition.

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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Ref No: Q3375 | Published On: 15-Mar-2019 | Status: Current

Subject: 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 *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)

ACS 1122 *Helicobacter Pylori* states:

> Helicobacter pylori (H. pylori) *infection is associated with:*
>
> - *H. pylori-associated chronic gastritis (active chronic gastritis)*
> - *duodenal ulcers*
> - *MALT (mucosa associated lymphoid tissue) lymphoma*
> - *gastric ulcers*
>
> *B96.81* Helicobacter pylori [H. pylori] as the cause of diseases classified to other chapters ***is*** *assigned when it is found in the presence of the above conditions or there is a documented association with another condition.*
>
> *B96.81 is* ***not*** *assigned 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 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.

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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Ref No: Q3378 | Published On: 15-Mar-2019 | Status: Current

Subject: Hookwire localisation of extramammary lesions

Q:

What code is assigned for hookwire localisation of lesions other than breast lesions (ie extramammary lesions)?

A:

Guide/hook wire localisation (biopsy) of lesions is a technique performed with specific interventional imaging procedures (ie ultrasound, mammography, computerised tomography (CT) etc). For example, CT may be performed to identify the location, size and shape of a lesion. A cannula needle housing a hook wire is inserted using CT guidance and placed close to the lesion. When the outer cannula needle is withdrawn, the horn of the hook wire remains anchored to the lesion, and the patient is transferred to the operating theatre for excisional biopsy of the lesion, which is identified by the location of the hook wire (Li et al 2012).

Where guide/hook wire localisation (biopsy) of a lesion other than the breast (ie extramammary) is performed, do not assign an ACHI code for the guide/hook wire localisation component, as per the guidelines in ACS 0016 *General procedure guidelines,* as it is inherent in the excisional biopsy procedure performed.

References:

Li, W, Wang, Y, He, X, Li, G, Wang, S, Xu, L Yuan, Z 2012, 'Combination of CT-guided hookwire localization and video-assisted thoracoscopic surgery for pulmonary nodular lesions: Analysis of 103 patients', *Oncology letters,* Oct; 4(4): 824–828, viewed 17 September 2018, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3506590/

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Ref No: Q3379 | Published On: 15-Mar-2019 | Status: Current

Subject: Tonic-clonic seizures without documentation of epilepsy

Q:

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

A:

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

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

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

Follow the Alphabetic Index:

Grand mal

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

Amendments may be considered for a future edition.

References:

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

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

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

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Ref No: Q3380 | Published On: 15-Mar-2019 | Status: Current

Subject: Alpha-methylacyl-CoA racemase (AMACR) deficiency

Q:

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

A:

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

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

Follow the Alphabetic Index:

Error

- metabolism, inborn — *see Disorder/metabolism*

Disorder (of)

- metabolism NEC

- - specified NEC E88.8

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

Amendments may be considered for a future edition.

References:

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

Published 15 March 2019,
for implementation 01 April 2019.

Ref No: Q3384 | Published On: 15-Mar-2019 | Status: Current

Subject: 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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for implementation 01 April 2019.

Ref No: Q3390 | Published On: 15-Mar-2019 | Status: Current

Subject: 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* as a best fit 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* as a best fit 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 *Laparoscopic/arthroscopic/endoscopic surgery.*

Amendments may be considered for a future edition.

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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Ref No: Q3392 | Published On: 15-Mar-2019 | Status: Current

Subject: Neurocognitive disorder

Q:

What code is assigned for neurocognitive disorder?

A:

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

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

Where there is documentation of 'mild neurocognitive disorder', assign:

F06.7 *Mild cognitive disorder*

Follow the alphabetic index:

Disorder (of) — *see also Disease*

- cognitive

- - mild F06.7

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

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

Reference:

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

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Ref No: Q3396 | Published On: 15-Mar-2019 | Status: Current

Subject: Behavioural and psychological symptoms of dementia (BPSD)

Q:

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

A:

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

Examples of BPSD include:

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

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

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

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

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

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

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

References:

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

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

Woodward, M 2014, 'Behavioural and psychological symptoms of dementia', in G Caplan (ed.), *Geriatric medicine: An introduction,* viewed 7 November 2018, https://books.google.com.au/books?hl=enlr=id=AfnwAwAAQBAJoi=fndpg=PA125dq=behavioural+and+psychological+symptoms+of+dementiaots=emYekucArUsig=oXI3k0aEKIWg4r9vhnvBEKIxQHs#v=onepageq=behavioural%20and%20psychological%20symptoms%20of%20dementiaf=false

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Subject: 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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Ref No: Q3399 | Published On: 15-Mar-2019 | Status: Current

Subject: 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

Published 15 March 2019,
for implementation 01 April 2019.

Ref No: Q3404 | Published On: 15-Mar-2019 | Status: Current

Subject: 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

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for implementation 01 April 2019.

Ref No: Q3408 | Published On: 15-Mar-2019 | Status: Current

Subject: 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* by following 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, as applicable.

For a nontraumatic injury assign M24.23 *Disorder of ligament, forearm* by following 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 by following 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 *Laparoscopic/arthroscopic/endoscopic surgery*, if applicable.

Amendments may be considered for a future edition.

References:

Lex Medicus, 2018, *'Triangular Fibrocartilage Complex Injury',* viewed 4 December 2018, http://pathologies.lexmedicus.com.au/pathologies/triangular-fibrocartilage-complex-injury

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for implementation 01 April 2019.

Ref No: Q3413 | Published On: 15-Mar-2019 | Status: Current

Subject: Rebubbling of DSEK/DSAEK graft

Q:

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

A:

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

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

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

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

- specified site

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

References:

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

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

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Coding Rules

Published 15 December 2018

Ref No: Q3336 | Published On: 15-Dec-2018 | Status: Updated | Updated On: 16-Dec-2019

Subject: 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*
>
> *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*
>
> ***PROBLEMS AND UNDERLYING CONDITIONS***
>
> *If a problem with a known underlying cause is being treated, then both conditions should be coded (see also ACS 0001* Principal diagnosis/Problems and underlying conditions*).*

Therefore, assign a code from subcategories P07.2 *Extreme immaturity* or P07.3 *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 (P07.22) is assigned as it meets the criteria in ACS 0002 (ie it is the underlying cause of the patient's 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*

P07.22 *Extreme immaturity, 24 or more completed weeks but less than 28 completed weeks*

P07.02 *Extremely low birth weight 500–749g*

90677-00 **[1611]** *Other phototherapy, skin*

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Ref No: Q3282 | Published On: 15-Dec-2018 | Status: Current

Subject: 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

Published 15 December 2018,
for implementation 01 January 2019.

Ref No: Q3288 | Published On: 15-Dec-2018 | Status: Current

Subject: 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

Published 15 December 2018,
for implementation 01 January 2019.

Ref No: Q3259 | Published On: 15-Dec-2018 | Status: Current

Subject: 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*.

ACCD acknowledges that 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, 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.

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Ref No: Q3278 | Published On: 15-Dec-2018 | Status: Current

Subject: Liver lacerations

Q:

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

A:

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

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

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

Amendments may be considered for a future edition.

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for implementation 01 January 2019.

Ref No: Q3281 | Published On: 15-Dec-2018 | Status: Current

Subject: 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: Current

Subject: 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 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 cardiac pacemaker generator*

and

38350-00 **[648]** *Insertion of permanent transvenous electrode into other heart chamber(s) for cardiac pacemaker* as a best fit.

Follow the Alphabetic Index:

Insertion

- electrode(s) lead(s)

- - cardiac (for)

- - - pacemaker

- - - - permanent

- - - - - transvenous (atrium) (right ventricle) 38350-00 **[648]**

- pacemaker

- - cardiac

- - - generator (biventricular) (cardiac resynchronisation therapy) (dual chamber) (single chamber) (triple chamber) 38353-00 **[650]**

Amendments may be considered for a future edition.

References:

Impulse Dynamics, CCM and the Optimizer System 2018, Impulse Dynamics, Stuttgart, viewed 31 July 2018, https://www.impulse-dynamics.com/int/patients/ccm-and-the-optimizer-system/

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Ref No: Q3292 | Published On: 15-Dec-2018 | Status: Current

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

Q:

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

A:

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

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

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

Follow the Alphabetic Index:

Repair

- aorta, aortic

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

Amendments may be considered for a future edition.

References:

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

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

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Ref No: Q3295 | Published On: 15-Dec-2018 | Status: Current

Subject: *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

Subject: 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

Subject: 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: Q3310 | Published On: 15-Dec-2018 | Status: Current

Subject: Functional Neurological Disorder

Q:

What codes are assigned for functional neurological disorder?

A:

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

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

Disorder (of) — *see also Disease*

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

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

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

Amendments may be considered for a future edition.

References:

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

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

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Ref No: Q3315 | Published On: 15-Dec-2018 | Status: Current

Subject: Drug seeking behaviour

Q:

What code is assigned for drug seeking behaviour?

A:

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

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

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

or

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

Follow the Alphabetic Index:

Seeking and accepting known hazardous and harmful

- chemical, nutritional or physical interventions Z64.2

Amendments may be considered for a future edition.

References:

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

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

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Ref No: Q3318 | Published On: 15-Dec-2018 | Status: Current

Subject: Lipomodelling following breast reconstruction

Q:

What codes are assigned for lipomodelling following breast reconstruction?

A:

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

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

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

ACS 1204 *Plastic surgery* states:

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

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

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

Follow the ICD-10-AM Alphabetic Index:

Aftercare

- following surgery

- - plastic (of)

- - - breast Z42.1

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

Administration

- specified site

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

Amendments may be considered for a future edition.

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Ref No: Q3321 | Published On: 15-Dec-2018 | Status: Current

Subject: Fungal pneumonia

Q:

What codes are assigned for fungal pneumonia, not elsewhere classified (NEC)?

A:

ICD-10-AM *Conventions used in the Tabular List of diseases/Multiple condition coding* state:

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

Fungal infections are classified in ICD-10-AM to category B35-B49 *Mycoses.* For fungal pneumonia NEC assign:

J16.8 *Pneumonia due to other specified infectious organisms*

B48.8 *Other specified mycoses*

Follow the Alphabetic Index:

Pneumonia

- in (due to)

- - specified

- - - organism NEC J16.8

Mycosis, mycotic

- specified NEC B48.8

It is noted that there is inconsistency within the ICD-10-AM in regard to classification of infectious agents.

This may be reviewed for a future edition.

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Ref No: Q3324 | Published On: 15-Dec-2018 | Status: Current

Subject: Hormone Resistance in Prostate Cancer

Q:

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

A:

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

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

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

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

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

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

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

Follow the ICD-10-AM Alphabetic Index:

Resistance, resistant (to)

- antineoplastic drug(s) Z07

Amendments may be considered for a future edition.

References

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

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

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Ref No: Q3338 | Published On: 15-Dec-2018 | Status: Current

Subject: Endoscopic clipping of bleeding upper gastrointestinal lesions

Q:

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

A:

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

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

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

Follow the Alphabetic Index:

Clipping (of)

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

Amendments may be considered for a future edition.

References:

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

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

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Ref No: Q3342 | Published On: 15-Dec-2018 | Status: Current

Subject: 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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Ref No: Q3343 | Published On: 15-Dec-2018 | Status: Current

Subject: 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* by following 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 *Laparoscopic/arthroscopic/endoscopic surgery*.

Amendments may be considered for a future edition.

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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Ref No: Q3345 | Published On: 15-Dec-2018 | Status: Current

Subject: 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*).

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 abortion and ectopic and molar pregnancy* and ACS 1511 *Termination of pregnancy.*

Amendments to ICD-10-AM and the ACS have been undertaken for Eleventh Edition.

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Ref No: Q3372 | Published On: 15-Dec-2018 | Status: Current

Subject: Drug induced postural hypotension

Q:

What codes are assigned for drug induced postural hypotension?

A:

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

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

Hypotension

- orthostatic

- - specified NEC I95.19

- postural

- - specified NEC I95.19

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

Also assign a code for place of occurrence:

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

OR

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

Follow the Alphabetic Index (Section II):

Place of occurrence of external cause

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

- - this facility Y92.24

Amendments may be considered for a future edition.

References:

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

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

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Ref No: Q3386 | Published On: 15-Dec-2018 | Status: Current

Subject: 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 < 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.*

Amendments may be considered for a future edition.

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Ref No: Q3389 | Published On: 15-Dec-2018 | Status: Current

Subject: Terminology for malnutrition

Q:

Is malnourished or malnourishment classified as per malnutrition?

A:

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

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

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

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

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

Amendments may be considered for a future edition.

References:

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

Published 15 December 2018,
for implementation 01 January 2019.

Coding Rules

Published 15 September 2018

Ref No: Q3274 | Published On: 15-Sep-2018 | Status: Updated | Updated On: 16-Dec-2019

Subject: 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: 30-Jun-2019

Subject: Clot retention secondary to transurethral resection of the prostate (TURP)

Q:

What codes are assigned for clot retention and urinary retention secondary to transurethral resection of the prostate (TURP)?

A:

As per ACS 1904 *Procedural complications* a condition is classified as a procedural complication when:

- *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')*

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*
>
> *An additional code from Chapters 1 to 19 may be assigned where it provides further specificity.*

Therefore, when a patient is documented with urinary retention due to blood clots following a TURP (transurethral resection of the prostate), assign:

N99.89 *Other intraoperative and postprocedural disorder of genitourinary system*

R33 *Retention of urine*

Y83.6 *Removal of other organ (partial)(total)*

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 Alphabetic Index (Section I):

Complication(s) (from) (of)

- postprocedural

- - urinary

- - - specified NEC N99.89

Retention, retained

- urine R33

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

Complication(s) (delayed) (medical or surgical procedure) (of or following)

- removal of organ (partial) (total) NEC Y83.6

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.

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Ref No: Q3238 | Published On: 15-Sep-2018 | Status: Current

Subject: 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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Ref No: Q3240 | Published On: 15-Sep-2018 | Status: Current

Subject: 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: Q3261 | Published On: 15-Sep-2018 | Status: Current

Subject: Intraoperative radiation therapy

Q:

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

A:

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

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

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

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

Follow the Alphabetic Index:

Brachytherapy

- intracavitary NEC

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

Amendments may be considered for a future edition.

References:

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

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

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

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

Published 15 September 2018,
for implementation 01 October 2018.

Ref No: Q3277 | Published On: 15-Sep-2018 | Status: Current

Subject: 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

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for implementation 01 October 2018.

Ref No: Q3284 | Published On: 15-Sep-2018 | Status: Current

Subject: Fracture blisters

Q:

What code is assigned for fracture blister?

A:

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

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

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

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

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

Amendments will be considered for a future edition.

References:

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

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

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

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

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for implementation 01 October 2018.

Ref No: Q3287 | Published On: 15-Sep-2018 | Status: Current

Subject: Removal of thrombus from central venous catheter

Q:

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

A:

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

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

Maintenance (of)

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

Amendments will be considered for a future edition.

References:

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

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for implementation 01 October 2018.

Ref No: Q3289 | Published On: 15-Sep-2018 | Status: Current

Subject: 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

Subject: 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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Ref No: Q3301 | Published On: 15-Sep-2018 | Status: Current

Subject: Intraductal Papillary Mucinous Neoplasm (IPMN)

Q:

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

A:

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

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

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

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

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

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

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

M8473/1 *Papillary mucinous cystadenoma, borderline malignancy*

Follow the Alphabetic Index:

Neoplasm, neoplastic

- pancreas (uncertain or unknown behaviour) D37.71

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

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

- - mucinous

- - - intraductal (of) (with)

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

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

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

Amendments will be considered for a future edition.

References:

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

Published 15 September 2018,
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Ref No: Q3325 | Published On: 15-Sep-2018 | Status: Current

Subject: Arthroscopic ACL reconstruction with meniscectomy

Q:

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

A:

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

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

Follow the Alphabetic Index:

Reconstruction

- ligament

- - cruciate or collateral, knee (open)

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

Meniscectomy

- knee (open) (total)

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

Amendments will be considered for a future edition.

References:

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

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

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

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for implementation 01 October 2018.

Ref No: Q3353 | Published On: 15-Sep-2018 | Status: Current

Subject: Cervical Screening Test

Q:

What code is assigned for the Cervical Screening Test?

A:

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

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

Amendments will be considered for a future edition.

References:

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

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Coding Rules

Published 15 June 2018

Ref No: Q3206 | Published On: 15-Jun-2018 | Status: Updated | Updated On: 16-Dec-2019

TNM stage documentation

Q:

Can a code formetastatic (secondary) lymph node neoplasm be assigned based on documentationof 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 maybe 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/Findings that provide more specificity about a diagnosis* states:

> *Laboratory, x-ray, pathological and other diagnostic results should be coded where they clearly add specificity to already documented conditions that meet the criteria for a principal diagnosis (see ACS 0001* Principal diagnosis*) or an additional diagnosis (see ACS 0002* Additional diagnoses*).*

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

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for implementation 01 January 2020.

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Current complications of AMI

Q:

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

A:

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

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

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

Follow the Alphabetic Index:

Haemopericardium

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

Infarct, infarction (of)

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

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

Amendments may be considered for a future edition.

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

References:

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

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for implementation 01 July 2018.

Ref No: Q3212 | Published On: 15-Jun-2018 | Status: Current

Subject: Toenail avulsion

Q:

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

A:

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

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

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

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

Removal — *see also Excision*

- nail

- - toe

- - - ingrown

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

Amendments will be considered for a future edition.

Reference:

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

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

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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/

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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

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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/

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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

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Ref No: Q3280 | Published On: 15-Jun-2018 | Status: Current

Subject: Denervation of proximal interphalangeal joint

Q:

What code is assigned for denervation of proximal interphalangeal joint?

A:

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

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

Follow the Alphabetic Index:

Division (freeing)

- nerve

- - peripheral

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

Amendments will be considered for a future edition.

References:

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

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

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Ref No: Q3297 | Published On: 15-Jun-2018 | Status: Current

Subject: 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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Coding Rules

Published 15 March 2018

Ref No: Q3209 | Published On: 15-Mar-2018 | Status: Updated | Updated On: 30-Jun-2019

Subject: 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…*
>
> *An additional code from Chapters 1 to 19 may be assigned where it provides further specificity.*

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 Alphabetic Index (Section I):

Obstruction, obstructed, obstructive

- device, implant or graft

- - catheter

- - - urinary (indwelling) T83.0

Retention, retained

- urine R33

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

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.

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Ref No: Q3160 | Published On: 15-Mar-2018 | Status: Updated | Updated On: 15-Jun-2019

Subject: 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

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Ref No: Q3215 | Published On: 15-Mar-2018 | Status: Updated | Updated On: 15-Jun-2019

Subject: 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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Ref No: Q3196 | Published On: 15-Mar-2018 | Status: Updated | Updated On: 15-Jun-2019

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

Q:

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

A:

Where there is documentation of:

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

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

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

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

Amendments will be considered for a future edition.

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

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Ref No: Q3190 | Published On: 15-Mar-2018 | Status: Current

Subject: 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:

ACCD acknowledges the ambiguity in the guidelines of coding patient controlled analgesia (PCA) initiated in theatre or recovery after general anaesthesia (GA). The advice 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.

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for implementation 01 April 2018.

Ref No: Q3202 | Published On: 15-Mar-2018 | Status: Current

Subject: 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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for implementation 01 April 2018.

Ref No: Q3213 | Published On: 15-Mar-2018 | Status: Current

Subject: 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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for implementation 01 April 2018.

Ref No: Q3217 | Published On: 15-Mar-2018 | Status: Current

Subject: Wound dehiscence/breakdown of an amputation stump

Q:

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

A:

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

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

Y83.5 *Amputation of limb(s)*

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

Z89.- *Acquired absence of limb*

Follow the Alphabetic Index (Section I):

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

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

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

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

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

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

Amendments will be considered for a future edition.

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Ref No: Q3222 | Published On: 15-Mar-2018 | Status: Current

Subject: 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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for implementation 01 April 2018.

Ref No: Q3223 | Published On: 15-Mar-2018 | Status: Current

Subject: 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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Ref No: Q3247 | Published On: 15-Mar-2018 | Status: Current

Subject: 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

Subject: 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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for implementation 01 April 2018.

Ref No: Q3268 | Published On: 15-Mar-2018 | Status: Current

Subject: 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 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.

Amendments to ACHI Chapter 14 *Obstetric procedures* is in progress for Eleventh Edition.

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

Published 15 March 2018,
for implementation 01 April 2018.

Ref No: Q3311 | Published On: 15-Mar-2018 | Status: Current

Subject: 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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for implementation 01 April 2018.

Coding Rules

Published 15 December 2017

Ref No: Q3204 | Published On: 15-Dec-2017 | Status: Updated | Updated On: 15-Jun-2019

Subject: 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 *Clinial documentation and General abstraction guidelines/Findings that provide more specificity about a diagnosis:*

> *Laboratory, x-ray, pathological and other diagnostic results should be coded where they clearly add specificity to already documented conditions that meet the criteria for a principal diagnosis.*

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.

Published 15 December 2017,
for implementation 01 January 2018.

Ref No: Q3169 | Published On: 15-Dec-2017 | Status: Updated | Updated On: 15-Jun-2019

Subject: Short gut syndrome (short bowel syndrome)

Q:

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

A:

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

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

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

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

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

Follow the Alphabetic Index:

Malabsorption

- syndrome K90.9

- - postprocedural K91.2

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

Amendments will be considered for a future edition.

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

References:

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

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for implementation 01 January 2018.

Ref No: Q3161 | Published On: 15-Dec-2017 | Status: Updated | Updated On: 15-Jun-2019

Subject: Drug-induced conditions

Q:

Many codes for drug-induced conditions list an *Instructional* note; *Use additional external cause code (Chapter 20) to identify cause.* Is it mandatory to assign an external cause code for these drug-induced conditions when they are due to harmful use?

A:

The assignment of an external cause code from Chapter 20 *External causes of morbidity and mortality* to identify the drug in a drug-induced condition is an ICD-10 (and hence ICD-10-AM) convention. These conventions are **mandatory** coding directives.

ICD-10-AM *Conventions used in the Tabular List* states:

> *Instructional notes/terms*
>
> *The Use additional code and Code also instructions indicate that an additional code should be assigned to fully describe the condition or injury…*

ACS 0001 *Principal diagnosis* also states:

> *…the coding directives in the ICD-10-AM manuals take precedence over all other guidelines.*

Assignment of external cause codes for drug-induced conditions requires differentiation between 'poisoning' and 'adverse effect' cases.

Example 1:

- Amphetamine induced cardiomyopathy, due to amphetamine use in the past. The patient no longer uses amphetamines: ICD-10-AM Conventions used in the Tabular List states:

  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*

  appropriate external cause codes. Check documentation in the medical record, or seek clinical clarification to determine if the cardiomyopathy is due to past recreational use (ie improper use – see ACS 1901 *Poisoning*) or adverse effect following therapeutic use (see ACS 1902 *Adverse effects*) of amphetamines.

Example 2:

- *Diarrhoea due to regular unprescribed overuse of laxatives:*

  Overuse (ie improper use) of a drug is classified as poisoning. ACS 1901 *Poisoning* states:

  > *Poisoning by drugs includes wrong drug or dose 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****.*

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*

Appropriate place of occurrence and activity codes

F55.1 *Harmful use of laxatives*

Note: ICD-10-AM Conventions used in the Tabular List states:

> *In classifying a problem 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 problem and the underlying cause.*

In this case, T36-T50 *Poisoning by drugs, medicaments and biological substances Excludes:* nondependence-producing substance use disorder (F55). Assign both the above poisoning codes and F55.1 to indicate that this 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*.

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: Q3214 | Published On: 15-Dec-2017 | Status: Updated | Updated On: 15-Jun-2019

Subject: 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 as a best fit 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 Alphabetical Index:

Drainage

- pancreas, pancreatic (by catheter) 30375-14 **[976]**

Panendoscopy (to duodenum) 30473-00 **[1005]**

Ultrasound

- endoscopic 30688-00 **[1949]**

See also Coding Rule Q2939 *Endoscopic ultrasound (EUS).*

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/

Published 15 December 2017,
for implementation 01 January 2018.

Ref No: Q3188 | Published On: 15-Dec-2017 | Status: Updated | Updated On: 15-Jun-2019

Subject: 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 *Abnormal coagulation profile due to anticoagulants/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*

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 Alphabetic Index:

Haematoma (skin surface intact) (traumatic) *(see also Contusion)*

- muscle — *see also Contusion/by site*

- - nontraumatic M79.8-

- nontraumatic, due to circulating anticoagulants (heparin) (warfarin) D68.3

Contusion (skin surface intact) *(see also Injury/superficial)*

- abdomen, abdominal (muscle) (wall) S30.1

Follow the Table of drugs and chemicals:

Anticoagulant…(Adverse effect in therapeutic use) Y44.2

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

- - 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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for implementation 01 January 2018.

Ref No: Q3142 | Published On: 15-Dec-2017 | Status: Current

Subject: 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

Subject: 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

Subject: 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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for implementation 01 January 2018.

Ref No: Q3164 | Published On: 15-Dec-2017 | Status: Current

Subject: Bursectomy of other joint

Q:

What code is assigned for bursectomy of a site that is not indexed?

A:

Bursae are fluid-filled sacs that lubricate and cushion soft tissues adjacent to joints and the surrounding soft tissue such as muscles and tendons, and help the joint move smoothly. The size of a bursa varies from person to person. They may be present from birth but may also develop later depending on the individual and their activity (Funiciello 2012, Winchester Hospital 2016).

Where bursectomy of one of the sites listed below is documented, assign an appropriate code by following the Alphabetic Index:

Bursectomy

- calcaneum 30111-00 **[1566]**
- hand 30107-01 **[1566]**
- olecranon 30111-00 **[1566]**
- patella 30111-00 **[1566]**

Where bursectomy is documented as either ‘large’ or ‘small’ only, assign an appropriate code by following the Alphabetic Index:

Bursectomy

- large NEC 30111-00 **[1566]**
- small NEC 30107-01 **[1566]**

In all other cases, assign 30107-01 **[1566]** *Excision of small bursa* by following the Alphabetic Index:

Bursectomy 30107-01 **[1566]**

Amendments will be considered for a future edition.

References:

Funiciello, M, Arthritis-Health 2012, What Is a Bursa?, Arthritis-health, Deerfield, viewed 14 April 2017, https://www.arthritis-health.com/types/bursitis/what-bursa

Winchester Hospital, *Bursectomy* 2016, Winchester Hospital, viewed 19 April 2017, http://www.winchesterhospital.org/health-library/article?id=947490.

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for implementation 01 January 2018.

Ref No: Q3168 | Published On: 15-Dec-2017 | Status: Current

Subject: Medial patellofemoral ligament (MPFL) reconstruction

Q:

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

A:

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

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

Stabilisation

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

Amendments will be considered for a future edition.

References:

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

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for implementation 01 January 2018.

Ref No: Q3170 | Published On: 15-Dec-2017 | Status: Current

Subject: 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 (Wegener's granulomatosis)
- 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 (Wegener's granulomatosis) with lung involvement assign:

  M31.3 *Wegener's granulomatosis*
  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.

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: Q3171 | Published On: 15-Dec-2017 | Status: Current

Subject: Extended spectrum beta-lactamase (ESBL) resistance

Q:

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

A:

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

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

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

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

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

References:

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

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

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Ref No: Q3174 | Published On: 15-Dec-2017 | Status: Current

Subject: 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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Ref No: Q3177 | Published On: 15-Dec-2017 | Status: Current

Subject: 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* as a best fit code for neuropathic cornea NOS (not otherwise specified) by following the 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* as an additional diagnosis (see ACS 1807 *Acute and chronic pain*).

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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Ref No: Q3179 | Published On: 15-Dec-2017 | Status: Current

Subject: 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: Q3183 | Published On: 15-Dec-2017 | Status: Current

Subject: Hemiarthroplasty of elbow

Q:

What code is assigned for hemiarthroplasty of the elbow?

A:

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

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

Arthroplasty

- elbow NEC

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

Amendments will be considered for a future edition.

References:

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

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Ref No: Q3185 | Published On: 15-Dec-2017 | Status: Current

Subject: 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

Subject: 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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Subject: 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

Subject: 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

Subject: 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

Subject: 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: Current

Subject: 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 Alphabetic Index:

Removal — *see also Excision*

- neurostimulator (epidural) (intracranial) (peripheral) (sacral) 39135-00 **[1604]**

Insertion

- neurostimulator (epidural) (intracranial) (peripheral) (sacral) 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), by following the 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 and the AR-DRG implications will be considered for a future edition.

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

Subject: 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: Current

Subject: 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*

B97.8 *Other viral agents as the cause of diseases classified to other chapters*

Follow the Alphabetic Index:

Wheezing R06.2

Infection, infected (opportunistic) *(see also Infestation)*

- virus NEC

- - as cause of disease classified elsewhere B97.8

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.

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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Coding Rules

Published 15 September 2017

Ref No: Q3062 | Published On: 15-Sep-2017 | Status: Updated | Updated On: 30-Jun-2019

Subject: Recurrent post procedural wound infection due to mesh

Q:

What code is assigned for a recurrent wound infection due to mesh from a hernia repair?

A:

Deep wound infections due to the mesh used in hernia repair procedures are uncommon, but may occur years after the hernia repair and mesh implantation procedure. If the infection is recurrent, the infected mesh may be removed to eradicate the source of infection (Delikoukos et al. 2007; Maheshwari & Garg 2016).

As per ACS 1904 *Procedural Complications/Sequelae*:

> *A sequela of a complication is a current condition that is the result of a previously occurring procedural complication.*

While the infection is still receiving active treatment it is not classified as a sequela of a procedural complication.

Assign T85.78 *Infection and inflammatory reaction due to other internal prosthetic devices, implants and grafts* by following the Alphabetic Index:

Infection, infected (opportunistic)

- due to or resulting from

- - device, implant or graft NEC *(see also Complication(s)/by site and type)* T85.78

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

Y83.1 *Surgical operation with implant of artificial internal device*

and

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

or

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

Reference:

Delikoukos, S, Tzovaras, G, Liakou, P, Mantzos, F & Hatzitheofilou, C 2007, 'Late-onset deep mesh infection after inguinal hernia repair', *The World Journal of Hernia and Abdominal Wall Surgery,* vol. 11, no. 1, pp. 15-17, viewed 21 March 2017, https://www.ncbi.nlm.nih.gov/pubmed/16941077

Maheshwari, J & Garg, KM 2016, 'Mesh Infection after Inguinal Hernia Mesh Repair – Experience of Five Mesh Removal', *Journal of Dental and Medical Sciences*, vol.15, no. 4, pp. 78-80, viewed 21 March 2017, http://www.iosrjournals.org/iosr-jdms/papers/Vol15-Issue%204/Version-12/P1504127880.pdf

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Ref No: Q3162 | Published On: 15-Sep-2017 | Status: Updated | Updated On: 15-Jun-2019

Subject: 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*, by following the Alphabetic Index:

Damage

- brain (nontraumatic) G93.9

Amendments will be considered for a future edition.

See also Coding Rule *Inappropriate behaviour due to acquired brain injury.*

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-2019

Subject: 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 as a best fit:

D89.8 *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/

Published 15 September 2017,
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Ref No: Q3146 | Published On: 15-Sep-2017 | Status: Updated | Updated On: 15-Jun-2019

Subject: 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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Ref No: Q3133 | Published On: 15-Sep-2017 | Status: Updated | Updated On: 15-Jun-2019

Subject: Osseointegration of limb implants on amputees

Q:

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

A:

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

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

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

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

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

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

or

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

Follow the Alphabetic Index:

Surgery

- reconstructive (following healed injury or operation)
- - lower limb Z42.4
- - upper limb Z42.3.

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

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

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

References:

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

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Ref No: Q3100 | Published On: 15-Sep-2017 | Status: Updated | Updated On: 15-Jun-2019

Subject: 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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for implementation 01 October 2017.

Ref No: Q3109 | Published On: 15-Sep-2017 | Status: Current

Subject: 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

Published 15 September 2017,
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Ref No: Q3119 | Published On: 15-Sep-2017 | Status: Current

Subject: Angiomyomatous hamartoma of the lymph node

Q:

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

A:

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

Treatment is by excision of the lymph node.

Assign:

D36.0. *Benign neoplasm of lymph nodes*

and

M8000/0 *Neoplasm, benign*

Follow the Alphabetic Index:

Neoplasm, neoplastic

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

Tumour

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

Amendments will be considered for a future edition.

Reference:

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

Published 15 September 2017,
for implementation 01 October 2017.

Ref No: Q3138 | Published On: 15-Sep-2017 | Status: Current

Subject: Bone graft with open reduction and internal fixation of fracture

Q:

What code is assigned for a bone graft when performed inconjunction with an open reduction and internal fixation of fracture?

A:

Bone graftsmay 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 fracturedbone. The bone graft itself may or may not also be held in place with internalfixation.

Where a bonegraft is performed with ORIF and the bone graft is documented as being held inplace with internal fixation, assign an appropriate code by following the Alphabetic Index at *Graft/bone/*by site*/withinternal fixation.*

Where a bonegraft is performed with ORIF but there is no documentation clearly indicatingthat the bone graft is being held in place with internal fixation, assign acode 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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for implementation 01 October 2017.

Ref No: Q3143 | Published On: 15-Sep-2017 | Status: Current

Subject: 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* as a best fit

and

41855-00 **[520]** *Microlaryngoscopy* as per the guidelines in ACS 0023 *Laparoscopic/arthroscopic/endoscopic surgery*.

Amendments will be considered for a future edition.

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 eiglottopexy for laryngomalacia, JAMA otolaryngology – head and neck surgery, viewed 2 July 2017, http://jamanetwork.com/journals/jamaotolaryngology/fullarticle/484496

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for implementation 01 October 2017.

Ref No: Q3144 | Published On: 15-Sep-2017 | Status: Current

Subject: 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 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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Ref No: Q3159 | Published On: 15-Sep-2017 | Status: Current

Subject: 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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Ref No: Q3167 | Published On: 15-Sep-2017 | Status: Current

Subject: 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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Ref No: Q3172 | Published On: 15-Sep-2017 | Status: Current

Subject: Migratory polyarthritis/polyarthropathy

Q:

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

A:

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

Polyarthritis, polyarthropathy

- migratory — *see Fever/rheumatic*

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

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

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

Polyarthritis, polyarthropathy

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

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

References:

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

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

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

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

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for implementation 01 October 2017.

Ref No: Q3176 | Published On: 15-Sep-2017 | Status: Current

Subject: Prophylactic internal fixation

Q:

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

A:

Prophylactic (internal) fixation of bone is performed for impending pathological fracture (that is, patients at risk of pathological fracture, but **without a current fracture**). Prophylactic fixation is performed to stabilise and protect the bone, alleviate pain, and improve weight-bearing/ mobilisation. The intervention is usually performed on long bones (eg femur, humerus, tibia) (Miller et al. 2011, O'Donnell 2017, van der Hulst et al. 1994).

The current ACHI classification of fixation of bones assumes that the procedure is performed for a fracture. It is inappropriate to assign codes from blocks that classify fixation/reduction of fracture for prophylactic internal fixation (that is, where there is risk of pathological fracture, but **without a current fracture**).

Where prophylactic internal fixation of any bone is performed (for example, insertion of femoral nail for a patient with bone metastases who is at risk of pathological fracture but does not have a current fracture), assign 47921-00 **[1554]** *Insertion of internal fixation device, not elsewhere classified,* by following the Alphabetic Index:

Insertion

- fixation device

- - bone

- - - orthopaedic (pin) (plate) (wire) 47921-00 **[1554]**

Amendments will be considered for a future edition.

References

Miller, BJ, Soni, EE, Gibbs, CP & Scarborough, MT 2011, 'Intramedullary nails for long bone metastases: why do they fail?', Orthopedics, 2011 Apr 11;34(4), viewed 7 March 2017, https://www.ncbi.nlm.nih.gov/pubmed/21469628

O'Donnell, P 2017, Impending Fracture Prophylactic Fixation, Lineage Medical Inc, viewed 7 March 2017, http://www.orthobullets.com/pathology/8002/impending-fracture-and-prophylactic-fixation

van der Hulst, RR, van den Wildenberg, FA, Vroemen, JP & Greve, JW 1994, 'Intramedullary nailing of (impending) pathologic fractures', The Journal of Trauma, 1994 Feb;36(2):211-5, viewed 7 March 2017, https://www.ncbi.nlm.nih.gov/pubmed/8114139

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for implementation 01 October 2017.

Ref No: Q3194 | Published On: 15-Sep-2017 | Status: Current

Subject: 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)

Ref No: Q3221 | Published On: 15-Sep-2017 | Status: Current

Subject: 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.

Minor amendments will be made to the Alphabetic Index via errata 2.

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Coding Rules

Published 15 June 2017

Ref No: Q3132 | Published On: 15-Jun-2017 | Status: Updated | Updated On: 15-Jun-2019

Subject: 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 *Health care associated Staphylococcus aureus bacteraemia.*

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.

Published 15 June 2017,
for implementation 01 July 2017.

Ref No: Q3053 | Published On: 15-Jun-2017 | Status: Current

Subject: 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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for implementation 01 July 2017.

Ref No: Q3053 | Published On: 15-Jun-2017 | Status: Current

Subject: 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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for implementation 01 July 2017.

Ref No: Q3064 | Published On: 15-Jun-2017 | Status: Current

Subject: Deconditioning

Q:

What are the correct codes to assign for deconditioning?

A:

Deconditioning is a term used to describe a decrease in muscle mass and other physiologic changes that result from either aging or immobility or both, and contribute to overall weakness (Graf, 2006).

Deconditioning is also known as sarcopenia, which is described as low muscle mass plus low muscle strength or low physical performance. Sarcopenia was approved for addition to ICD-10 in October 2016 by the World Health Organisation (WHO) Update Reference Committee as an *Inclusion* term at M62.5 *Muscle wasting and atrophy, not elsewhere classified*.

Therefore, assign M62.50 *Muscle wasting and atrophy, not elsewhere classified, multiple sites* for deconditioning, following the Alphabetic Index:

Atrophy, atrophic

- muscle, muscular M62.5-

or

Wasting

- muscle NEC M62.5-

Where there is documentation of the underlying cause of the deconditioning, apply the guidelines in ACS 0001 *Principal diagnosis/problems and underlying conditions* or ACS 0002 *Additional diagnoses/Problems and underlying conditions*.

Amendments to the classification will be considered for a future edition.

Reference:

Graf, C 2006, *Functional Decline in Hospitalized Older Adults: It's often a consequence of hospitalization, but it doesn't have to be*, viewed 24 May 2016, http://www.ncbi.nlm.nih.gov/pubmed/16481783?ordinalpos=5itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_RVMedline

Published 15 June 2017,
for implementation 01 July 2017.

Ref No: Q3079 | Published On: 15-Jun-2017 | Status: Current

Subject: 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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for implementation 01 July 2017.

Ref No: Q3082 | Published On: 15-Jun-2017 | Status: Current

Subject: Septic shower

Q:

What code is assigned for septic shower?

A:

Septic shower:

- is the sudden systemic influx of colonised pathogens
- most commonly associated with an in situ/implanted device
- often follows infusion of fluids into an in situ/implanted device
- may result in septic shock.

Where septic shower is documented as associated with the presence of a device, assign an appropriate code from T82-T85 by following the Alphabetic Index at *Sepsis/due to/device, implant or graft*/by type of device.

Assign codes for sepsis and septic shock as per the guidelines in ACS 0110 *SIRS, sepsis, severe sepsis and septic shock*. Assign external cause and place of occurrence codes, as applicable.

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

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for implementation 01 July 2017.

Ref No: Q3089 | Published On: 15-Jun-2017 | Status: Current

Subject: 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

Published 15 June 2017,
for implementation 01 July 2017.

Ref No: Q3096 | Published On: 15-Jun-2017 | Status: Current

Subject: Urosepsis

Q:

Is the indexing at the lead term *Urosepsis* a sequencing instruction?

A:

The indexing at the lead term *Urosepsis* in the Alphabetic Index is:

> **Urosepsis** — *see Sepsis AND Infection, infected (opportunistic)/urinary (tract) NEC*

The *See* reference in the above indexing:

- directs coders to two lead terms, as two codes are assigned to classify urosepsis
- is **not** a sequencing instruction.

Apply the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses* to determine whether sepsis or urinary tract infection (UTI) is the principal diagnosis for each individual case, based on the clinical documentation.

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for implementation 01 July 2017.

Ref No: Q3099 | Published On: 15-Jun-2017 | Status: Current

Subject: 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]**

Published 15 June 2017,
for implementation 01 July 2017.

Ref No: Q3121 | Published On: 15-Jun-2017 | Status: Current

Subject: 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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for implementation 01 July 2017.

Ref No: Q3122 | Published On: 15-Jun-2017 | Status: Current

Subject: 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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for implementation 01 July 2017.

Ref No: Q3129 | Published On: 15-Jun-2017 | Status: Current

Subject: 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.

Published 15 June 2017,
for implementation 01 July 2017.

Ref No: Q3136 | Published On: 15-Jun-2017 | Status: Current

Subject: 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

Subject: 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.

Published 15 June 2017,
for implementation 01 July 2017.

Ref No: Q3141 | Published On: 15-Jun-2017 | Status: Current

Subject: 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.

Published 15 June 2017,
for implementation 01 July 2017.

Ref No: Q3156 | Published On: 15-Jun-2017 | Status: Current

Subject: 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.

Published 15 June 2017,
for implementation 01 July 2017.

Ref No: Q3163 | Published On: 15-Jun-2017 | Status: Current

Subject: 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

Published 15 June 2017,
for implementation 01 July 2017.

Ref No: Q3166 | Published On: 15-Jun-2017 | Status: Current

Subject: Removal of external fixation involving removal of pins and/or wires

Q:

How do you code removal of external fixation involving removal of pins and/or wires?

A:

Pins and wires in internal fixation are part of the fixation device itself; pins and wires in external fixation are an anchoring component of the external fixator.

For removal of external fixation involving removal of (anchoring) pins and wires, assign 47948-00 **[1554]** *Removal of external fixation device.*

Amendments to ACHI will be considered for a future edition.

Published 15 June 2017,
for implementation 01 July 2017.

Coding Rules

Published 15 March 2017

Ref No: Q3102 | Published On: 15-Mar-2017 | Status: Updated | Updated On: 30-Jun-2019

Subject: CPR related injuries

Q:

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

A:

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

Skeletal chest injuries secondary to CPR meet the definition of a procedural complication/misadventure as per ACS 1904 *Procedural complications*:

> *Documentation clearly states that the condition arose as a complication of the procedure.*

Assign the following codes:

M96.8 *Other intraoperative or postprocedural disorders of musculoskeletal system*

Complication(s) (from) (of)

- musculoskeletal

- - intraoperative or postprocedural

- - - specified NEC M96.8

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 occurs in a clinical setting (eg ambulance, health facility), assign

Y92.23 Place of occurrence, health service area, not specified as thisfacility

OR

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

Where the injury occurs in the community (ie a nonclinical setting), assign an appropriate place of occurrence code from the External Cause of Injury Alphabetic Index at the lead term *Place of occurrence of external cause*.

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

Published 15 March 2017,
for implementation 01 April 2017.

Ref No: Q3147 | Published On: 15-Mar-2017 | Status: Updated | Updated On: 15-Jun-2019

Subject: Selection of morphology codes from pathology reports

Q:

Should coders use the summary or the microscopic section of the pathology report to determine the correct morphology code?

A:

ACS 0010 *Clinical documentation and general abstraction guidelines/Findings that provide more specificity about a diagnosis* states:

> *Laboratory, x-ray, pathological and other diagnostic results should be coded where they clearly add specificity to already documented conditions that meet the criteria for a principal diagnosis (see ACS 0001* Principal diagnosis*) or an additional diagnosis (see ACS 0002* Additional diagnoses*).*

A discharge summary is a summation of the whole episode of care; similarly the summary on a pathology report provides a brief summation of the body of the report. The entire pathology report must be used to abstract information for the purposes of clinical coding and therefore determine the correct morphology code.

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

Published 15 March 2017,
for implementation 01 April 2017.

Ref No: Q3116 | Published On: 15-Mar-2017 | Status: Updated | Updated On: 15-Jun-2019

Subject: 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*

As stated above, DDS is a known complication of haemodialysis.

Therefore, as DDS involves neurological symptoms, assign G97.8 *Other intraoperative or postprocedural disorders of nervous system* by following the Alphabetic Index:

Complication(s)(from) (of)

- nervous system

- - intraoperative or postprocedural

- - - specified NEC G97.8

Assign additional diagnoses for specific symptoms and U91 *Syndrome, not elsewhere classified*.

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 Alphabetic Index at *Complication(s)/dialysis/specified NEC* T80.8.

T80-T88 *Complications of surgical and medical care, not elsewhere classified* is a residual category, and lists an *Excludes* note: *specified complications classified elsewhere*.

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

Subject: 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.

Published 15 March 2017,
for implementation 01 April 2017.

Ref No: Q2937 | Published On: 15-Mar-2017 | Status: Current

Subject: Iliac artery stenosis with Type2 diabetes mellitus and peripheral vascular disease

Q:

What is the correct code assignment for iliac artery stenosis in a Type2 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.

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for implementation 01 April 2017.

Ref No: Q2958 | Published On: 15-Mar-2017 | Status: Current

Subject: Decompressive laminectomy of thoracic and lumbar spine by posterior approach

Q:

What is the correct code for decompressive laminectomy of thoracic and lumbar spine by posterior approach?

A:

In the absence of a specific code or index entries for posterior decompressive laminectomy of thoracic and lumbar spine, clinical advice supports the assignment of the following codes as best fit:

40345-00 **[47]** *Decompression of thoracic spinal cord via costotransversectomy*

and

90024-XX **[48]** *Decompression of lumbar spinal canal*

Amendments to ACHI will be considered for a future edition.

Published 15 March 2017,
for implementation 01 April 2017.

Ref No: Q2984 | Published On: 15-Mar-2017 | Status: Current

Subject: 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

Subject: 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

Subject: 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: Current

Subject: 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 best fit 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 *Laparoscopic/arthroscopic/endoscopic surgery.*

Amendments to ACHI will be considered for a future edition.

Published 15 March 2017,
for implementation 01 April 2017.

Ref No: Q3086 | Published On: 15-Mar-2017 | Status: Current

Subject: Insertion of seton for pilonidal disease

Q:

What code is assigned for insertion of seton for pilonidal disease?

A:

Pilonidal disease ranges from asymptomatic hair-containing cysts and sinuses to chronic infection of cysts (also called pilonidal abscess) that develop at the natal cleft (the groove between the buttocks) and do not heal. A pilonidal sinus (or blind fistula) is a small hole, pit or abnormal channel that goes from the infection site in the deeper tissues to the surface of the skin.

A seton is used on fistulas to assist healing by allowing the fistula tract to drain while preventing the wound from healing over. There are two types of seton: a non-cutting seton (referred to as draining, or loose seton), and a cutting seton where the seton is tightened intermittently over a period of time to slowly cut tissue while a scar forms or the wound heals behind the seton loop.

In the absence of a specific code for insertion of seton for pilonidal disease, as seton is a form of drainage assign 30676-00 **[1659]** *Incision of pilonidal sinus or cyst* by following the Alphabetic Index:

Drainage

- cyst

- - pilonidal 30676-00 **[1659]**

Amendments to ACHI will be considered for a future edition.

Published 15 March 2017,
for implementation 01 April 2017.

Ref No: Q3091 | Published On: 15-Mar-2017 | Status: Current

Subject: Reduction of manubriosternal joint dislocation

Q:

What is the appropriate code for reduction of a manubriosternal joint dislocation?

A:

The sternum has three distinct parts: the manubrium, the body of the sternum, and the xiphoid process. A manubriosternal dislocation is a rare injury, resulting from direct chest trauma such as in a motor vehicle accident or as an indirect compression injury.

Block **[1377]** *Reduction of fracture/dislocation of neck or thorax* classifies reduction of fracture of sternum, as well as reduction of fracture/dislocation of rib as per the Alphabetic Index:

Reduction

- dislocation (bone) (with cast) (with splint)

- - rib (closed) (with internal fixation) 90610-00 **[1377]**

- - - open 90610-01 **[1377]**

…

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

- - rib (closed) (with internal fixation) 90610-00 **[1377]**

- - - open 90610-01 **[1377]**

…

- - sternum (closed) (with fixation) 47466-00 **[1377]**

- - - open 47467-00 **[1377]**

In the absence of Alphabetic Index entries for *Reduction/dislocation/sternum*, apply the logic for indexing of reduction of fracture/dislocation of rib (see above) and assign 47466-00 **[1377]** *Closed reduction of fracture of sternum* or 47467-00 **[1377]** *Open reduction of fracture of sternum* for reduction of sternal dislocation (eg reduction of a manubriosternal joint dislocation) as a best fit.

Amendments to ACHI will be considered for a future edition.

Published 15 March 2017,
for implementation 01 April 2017.

Ref No: Q3104 | Published On: 15-Mar-2017 | Status: Current

Subject: 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.

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for implementation 01 April 2017.

Ref No: Q3105 | Published On: 15-Mar-2017 | Status: Current

Subject: Hyperplastic rectosigmoid polyp

Q:

What code is assigned for hyperplastic rectosigmoid polyp?

A:

The large intestine is comprised of: the caecum, appendix, colon (ascending, transverse, descending and sigmoid), rectum, and the anus. The rectosigmoid junction is the part of the large intestine where the distal sigmoid colon transitions into the rectum.

There is no specific site code in ICD-10-AM for hyperplastic rectosigmoid polyps.

Assign K63.58 *Other polyp of colon* by following the Alphabetic Index:

Polyp, polypus

- colon NOS

- - hyperplastic K63.58

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

Published 15 March 2017,
for implementation 01 April 2017.

Ref No: Q3130 | Published On: 15-Mar-2017 | Status: Current

Subject: 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.

Published 15 March 2017,
for implementation 01 April 2017.

Ref No: Q3134 | Published On: 15-Mar-2017 | Status: Current

Subject: 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

Subject: 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-2019

Subject: Non accidental injury

Q:

Can an injury documented as ‘non accidental’ be classified as assault?

A:

In Chapter 20 *External causes of morbidity and mortality*, the category for *Assault* (X85–Y09) includes injuries inflicted by another person with the intent to injure or kill, by any means.

The *General arrangement of the ICD-10-AM Alphabetic Index* states that Section II (External causes of injury):

- priority modifiers include transport accidents, complications of medical and surgical procedures, intentional self-harm, assault, legal intervention, or war operations
- key words are ‘Complication’ (for medical and surgical procedures), ‘Sequelae’, ‘Suicide’, ‘Assault’, ‘Legal intervention’ and ‘War operations’:

  Users should remember the presence of these special lists whenever they have difficulty locating index entries for the relevant conditions, problems or circumstances; by scrutinizing the indented terms, guidance can be found as to the code numbers of all the relevant categories ***even if not reported in precisely the same words****.*

The term ‘non-accidental’ indicates purposeful intent. Therefore, a non-accidental 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 External causes of injury Alphabetic Index:

Injury, injured (accidental(ly)) NEC X59

- 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*)
- an external cause code for assault (see External causes of injury Alphabetic Index: *Assault*)
- Y92.- *Place of occurrence*
- U50–U73 *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,
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Ref No: Q3073 | Published On: 15-Dec-2016 | Status: Updated | Updated On: 15-Jun-2019

Subject: Same-day admissions for chemotherapy/pharmacotherapy for neoplasm(s) and neoplasm related conditions

Q:

What are the correct codes to assign for same-day admissions for administration of Neulasta, IV hydration or other prophylactic pharmacotherapy?

A:

Neulasta is a drug used to treat or prevent neutropenia in patients with neoplasms or undergoing pharmacotherapy. It is administered subcutaneously and must be administered 24 hours post pharmacootherapy to avoid interaction.

Same-day episode of care for administration of intravenous (IV) hydration is also a common pharmacotherapy protocol to treat or prevent dehydration and/or kidney function disorders in patients undergoing pharmacotherapy, as these are common neoplasm/pharmacotherapy related conditions.

ACS 0044 *Pharmacotherapy* states:

> *For classification purposes, pharmacotherapy is defined as: "The administration of any therapeutic substance (usually a drug), excluding blood and blood products."*

Therefore, for a same-day episode of care for administration of Neulasta, IV hydration or other prophylactic pharmacotherapy (which meets the definition of pharmacotherapy as stated above) for a patient with a neoplasm or neoplasm related condition, assign:

- Z51.1 *Pharmacotherapy session for neoplasm* as principal diagnosis
- a code for the neoplasm being treated as the first additional diagnosis (see also ACS 0236 *Neoplasm coding and sequencing*)
- additional diagnosis code(s) for any neoplasm related condition or neoplasm treatment related conditions(s) meeting the criteria in ACS 0002 *Additional diagnoses.*
- Assign the appropriate ACHI code(s), for example:
- 96200-00 **[1920]** *Subcutaneous administration of pharmacological agent, antineoplastic agent* for administration of Neulasta
- 96199-00 **[1920]** *Intravenous administration of pharmacological agent, antineoplastic agent* for administration of IV hydration

Note: As per Example 2 in ACS 0044 *Pharmacotherapy* and the Instructional note at block **[1920]** *Administration of pharmacotherapy*, the extension -00 *Antineoplastic agent* is assigned for agents used in the treatment of neoplasms and/or neoplasm related conditions.

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

Published 15 December 2016,
for implementation 01 January 2017.

Ref No: Q3071 | Published On: 15-Dec-2016 | Status: Updated | Updated On: 01-Jan-2018

Subject: 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.

Published 15 December 2016,
for implementation 01 January 2017.

Ref No: Q3072 | Published On: 15-Dec-2016 | Status: Updated | Updated On: 01-Jul-2017

Subject: 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 surgicalperipheral catheterisation — *see Embolisation/blood vessel, transcatheter/by site*

…

- bloodvessel, 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.

Published 15 December 2016,
for implementation 01 January 2017.

Ref No: Q3074 | Published On: 15-Dec-2016 | Status: Current

Subject: 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.

Published 15 December 2016,
for implementation 01 January 2017.

Ref No: Q3085 | Published On: 15-Dec-2016 | Status: Current

Subject: 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*

by following the Alphabetic Index:

Removal

- arteriovenous fistula

- - surgically created 34130-00 **[765]**

Amendments to ACHI will be considered for a future edition.

Published 15 December 2016,
for implementation 01 January 2017.

Ref No: Q3088 | Published On: 15-Dec-2016 | Status: Current

Subject: 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.

Published 15 December 2016,
for implementation 01 January 2017.

Ref No: Q3097 | Published On: 15-Dec-2016 | Status: Current

Subject: Laminectomy

Q:

What is the appropriate code to assign for documentation of laminectomy without further specificity?

A:

A laminectomy is a surgical excision of the angled segments of bone (laminae) of the vertebra to gain access to the structures associated with the spinal cord. A laminectomy is performed to reduce pressure on the spinal nerve roots or the spinal cord, but may also provide access (ie the operative approach) for removal of intervertebral discs (discectomy) or spinal lesions/tumours.

Where there is documentation of ‘laminectomy’ without any further specificity, clinical consultation should be sought to clarify the purpose of the laminectomy ie for ‘decompression’ and/or any other procedures performed.

If, after clinical consultation (or if consultation is not possible), ‘laminectomy’ was not associated with other procedures or clarified further, follow the Alphabetic Index:

Laminectomy

- decompressive — see Decompression/spinal

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for implementation 01 January 2017.

Ref No: Q3115 | Published On: 15-Dec-2016 | Status: Current

Subject: 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.

Published 15 December 2016,
for implementation 01 January 2017.

Ref No: Q3117 | Published On: 15-Dec-2016 | Status: Current

Subject: 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]**

Note: Assignment of the above ACHI code with principal diagnosis M62.08 *Diastasis of muscle, other* will result in assignment of DRG 801C *OR Procedures Unrelated to Principal Diagnosis, Minor Complexity* in version 9 of the grouper. ACCD will consider this issue in a future version of the AR-DRG classification

Published 15 December 2016,
for implementation 01 January 2017.

Ref No: Q3120 | Published On: 15-Dec-2016 | Status: Current

Subject: Insufficiency fracture

Q:

How should insufficiency fractures be classified?

A:

An insufficiency fracture is a type of pathological or stress fracture that occurs as a result of normal physiological stress on abnormal bone. These fractures are seen in patients with conditions such as osteoporosis, rheumatoid arthritis, Paget's disease, osteomalacia, diabetes, and sometimes as a result of radiotherapy. These fractures are usually located in the vertebra, tibia or fibula or the calcaneus in the foot.

Assign an appropriate code from the Alphabetic Index at:

Fracture

- pathological (cause unknown) M84.4-

- - with osteoporosis M80.9-

- - - disuse M80.2-

- - - drug-induced M80.4-

- - - idiopathic M80.5-

- - - postmenopausal M80.0-

- - - postoophorectomy M80.1-

- - - postprocedural malabsorption M80.3-

- - - specified NEC M80.8-

- - due to neoplastic disease NEC (M8000/1) (*see also Neoplasm*) D48.9† M90.7-*

For insufficiency fractures in a patient with osteoporosis NOS, assign M80.9- *Unspecified osteoporosis with pathological fracture.* Where the type of osteoporosis is known, assign a code from one of the options at *Fracture/pathological/with osteoporosis* (see above).

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

Published 15 December 2016,
for implementation 01 January 2017.

Coding Rules

Published 15 September 2016

Ref No: Q3057 | Published On: 15-Sep-2016 | Status: Updated | Updated On: 15-Jun-2019

Subject: 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

- cerebellar (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.

Published 15 September 2016,
for implementation 01 October 2016.

Ref No: Q3098 | Published On: 15-Sep-2016 | Status: Updated | Updated On: 01-Jul-2017

Subject: 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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for implementation 01 October 2016.

Ref No: Q3070 | Published On: 15-Sep-2016 | Status: Updated | Updated On: 01-Jul-2017

Subject: 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.

Published 15 September 2016,
for implementation 01 October 2016.

Ref No: Q3076 | Published On: 15-Sep-2016 | Status: Updated | Updated On: 15-Mar-2017

Subject: Insertion of leadless/transvenous pacemaker

Q:

What is the code assignment for insertion of a leadless/transvenous pacemaker?

A:

A leadless/transvenous pacemaker is a single chamber pacemaker device that does not require the use of wired leads to provide an electrical connection between the pulse generator and the heart. It is implanted directly in the right ventricle of the heart through a catheter via the femoral or jugular vein. The steroid eluting electrode that delivers pacing is located within the device.

There is no specific code in ACHI for this procedure. Clinical advice indicates that 38353-00 [**650**] *Insertion of cardiac pacemaker generator* does not fully reflect the procedure of placing a leadless pacemaker. The extra complexity, resources and potential risk for more complications in placing the pacemaker generator transvenously are similar to that reflected in 38350-00 [**648**] *Insertion of permanent transvenous electrode into other heart chamber(s) for cardiac pacemaker*.

Therefore for insertion of a leadless/transvenous pacemaker, assign:

38353-00 [**650**] *Insertion of cardiac pacemaker generator*

and

38350-00 [**648**] *Insertion of permanent transvenous electrode into other heart chamber(s) for cardiac pacemaker*

Improvements to ACHI will be considered for a future edition.

Published 15 September 2016,
for implementation 01 October 2016.

Ref No: Q2995 | Published On: 15-Sep-2016 | Status: Current

Subject: 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. It should be noted that in some instances a revision code will be assigned even if the term ‘revision’ is not utilised.

  For example, where an operation report states removal of screws and turning of ACDF (anterior cervical disc fusion) plate to permit discectomy and insertion of prosthetic disc, and lateral rhizolysis, but there is no documentation of revision, assign:

  48691-00 **[59]** Insertion of intervertebral disc prosthesis, 1 level

  50616-01 **[1393]** Revision of spinal procedure with removal of spinal fixation

  40330-00 **[49]** Spinal rhizolysis

  by following the Alphabetic Index:

  Insertion

  - prosthesis, prosthetic device

  - - disc, intervertebral (1 level) 48691-00 **[59]**

  Removal

  - fixation device

  - - internal

  - - - spinal 50616-01 **[1393]**

  Rhizolysis

  - spinal 40330-00 **[49]**

  In this case, although revision is not documented, by following the correct terms in the Alphabetic Index (ie Removal/fixation device/internal/spinal) a revision code is assigned.

A review of the classification of revision/replacement/adjustment of prosthetic devices in ACHI is being considered for a future edition.

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for implementation 01 October 2016.

Ref No: Q3014 | Published On: 15-Sep-2016 | Status: Current

Subject: 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.

Published 15 September 2016,
for implementation 01 October 2016.

Ref No: Q3045 | Published On: 15-Sep-2016 | Status: Current

Subject: 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

Published 15 September 2016,
for implementation 01 October 2016.

Ref No: Q3060 | Published On: 15-Sep-2016 | Status: Current

Subject: 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/

Published 15 September 2016,
for implementation 01 October 2016.

Coding Rules

Published 15 June 2016

Ref No: Q3063 | Published On: 15-Jun-2016 | Status: Updated | Updated On: 15-Jun-2019

Subject: 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

- lymph node — *see also Excision/lymphatic structure/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

- lymph node — *see also Excision/lymphatic structure /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.

Published 15 June 2016,
for implementation 01 July 2016.

Ref No: Q3001 | Published On: 15-Jun-2016 | Status: Updated | Updated On: 15-Jun-2019

Subject: 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.

Published 15 June 2016,
for implementation 01 July 2016.

Ref No: Q3055 | Published On: 15-Jun-2016 | Status: Updated | Updated On: 15-Mar-2017

Subject: 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:

The Introduction to the Australian Coding Standards states:

> It is assumed that coding decisions are not made solely based on information provided on the clinical record front sheet and/or the discharge summary (or a copy of same) but that analysis of the entire clinical record is performed before code assignment.
>
> If a clinical record is inadequate for complete, accurate coding, the clinical coder should seek more information from the clinician. When a diagnosis is recorded for which there is no supporting documentation in the body of the clinical record, it may be necessary to consult with the clinician before assigning a code.

Applying the above and gaining an understanding of the circumstances of an admitted episode of care should be sufficient in most instances to establish a principal diagnosis as per the definition in 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, therefore a flowchart is not appropriate.

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).

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for implementation 01 July 2016.

Ref No: Q3033 | Published On: 15-Jun-2016 | Status: Current

Subject: 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]** *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* as per ACS 0023 *Laparoscopic/arthroscopic/endoscopic surgery*.

Improvements to this area of the classification will be considered for a future edition of ACHI.

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for implementation 01 July 2016.

Ref No: Q2903 | Published On: 15-Jun-2016 | Status: Current | Supersedes: Q2728

Subject: 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.

Published 15 June 2016,
for implementation 01 July 2016.

Ref No: Q2953 | Published On: 15-Jun-2016 | Status: Current | Supersedes: TN565

Subject: 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), it cannot be produced with a face mask. 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). If *high flow* is documented without being administered via these techniques, clinical coders should verify with the clinician whether it is HFT before classifying as NIV.

When HFT 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.*

Improvements to ACHI will be considered for a future edition.

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for implementation 01 July 2016.

Ref No: Q2987 | Published On: 15-Jun-2016 | Status: Current

Subject: 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.

Published 15 June 2016,
for implementation 01 July 2016.

Ref No: Q2994 | Published On: 15-Jun-2016 | Status: Current

Subject: 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

Subject: 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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for implementation 01 July 2016.

Ref No: Q3028 | Published On: 15-Jun-2016 | Status: Current

Subject: 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.

Published 15 June 2016,
for implementation 01 July 2016.

Ref No: Q3036 | Published On: 15-Jun-2016 | Status: Current

Subject: 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: Q3041 | Published On: 15-Jun-2016 | Status: Current

Subject: External fixation using pins or wires

Q:

When external fixation using pins or wires is documented should this be coded as external fixation or internal fixation?

A:

Application of external fixation devices (including those involving pins and wires but not involving correction of limb deformity, fracture reduction, limb lengthening, mandible, maxilla or pelvis surgery) are classified in ACHI to 50130-00 **[1550]** *Application of external fixation device, not elsewhere classified* as clarified in the *Note* at this code which states:

> *This code classifies external fixation devices, not classified elsewhere, that are invasive (ie applied to bone). External fixation devices that are noninvasive are classified elsewhere.*

Follow the Alphabetic Index:

Fixation

- bone

- - external (invasive) 50130-00 **[1550]**

Amendments to ACHI will be considered for a future edition.

Published 15 June 2016,
for implementation 01 July 2016.

Ref No: Q3049 | Published On: 15-Jun-2016 | Status: Current

Subject: 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.

Published 15 June 2016,
for implementation 01 July 2016.

Ref No: Q3054 | Published On: 15-Jun-2016 | Status: Current | Supersedes: Q2642

Subject: 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.

Published 15 June 2016,
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

Subject: 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.

Published 15 March 2016,
for implementation 01 April 2016.

Ref No: Q3034 | Published On: 15-Mar-2016 | Status: Current

Subject: 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

Subject: 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.

Published 15 March 2016,
for implementation 01 April 2016.

Ref No: Q3025 | Published On: 15-Mar-2016 | Status: Current

Subject: 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) < 3% of body surface area (BSA) grafted:

  45400-01 **[1641]** Split skin graft of small granulating burn site, < 3% of body surface area grafted

- *extensive* is applicable to ≥3% of BSA grafted:

  45403-01 **[1641]** Split skin graft of extensive granulating burn site, ≥3% of body surface area grafted

as per the index pathways:

Graft

- skin

- - for burn

- - - specified site NEC

- - - - split thickness

- - - - - granulating (< 3% body surface area) 45400-01 **[1641]**

- - - - - - ≥ 3% body surface area grafted 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.

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

Published 15 March 2016,
for implementation 01 April 2016.

Ref No: Q3010 | Published On: 15-Mar-2016 | Status: Current

Subject: 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.

Published 15 March 2016,
for implementation 01 April 2016.

Ref No: Q3003 | Published On: 15-Mar-2016 | Status: Current

Subject: 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: Current

Subject: 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*
>
> 13020-00 **[1888]** *Hyperbaric oxygen therapy, > 90 minutes and ≤ 3 hours*
>
> 13025-00 **[1888]** *Hyperbaric oxygen therapy, > 3 hours*.

Published 15 March 2016,
for implementation 01 April 2016.

Coding Rules

Published 03 February 2016

Ref No: TN1037 | Published On: 03-Feb-2016 | Status: Updated | Updated On: 15-Jun-2018

Subject: Zika virus; use of WHO code for emergency use

Effective from 21 December 2015

Zika virus (synonymously known as Zika fever and Zika virus infection) is a mosquito-borne viral disease caused by Zika virus (ZIKV). Symptoms include mild fever, rash, headaches, arthralgia, myalgia, asthenia, and non-purulent conjunctivitis. Symptoms appear between three to twelve days after the mosquito vector bite. One in four people may not develop symptoms, but in those who are affected the disease is usually mild with symptoms that last between two and seven days, and usually clears from the blood within a week.

A recent concern has arisen due to an increase in the incidence of Zika virus internationally, with possible links between the infection in pregnant women and subsequent birth defects (including microcephaly). As a result, the WHO has advised that **effective from 21 December 2015** U06.9 *Emergency use of U06.9* is to be assigned to monitor Zika virus internationally.

Zika virus is currently classified to A92.8 *Other specified mosquito-borne viral fevers.* This is a residual code that classifies a number of disease concepts and so WHO have requested that U06.9 is assigned for all cases of Zika virus from 21 December 2015 to facilitate unique identification of Zika virus for global monitoring.

Therefore, in the event that cases of Zika virus are confirmed, assign both:

A92.8 *Other specified mosquito-borne viral fevers* and

U06.9 *Emergency use of U06.9.*

For confirmed Zika virus in pregnant patients, assign:

O98.5 *Other viral diseases in pregnancy, childbirth and the puerperium*

with A92.8 and U06.9 as additional diagnoses.

Assign P00.2 *Fetus and newborn affected by maternal infectious and parasitic diseases* if maternal infection with Zika virus is documented as affecting a fetus or newborn (meeting the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses)*. However, do not assign A92.8 or U06.9 to the infant's episode of care unless the infant has documentation of confirmed (congenital) Zika virus.

Where patients are transferred to another facility for *suspected Zika virus*, follow the guidelines in ACS 0012 *Suspected conditions* and assign:

A92.8 *Other specified mosquito-borne viral fevers*

Z75.6 *Transfer for suspected condition*

Do not assign U06.9 for patients transferred with unconfirmed cases of Zika virus.

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

References

Centers for Disease Control and Prevention 2016, *'Questions and answers for pediatric healthcare providers: infants and Zika virus infection,* viewed 2 February 2016 http://www.cdc.gov/zika/hc-providers/qa-pediatrician.html

Medew, J, Miletic, D & Flitton, D 2016, 'Six cases of Zika virus in Australia last year as pregnant women warned not to travel', *The Sydney Morning Herald,* 26 January, viewed 1 February 2016, http://www.smh.com.au/national/urgent-travel-warning-for-pregnant-australian-women-at-risk-of-zika-virus-20160125-gmdv5u.html

Pan American Health Organisation n.d. '*Zika virus infection',* viewed 17 December 2015 http://www.paho.org/hq/index.php?option=com_topics&view=article&id=427&Itemid=41484&lang=en

Published 03 February 2016,
for implementation 21 December 2015.

Coding Rules

Published 15 December 2015

Ref No: Q2985 | Published On: 15-Dec-2015 | Status: Updated | Updated On: 01-Jul-2017

Subject: 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

See also Coding Rule ‘Clinical diagnosis versus histology’.

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: Current

Subject: 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* 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* for OA of another site.

Published 15 December 2015,
for implementation 01 January 2016.

Ref No: TN1035 | Published On: 15-Dec-2015 | Status: Current

Subject: Low magnesium

Q:

What is the correct code to assign for a documented low serum magnesium level, confirmed as low on biochemistry, and for which magnesium replacement is given (i.e. Mg 0.42 on admission commenced on Magmin 3 tabs TDS)? Is it correct to follow the advice in the Coding Rule *Use of abbreviations, symbols and test results values* (originally published 15 September 2009 and updated 15 September 2015) and follow the index pathway *Deficiency/magnesium* to assign E61.*2 Magnesium deficiency* as per the example of low potassium cited in this Coding Rule?

A:

The index pathways in ICD-10-AM for low magnesium are not consistent with those for low potassium. For low potassium following the lead terms **Deficiency**, **Depletion**, **Hypokalaemia**, **Hypopotassaemia** or **Syndrome** result in only one code, E87.6 *Hypokalaemia.* However three different codes may be assigned for low magnesium depending on the lead term chosen:

E83.4 *Disorders of magnesium metabolism*

E61.2 *Magnesium deficiency*

R79.0 *Abnormal level of blood mineral*

For low magnesium without further specification use the lead term **Hypomagnesaemia** to assign E83.4 *Disorders of magnesium metabolism* in category E83 *Disorders of mineral metabolism* which is the same block where low potassium is classified (*Metabolic disorders* (E70–E89)).

Do not follow the index pathway ***Deficiency/magnesium*** to assign E61.2 *Magnesium deficiency*, in block E50–E64 *Other nutritional deficiencies*, unless there is documentation to support that the patient has a dietary deficiency.

Codes in category E61 *Deficiency of other nutrient elements* and E83 *Disorders of mineral metabolism* are mutually exclusive as per the *excludes notes* at E61 and E83.

R79.0 *Abnormal level of blood mineral* is also inappropriate, as this is a symptom code in Chapter 18 *Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified* (R00–R99) and is only to be used when a more specific code is not available elsewhere in the classification. R79.0 excludes both disorders of mineral metabolism (E83.-) and nutritional mineral deficiency (E58–E61).

See also Coding Rule *Use of abbreviations, symbols and test results values* (originally published 15 September 2009 and updated 15 September 2015)

Published 15 December 2015,
for implementation 01 January 2016.

Ref No: Q2991 | Published On: 15-Dec-2015 | Status: Current

Subject: Inadvertent or intentional removal of devices requiring replacement

Q:

What is the correct code to assign when a device or tube is inadvertently or intentionally removed requiring replacement, e.g. a gastrostomy tube being pulled out or falling out requiring replacement?

A:

Mechanical complications are device malfunctions or failures. Devices can fail or malfunction because they are improperly implanted, break down, wear out or migrate out of position.

A gastrostomy tube or device which is inadvertently or intentionally pulled out is not a device malfunction or failure and is not to be classified as a mechanical complication.

Inadvertent removal of a gastrostomy tube may require review or replacement; it should not be classified to T85.5 *Mechanical complication of gastrointestinal prosthetic devices, implants and grafts*. However, assign Z43.1 *Attention to gastrostomy* if the gastrostomy received attention or management during the episode of care.

Published 15 December 2015,
for implementation 01 January 2016.

Ref No: Q2988 | Published On: 15-Dec-2015 | Status: Current

Subject: Limbal stem cell deficiency and resulting corneal conjunctivalisation

Q:

What is the correct diagnosis code to assign for limbal stem cell deficiency resulting in corneal conjunctivalisation?

A:

Limbal Stem Cell Deficiency (LSCD) is characterised by a loss or deficiency of the stem cells in the limbus (the edge of the cornea where it joins the sclera) which act as a 'barrier' to conjunctival epithelial cells preventing them from migrating on to the corneal surface. When these stem cells are lost, the corneal epithelium is unable to repair and renew itself, resulting in epithelial breakdown and defects leading to corneal conjunctivalisation, neovascularisation, scarring and chronic inflammation, which may lead to corneal opacity and visual impairment or blindness. Causes of LSCD may be genetic, idiopathic or acquired such as infection, trauma and drugs.

Corneal conjunctivalisation is the pathological process whereby the conjunctival epithelial cells in the limbus migrate on to the corneal surface to replace the normal corneal epithelium.

Limbal stem cell deficiency resulting in corneal conjunctivalisation should be classified to H18.8 *Other specified disorders of cornea* following the Index pathway:

Disease

- cornea

- - specified NEC H18.8

Assign external cause codes as appropriate.

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

Published 15 December 2015,
for implementation 01 January 2016.

Ref No: Q2989 | Published On: 15-Dec-2015 | Status: Current

Subject: 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 procedures*

or

45752-00 **[1708]** *Osteotomies or ostectomies of mandible and maxilla, ≥ 6 procedures, with internal fixation*.

Improvements to this area of the classification will be considered for a future edition of ACHI.

Published 15 December 2015,
for implementation 01 January 2016.

Ref No: Q3008 | Published On: 15-Dec-2015 | Status: Current

Subject: 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:

The Introduction to the Australian Coding Standards states:

> "The responsibility for recording accurate diagnoses and procedures, in particular principal diagnosis, lies with the clinician, not the clinical coder.
>
> A joint effort between the clinician and clinical coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures".

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.

As per the Ninth Edition Education FAQs, it is not necessary to review medication charts to inform code assignment. Medications may be given for more than one diagnosis, and the presence of a prescribed medication is not an indication of a diagnosis. ACS 0003 *Supplementary codes for chronic conditions* (Errata 3 update) also confirms that conditions may be assumed to be current unless there is documentation that indicates otherwise.

Published 15 December 2015,
for implementation 01 January 2016.

Ref No: Q3012 | Published On: 15-Dec-2015 | Status: Current

Subject: 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.

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for implementation 01 January 2016.

Ref No: Q3016 | Published On: 15-Dec-2015 | Status: Current

Subject: Revision procedures for obesity

Q:

Can 30514-01 **[889]** Revision procedure for obesity be assigned in addition to codes from block **[881]** Gastrostomy, gastro-enterostomy or gastro-gastrostomy?

A:

30514-01 **[889]** *Revision procedure for obesity* is **only** assigned as an additional code with any of the specific obesity procedures listed as inclusion terms at 30514-01 in the Tabular List (*Code first*: obesity procedure(s) performed (see block **[889]**)) :

- biliopancreatic diversion (30512-02 **[889]** *Biliopancreatic diversion*)
- duodenal-jejunal bypass (90940-00 **[889]** *Duodenal-jejunal bypass [DJ bypass]*)
- gastric bypass (30512-00 **[889]** *Gastric bypass* or 30512-03 **[889]** *Laparoscopic gastric bypass*)
- gastroplasty (30511-08 **[889]** *Gastroplasty*)
- ileal interposition (90941-00 **[889]** *Ileal interposition*)
- sleeve gastrectomy (30511-10 **[889]** *Sleeve gastrectomy [SG]*)

Each of the above procedures requires a change to the patient's anatomy. The assignment of 30514-01 **[889]** is a flag to indicate that the procedure is more complex due to anatomical changes from a previous obesity procedure.

30515-00 **[881]** *Gastro-enterostomy* may be assigned with gastric bypass or biliopancreatic diversion as per the instructional notes (*code also when performed: gastro-enterostomy*). This includes when gastric bypass or biliopancreatic diversion are performed following a previous failed obesity procedure. *Gastro-enterostomy* or *gastro-gastrostomy* may also be performed without a code from block **[889]** following a failed obesity procedure.

If *gastro-enterostomy* or *gastro-gastrostomy* is performed following a failed obesity procedure **without** one of the above obesity procedures from block **[889]**, assign 30515-00 **[881]** *Gastro-enterostomy* or 30375-31 **[881]** *Gastro-gastrostomy,* as applicable but do not assign 30514-01 **[889]** *Revision procedure for obesity* as an additional code.

The *code also when performed* notes at 30515-00 **[881]**, 30375-31 **[881]** and 30514-01 **[889]** will be deleted as part of the third errata to Ninth Edition, December 2015.

Published 15 December 2015,
for implementation 01 January 2016.

Coding Rules

Published 15 September 2015

Ref No: Q2928 | Published On: 15-Sep-2015 | Status: Updated | Updated On: 15-Jun-2019

Subject: 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.

Published 15 September 2015,
for implementation 01 October 2015.

Ref No: Q2970 | Published On: 15-Sep-2015 | Status: Current

Subject: 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.

Published 15 September 2015,
for implementation 01 October 2015.

Ref No: Q2917 | Published On: 15-Sep-2015 | Status: Current

Subject: 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) (with penetrating foreign body)

- 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.*

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for implementation 01 October 2015.

Ref No: Q2930 | Published On: 15-Sep-2015 | Status: Current

Subject: 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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for implementation 01 October 2015.

Ref No: Q2932 | Published On: 15-Sep-2015 | Status: Current

Subject: 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: Q2942 | Published On: 15-Sep-2015 | Status: Current

Subject: Congestive cardiac failure (CCF) and left ventricular failure (LVF)

Q:

How do you code congestive cardiac failure (CCF) and left ventricular failure (LVF)?

A:

The following codes should be assigned for congestive heart/cardiac failure (CHF/CCF) and left ventricular failure (LVF):

Assign I50.0 *Congestive heart failure* for:

- CHF/CCF with or without acute pulmonary oedema
- CHF/CCF with LVF

Assign I50.1 *Left ventricular failure* for:

- LVF without mention of CHF/CCF
- Acute pulmonary oedema with mention of heart disease or non-congestive heart failure

See also ACS 0920 *Acute pulmonary oedema*.

Improvements to ICD-10-AM and the ACS will be considered for a future edition.

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for implementation 01 October 2015.

Ref No: Q2948 | Published On: 15-Sep-2015 | Status: Current

Subject: 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*

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.

Published 15 September 2015,
for implementation 01 October 2015.

Ref No: Q2962 | Published On: 15-Sep-2015 | Status: Current

Subject: 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

Subject: 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/

Published 15 September 2015,
for implementation 01 October 2015.

Ref No: Q2975 | Published On: 15-Sep-2015 | Status: Current

Subject: Micturition syncope

Q:

How do you code micturition syncope?

A:

Micturition syncope is a sudden transient loss of consciousness caused by a fall in blood pressure and decreased blood supply to the brain during or after urination and is most common after awakening from a deep sleep at night. Sudden decompression of the bladder superimposed on low blood pressure and heart rate during sleep can lead to hypotension and circulatory collapse. Vagal stimulation during straining on micturition may also result in hypotension and bradycardia. Precipitating factors include dehydration, excess alcohol, and antihypertensive and antidepressant medication.

Assign R55 *Syncope and collapse* for micturition syncope.

Do not assign a urinary symptom code such as R39.8 *Other and unspecified symptoms and signs involving the urinary system* as the syncope is not specifically related to or caused by any disorder or abnormality of the urinary system or I95.9 *Hypotension, unspecified* as low blood pressure is inherent in syncope.

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for implementation 01 October 2015.

Ref No: Q2986 | Published On: 15-Sep-2015 | Status: Current

Subject: Os acromiale

Q:

What is the correct code to assign for os acromiale?

A:

The acromial process of the scapula begins as separate osseous centres, which gradually fuse. The fusion process begins around age 15, and is normally complete by age 25. Os acromiale is a developmental disorder in which there is failure of fusion of these osseous centres of the scapula, resulting in the acromion being joined to the scapular spine by fibrous tissue rather than by bony union. The disorder may be completely painless and symptom free, but may also be associated with shoulder impingement, and rotator cuff pathology.

Assign M89.21, *Other disorders of bone development and growth, shoulder region*, for os acromiale by following the index pathway:

Disorder (of)

- bone

- - development and growth NEC M89.2-

with fifth character: 1 shoulder region

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

(Coding Rules, September 2015)

Published 15 September 2015,
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

Subject: 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

Published 15 June 2015,
for implementation 01 July 2015.

Ref No: Q2933 | Published On: 15-Jun-2015 | Status: Current

Subject: 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.

Published 15 June 2015,
for implementation 01 July 2015.

Ref No: Q2926 | Published On: 15-Jun-2015 | Status: Current

Subject: 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.

Published 15 June 2015,
for implementation 01 July 2015.

Ref No: Q2939 | Published On: 15-Jun-2015 | Status: Current

Subject: Endoscopic ultrasound (EUS)

Q:

What is the correct procedure code for biopsy of a lesion using EUS guidance?

A:

Endoscopic ultrasound (EUS) is similar to other endoscopies but with an ultrasound probe attached at the end of the endoscope, which permits both visualisation and tissue sampling of gastrointestinal walls and structures surrounding the gastrointestinal tract. EUS is primarily used for assessing lesions in the gastrointestinal tract, but has increasingly been used for evaluating lesions of adjacent organs such as lung, mediastinum, left kidney, adrenal gland and lymph nodes (intra-thoracic and intra-abdominal).

When biopsy of a lesion is performed under EUS guidance, assign an appropriate code for the type of endoscopy (e.g. gastroscopy, gastroscopy with biopsy) and 30688-00 **[1949]** *Endoscopic ultrasound*. For example, EUS guided FNA (fine needle aspiration) biopsy of pancreas, assign:

30075-16 **[977]** *Biopsy of pancreas*

30473-00 **[1005]** *Panendoscopy to duodenum*

30688-00 **[1949]** *Endoscopic ultrasound*

Improvements to ACHI will be considered for a future edition.

Reference

Vilmann, P. & Saftoiu, A. (2006). Endoscopic ultrasound-guided fine needle aspiration biopsy: equipment and technique. J Gastroenterol Hepatol. Vol 21(11), pages 1646-55. DOI: 10.1111/j.1440-1746.2006.04475.x

Published 15 June 2015,
for implementation 01 July 2015.

Ref No: Q2934 | Published On: 15-Jun-2015 | Status: Current

Subject: 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

- - obstruction (airway) (lung) J44.8

- - - with (acute)

- - - - exacerbation NEC J44.1

- - - - - infective J44.0

- - - - lower respiratory infection J44.0

Infection

- Streptococcus, streptococcal NEC A49.1

- - as cause of disease classified elsewhere B95.5

A review of ACS 1008 *Chronic obstructive pulmonary disease (COPD)* will be considered for a future edition.

Published 15 June 2015,
for implementation 01 July 2015.

Ref No: Q2929 | Published On: 15-Jun-2015 | Status: Current

Subject: 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.

Published 15 June 2015,
for implementation 01 July 2015.

Ref No: Q2923 | Published On: 15-Jun-2015 | Status: Current

Subject: 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

Published 15 June 2015,
for implementation 01 July 2015.

Ref No: Q2914 | Published On: 15-Jun-2015 | Status: Current

Subject: 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: Q2960 | Published On: 15-Jun-2015 | Status: Current

Subject: Revision procedure for obesity

Q:

What codes are assigned for laparoscopic gastric bypass performed on a patient who previously had a sleeve gastrectomy?

A:

As per the instructional note at 30514-01 **[889]** *Revision procedure for obesity*, assign first a code for the obesity procedure performed, followed by 30514-01 **[889]**:

30512-03 **[889]** *Laparoscopic gastric bypass*

30514-01 **[889]** *Revision procedure for obesity*

The following inclusion terms have been added to 30514-01 **[889]** for ACHI Ninth Edition, to clarify code assignment:

Revision (reoperation) of:

- biliopancreatic diversion
- duodenal jejunal bypass
- gastric bypass
- gastroplasty
- ileal interposition
- sleeve gastrectomy

30514-01 **[889]** should not be assigned for revision/replacement of gastric band or gastric band reservoir.

Published 15 June 2015,
for implementation 01 July 2015.

Ref No: Q2881 | Published On: 15-Jun-2015 | Status: Current

Subject: Hoarding disorder

Q:

What is the correct code to assign for hoarding disorder?

A:

Hoarding disorder is characterized by persistent difficulty discarding or parting with possessions, regardless of their actual value, as a result of a strong perceived need to save the items and to distress associated with discarding them. Hoarding disorder results in the accumulation of a large number of possessions that congest and clutter active living areas to the extent that their intended use is substantially compromised (DSM-5, 2013).

ICD-10-AM and its parent classification ICD-10 do not have a specific code for hoarding disorder. Both the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5), published by the American Psychiatric Association and the World Health Organization (WHO) ICD-11 Beta Draft classify hoarding disorder to obsessive compulsive and related disorders.

Therefore, hoarding disorder should be classified to F42.8 *Other obsessive-compulsive disorders* following the index pathway:

Disorder (of)

- obsessive-compulsive

- - specified NEC F42.8

Additional codes such as Z58.8 *Other problems related to physical environment* and Z59.1 *Inadequate housing* should also be assigned where these situations are documented and meet the criteria in ACS 0002 *Additional diagnoses*.

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

Reference:

American Psychiatric Association (2013), Diagnostic and statistical manual of mental disorders, Fifth edition,(DSM-5). doi, 10.1176/9780890425596

Published 15 June 2015,
for implementation 01 July 2015.

Ref No: Q2909 | Published On: 15-Jun-2015 | Status: Current

Subject: Epiphysiodesis of tibia

Q:

What is the correct code for epiphysiodesis of the tibia?

A:

Epiphysiodesis is a minimally invasive surgical procedure to slow or stop bone growth at epiphyseal (growth) plates located at either end of long bones such as the femur, tibia and fibula. This procedure is typically used in children to correct discrepancies in limb length.

Whilst usually performed on both the tibia and fibula, in older children, the procedure is sometimes performed on the tibia alone.

For epiphysiodesis of the tibia, assign 48503-00 **[1520]** *Epiphysiodesis of tibia and fibula* following the index pathway:

Epiphysiodesis

- tibia

- - with fibula 48503-00 **[1520]**

Improvements to ACHI will be considered for this procedure in a future edition.

Published 15 June 2015,
for implementation 01 July 2015.

Ref No: Q2927 | Published On: 15-Jun-2015 | Status: Current

Subject: 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.

Published 15 June 2015,
for implementation 01 July 2015.

Ref No: Q2936 | Published On: 15-Jun-2015 | Status: Current

Subject: 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

Subject: 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.

Published 15 March 2015,
for implementation 01 April 2015.

Ref No: Q2872 | Published On: 15-Mar-2015 | Status: Updated | Updated On: 15-Jun-2019

Subject: 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.

The World Health Organization (WHO) provides the following definition in the ICD-11 Beta version:

> The official genus name Noroviruses which is the group of viruses previously described as “Norwalk-like viruses” are a group of related, single-stranded RNA, non-enveloped viruses. Noroviruses cause self-limiting explosive acute gastroenteritis that last for 24–48hours in humans. The most common symptoms of acute gastroenteritis are diarrhea, vomiting, and stomach pain (WHO, 2015).

Therefore 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.

Published 15 March 2015,
for implementation 01 April 2015.

Ref No: Q2887 | Published On: 15-Mar-2015 | Status: Updated | Updated On: 15-Jun-2019

Subject: 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.

Published 15 March 2015,
for implementation 01 April 2015.

Ref No: Q2882 | Published On: 15-Mar-2015 | Status: Updated | Updated On: 01-Jul-2017

Subject: 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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for implementation 01 April 2015.

Ref No: Q2874 | Published On: 15-Mar-2015 | Status: Current

Subject: Interpretation of ACS 0936 *Cardiac 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 additional 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 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.

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*.

Published 15 March 2015,
for implementation 01 April 2015.

Ref No: Q2876 | Published On: 15-Mar-2015 | Status: Current

Subject: Total femur replacement

Q:

How do you code total femur resection with reconstruction including total femur replacement?

A:

Total femur replacement is a rare procedure, alternatively known as:

- Total femur endoprosthetic replacement
- Endoprosthetic femoral replacement
- Total femoral endoprosthetic reconstruction
- Total femur arthroplasty
- Total femur resection, and reconstruction with total femur replacement.

The last dot point above most accurately describes the intervention; resection of the whole femur with joint reconstruction, and replacement of the femur using metallic endoprosthesis. This procedure was originally performed for primary bone and soft tissue sarcomas, as a limb preservation/salvage procedure, an alternative to amputation.

More recently, indications have included:

- Multiple failed total hip or total knee arthropathies
- Chronic infections or other complications following multiple open reductions with internal fixation (ORIF) of the femur
- Complex periprosthetic fractures not amenable to other treatments.

Total femur replacement is considered for the above indications when patients have insufficient residual bone to support implantation of a revision arthroplasty prosthesis or fixation device. The procedure may require extensive soft tissue dissection (including detachment of relevant muscles) and reconstruction of the joints above and below (ie knee and hip).

ACHI contains a code for this procedure, created when the procedure was primarily performed for primary bone and soft tissue sarcomas. However, regardless of the indication for the procedure, assign the following code for total femur replacement (or any of its synonymous terms):

50218-03 **[1570]** *En bloc resection of lesion of long bone of lower limb with replacement of adjacent joint*.

The indication for the procedure will be identified by the assignment of an appropriate ICD-10-AM code.

Amendments will be considered for a future edition of ACHI.

Published 15 March 2015,
for implementation 01 April 2015.

Ref No: Q2886 | Published On: 15-Mar-2015 | Status: Current

Subject: 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]**

Published 15 March 2015,
for implementation 01 April 2015.

Coding Rules

Published 15 December 2014

Ref No: P182 | Published On: 15-Dec-2014 | Status: Updated | Updated On: 15-Jun-2019

Subject: 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

Subject: 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.

Published 15 December 2014,
for implementation 01 January 2015.

Ref No: Q2901 | Published On: 15-Dec-2014 | Status: Current

Subject: 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

Subject: 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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Ref No: Q2878 | Published On: 15-Dec-2014 | Status: Current

Subject: 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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Ref No: Q2902 | Published On: 15-Dec-2014 | Status: Current

Subject: 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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Coding Rules

Published 15 September 2014

Ref No: Q2802 | Published On: 15-Sep-2014 | Status: Updated | Updated On: 15-Jun-2019

Subject: Paediatric Autoimmune Neuropsychiatric Disorders (PANDAS)

Q:

What codes should be 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 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, follow ACS 0005 *Syndromes* and assign codes based on the documentation in the clinical record.

Diagnoses that may be assigned in these cases include:

- M35.9 *Systemic involvement of connective tissue, unspecified*
- F06.8 *Other specified mental disorders due to brain damage and dysfunction and to physical disease or condition*
- F42. - *Obsessive-compulsive disorders*
- F95. - *Tic disorders*
- B94.8 *Sequelae of other specified infectious and parasitic diseases* (where there is clear documentation of the association and not specified as current)

OR

- B95.0 *Streptococcus, group A, as the cause of diseases classified to other chapters* (if current).

For the scenario cited where the principal diagnosis is PANDAS and the admission is for IV administration of Intragam, assign the following:

M35.9 *Systemic involvement of connective tissue, unspecified*, as the principal diagnosis following the index pathway:

Disease, diseased — *see also Syndrome*

- autoimmune (systemic) NEC M35.9

and

F06.8 *Other specified mental disorders due to brain damage and dysfunction and to physical disease or condition* as an additional diagnosis following the index pathway:

Disorder (of) — *see also Disease*

- cognitive

- - due to (secondary to) general medical condition F06.9

- - - mixed F06.8

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:

U.S. National Institute of Mental Health (NIMH), Pediatrics and Developmental Neuroscience branch. (2012). Intramural Research Program. Retrieved from http://intramural.nimh.nih.gov/pdn/web.htm

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for implementation 01 October 2014.

Ref No: Q2867 | Published On: 15-Sep-2014 | Status: Current

Subject: ACS 0925 *Hypertension and related conditions*

Q:

Please clarify the classification guidelines in ACS 0925 *Hypertension and related conditions* and whether hypertension should be assigned in accordance with ACS 0002 *Additional diagnoses* when hypertension is present with heart or/and kidney disease but no causal relationship is documented between the conditions?

A:

The guidelines in ACS 0925 *Hypertension and related conditions* provide advice with respect to the classification of hypertension and in particular the classification of hypertension with another disease concept, pre-coordinated in a single code. The following advice is provided to clarify the content of this standard:

Where a causal relationship between hypertension and heart and/or kidney disease is stated, for example, heart and/or kidney disease 'due to hypertension' or 'hypertensive' heart and/or kidney disease, assign a code from:

- I11 *Hypertensive heart disease* for certain heart conditions (listed in I50.- or I51.4–I51.9) due to hypertension
- I12 *Hypertensive kidney disease* for certain kidney conditions (listed in N00–N07, N18.-, N19 or N26) due to hypertension
- I13 *Hypertensive heart and kidney disease*, when both hypertensive heart disease (I11) and hypertensive kidney disease (I12) are present.

Secondary hypertension is caused by another condition such as renal artery stenosis or phaeochromocytoma. When hypertension is stated to be 'due to' or 'secondary to' other conditions, assign an appropriate code from category I15 *Secondary hypertension*.

Where hypertension and heart or/and kidney disease are present but with no documented relationship between the conditions, assign I10 *Essential (primary) hypertension* when it meets the criteria in ACS 0002 *Additional diagnoses*.

The standard has been revised for the Ninth Edition to provide clarity.

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Ref No: Q2863 | Published On: 15-Sep-2014 | Status: Updated | Updated On: 01-Jul-2015

Subject: 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

Subject: 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

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Ref No: Q2883 | Published On: 15-Sep-2014 | Status: Current

Subject: Closure of ileostomy with resection

Q:

Is a separate code required for resection/excision of bowel with 30562-01 **[899]** *Closure of ileostomy with restoration of bowel continuity, without resection* as without resection is a nonessential modifier in the index?

A:

30562-01 **[899]** *Closure of ileostomy with restoration of bowel continuity, without resection* includes resection of small sections (freshening) (trimming) from the end of the stoma (exteriorised bowel/doughnuts) and distal intestine prior to anastomosis.

Resection/excision of intestine in excess of this freshening/trimming should be coded in addition to the closure of ileostomy code. This may occur if the diseased section of bowel was not resected prior to creation of the ileostomy or when further pathology is found during the closure procedure.

Where there is no documentation of further pathology of the bowel requiring resection, a separate code for the resection should not be assigned.

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Ref No: Q2908 | Published On: 15-Sep-2014 | Status: Current

Subject: 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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Coding Rules

Published 15 June 2014

Ref No: Q2720 | Published On: 15-Jun-2014 | Status: Updated | Updated On: 15-Jun-2019

Subject: Excision of neuroblastoma

Q:

Should the specific ACHI codes for neuroblastomas always be used when a neuroblastoma is removed, or can other more anatomically correct codes be used such as 40309-00 **[53]** *Removal of spinal extradural lesion*?

A:

The following site specific codes are available in ACHI for removal of neuroblastomas:

- 43987-01 **[989]** *Excision of intra-abdominal neuroblastoma*
- 43987-00 **[563]** *Excision of intrathoracic neuroblastoma*

For excision of neuroblastomas of other sites, assign 43987-02 **[80]** *Excision of neuroblastoma, not elsewhere classified*, following the index pathway:

Excision

- neuroblastoma NEC 43987-02 **[80]**

As per the definition in the Conventions used in the ACHI Alphabetic Index, the NEC indicates that this is the default option if the site of the neuroblastoma is not intra-abdominal or intrathoracic. It does not indicate that another index pathway can be selected to achieve a more site specific 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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for implementation 01 July 2014.

Ref No: Q2830 | Published On: 15-Jun-2014 | Status: Updated | Updated On: 01-Jul-2017

Subject: 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 – *seeDiabetes/with/arterial disease, peripheral*

…

- - arterialdisease, peripheral (without gangrene) E1-.51

- - - with

- - - - footulcer — *see ACS 0401 Diabetes mellitusand intermediate hyperglycaemia/6 Diabetic foot*

- - - - gangrene E1-.52

- - - - - and foot ulcer — *see ACS 0401 Diabetes mellitus and intermediate hyperglycaemia/6Diabetic 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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Ref No: Q2768 | Published On: 15-Jun-2014 | Status: Updated | Updated On: 01-Jul-2017

Subject: 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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Ref No: Q2841 | Published On: 15-Jun-2014 | Status: Current

Subject: Microscopically controlled serial excision of skin lesions

Q:

How many times should 31000-00 **[1626]** *Microscopically controlled serial excision of lesion(s) of skin* be assigned, if the patient has multiple sections taken from one lesion?

A:

Microscopically controlled serial excision of a skin lesion (Mohs chemosurgery) involves sections of tissue being excised around the target lesion and examined microscopically for evidence of neoplastic cells. The patient is held in recovery after each section is excised and is taken back into the operating room for further tissue removal if the findings are positive. This process may include a number of returns to the operating room (stages) and a number of sections being removed for a single lesion, until all neoplastic cells are removed. Clinically, this procedure is identified as one operative episode/visit to theatre. Therefore, the guidelines in ACS 0020 *Bilateral/Multiple procedures, Multiple procedures, Classification, (point) 1* do not apply.

Regardless of the number of stages or sections removed for a single lesion, this procedure fulfils the criteria in ACS 0020 *Bilateral/Multiple procedures, Classification, (point)5*:

> 5. Skin or subcutaneous lesion removal, excision or biopsy
>
> For multiple excisions or biopsies or removals performed on:

- separate skin lesions: assign relevant code(s) as many times as it is performed
- same lesion: assign relevant code once

Therefore, where this procedure is performed on a single lesion, assign 31000-00 **[1626]** *Microscopically controlled serial excision of lesion(s) of skin* once only, as implied by the terms serial excision in the code title. This code would only be assigned more than once if it was performed for multiple lesions during the same visit to theatre.

Amendments to ACHI and the ACS will be considered for a future edition.

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Ref No: TN697 | Published On: 15-Jun-2014 | Status: Current

Subject: Sclerotherapy of lesion of large intestine

Q:

How do you code injection of sclerosing agent into lesion of large intestine?

A:

Sclerotherapy (injection of sclerosing agent) is a type of destruction procedure that involves injection of a chemical irritant into a vein to produce hardening and destruction of the vein. The chemical irritates the lining of the vein, causing it to swell and the blood to clot. Scar tissue is produced, the vein shrinks and blood flow deviates to other healthy blood vessels.

When endoscopic sclerotherapy (injection of sclerosing agent) into lesion of large intestine is performed, assign 90308-00 **[908]** *Endoscopic destruction of lesion of large intestine* by following the index pathway:

Destruction

…

- lesion (tumour)

…

- - intestine, large

- - - endoscopic (closed) 90308-00 **[908]**

Amendments to ACHI Alphabetic Index will be considered for a future edition.

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for implementation 01 July 2014.

Ref No: Q2850 | Published On: 15-Jun-2014 | Status: Current

Subject: 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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Ref No: Q2839 | Published On: 15-Jun-2014 | Status: Current

Subject: 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-2019

Subject: Confusion or delirium with dementia

Q:

How do you code 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 should be assigned.

A code for delirium should only be assigned when this condition is documented OR when acute confusional state is specifically documented, as per the index pathway:

State (of)

…

- confusional (psychogenic) F44.88

- - acute or subacute (see also Delirium) F05.9

A code for confusion, acute confusion, confusional state and acute confusional state should only be 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 Delirium)

CONFUSIONAL STATE is documented: care should be taken before assigning F44.88 *Other specified dissociative [conversion] disorders.*

This code should not be assigned unless documentation within the clinical record indicates that the patient has a dissociative [conversion] disorder. Where documentation is inadequate, advice should be sought 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:

- **due to another medical condition**, assign F05.0 *Delirium not superimposed on dementia, so described* 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)

by following the index pathways:

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 F05.0

…

- 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 clinical record is unclear as to whether the patient has confusion or delirium, verification should be sought from the treating clinician.

Amendments to the Alphabetic Index 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 March 2014,
for implementation 01 April 2014.

Ref No: Q2786 | Published On: 15-Mar-2014 | Status: Updated | Updated On: 15-Jun-2019

Subject: 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: Current

Subject: 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.

(See also Coding Rules: Incisional hernia and Eighth Edition Education Workshop FAQs – Part 1, Hernia)

Published 15 March 2014,
for implementation 01 April 2014.

Ref No: Q2799 | Published On: 15-Mar-2014 | Status: Current

Subject: 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 Eighth Edition.

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.*

Please note "*Assignment of Chapter 17 Congenital malformations,deformations and chromosomal abnormalities codes (Q00–Q99) as additional diagnoses*" advice published 15 September 2006 *(Coding Matters, Volume 13, Number 2)* has been updated to remove the references to CADASIL.

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

Published 15 March 2014,
for implementation 01 April 2014.

Ref No: Q2803 | Published On: 15-Mar-2014 | Status: Current

Subject: 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

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for implementation 01 April 2014.

Ref No: Q2798 | Published On: 15-Mar-2014 | Status: Current

Subject: 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.

Ref No: Q2734 | Published On: 15-Mar-2014 | Status: Current

Subject: Delirium with dementia

Q:

How do you classify delirium in a patient with dementia?

A:

Where delirium is specifically documented in a patient who also has dementia, assign F05.1 *Delirium superimposed on dementia* by following the index pathways:

Delirium, delirious (acute or subacute) (not alcohol- or drug-induced) F05.9

…

- superimposed on dementia F05.1

Note: the documentation does not have to specify superimposed on dementia. The term superimposed implies delirium **with** dementia.

(see also Coding Rules: Confusion or delirium with dementia)

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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.

Published 15 December 2013,
for implementation 01 January 2014.

Ref No: Q2659 | Published On: 15-Dec-2013 | Status: Updated | Updated On: 01-Jul-2017

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, the NCCH assumes 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* (i.e. 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 Chapter18 Symptoms, signs and abnormal clinicalfindings, 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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for implementation 01 January 2014.

Ref No: Q2822 | Published On: 15-Dec-2013 | Status: Current

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.

The NCCH will consider amendments to ICD-10-AM 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/

Published 15 December 2013,
for implementation 01 January 2014.

Ref No: Q2815 | Published On: 15-Dec-2013 | Status: Current

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 Z30.2 *Sterilisation* (See Coding QA, Diagnosis code for sterilisation when performed in conjunction with other procedures, December 2012).

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for implementation 01 January 2014.

Ref No: Q2679 | Published On: 15-Dec-2013 | Status: Current

Coronary Optical Coherence Tomography (OCT) and Intravascular ultrasound (IVUS)

Q:

What codes should be assigned for Coronary OCT and IVUS?

A:

Coronary Optical Coherence Tomography (OCT) is a catheter based invasive imaging system that uses near infra-red light providing a high resolution image in vivo of the coronary arteries. This technology enables the extent of atherosclerosis to be seen within the artery and is being used to check previously implanted stents as some patients, like diabetics, are predisposed to re-stenosis of the stent.

Intravascular ultrasound (IVUS) is a catheter based invasive imaging system that uses sound waves to provide an image of the coronary artery walls and plaque deposits.

Both of these techniques are increasingly being used in percutaneous coronary interventions due to the detail of the images they are able to provide over the more traditional coronary angiograms.

There are no procedure codes in ACHI to distinguish these techniques, however as they are both catheter based imaging techniques used on coronary arteries, they should be classified to **[668]** *Coronary angiography* following either the lead term **Catheterisation** or **Angiography**.

Consideration will be given to incorporating these techniques within block **[668]** *Coronary angiography* for a future edition of ACHI.

Published 15 December 2013,
for implementation 01 January 2014.

Coding Rules

Published 15 June 2013

Ref No: Q2788 | Published On: 15-Jun-2013 | Status: Updated | Updated On: 15-Jun-2019

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

- - - male 37044-00 [1109]

- - - - revision 37044-03 [1109]

- - - revision

- - - - female 35599-01 [1110]

- - - - male 37044-03 [1109]

Amendments may be considered for a future edition.

Published 15 June 2013,
for implementation 01 July 2013.

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).

Published 15 June 2013,
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.

Published 15 June 2013,
for implementation 01 July 2013.

Ref No: Q2719 | Published On: 15-Jun-2013 | Status: Current

Management of tracheostomy

Q:

Could the NCCC clarify in what circumstances it is 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:

Could the NCCC clarify 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:

Could the NCCC clarify 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.

Published 15 June 2013,
for implementation 01 July 2013.

Ref No: Q2644 | Published On: 15-Jun-2013 | Status: Current

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 *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.

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for implementation 01 July 2013.

Coding Rules

Published 15 December 2012

Ref No: Q2782 | Published On: 15-Dec-2012 | Status: Updated | Updated On: 15-Jun-2019

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 is also supported by the advice in ACS 0236 *Neoplasm coding and sequencing/Primary neoplasm as a current condition* which states:

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

- treatment aimed at stopping progression of the neoplasm..."

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?",* accessed: September 2012, available: http://www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/EFAA19DECAA2111ACA2574EB007F73AF/$File/pap-smear.pdf.

Published 15 December 2012,
for implementation 01 January 2013.

Ref No: Q2687 | Published On: 15-Dec-2012 | Status: Updated | Updated On: 15-Jun-2019

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:

It is acknowledged there may be inconsistency in the assignment of Z51.4 *Preparatory care for subsequent treatment, not elsewhere classified*, and recently developed a discussion paper regarding the assignment of 'Z' codes as a principal diagnosis. However, the feedback received in response to the discussion paper provided no definitive outcome to the issue for inclusion in ICD-10-AM Eighth Edition, and ongoing evaluation is required to determine changes for a future edition.

In the interim, the neoplasm should be assigned as the principal diagnosis where the reason for admission is related to the treatment of the neoplasm. This follows the principle of the coding advice published by the NCCH in *Coding Matters* (2010) which states
"...assign the condition as the principal diagnoses for brachytherapy planning..."
as 'planning' is considered part of the treatment of the neoplasm.

Therefore, in the scenario cited assign the neoplasm of the tonsil as the principal diagnosis.

Reference:

National Centre for Classification in Health (2010), *Coding Matters, The 10-AM Commandments*, Vol. 16, No. 4.

Published 15 December 2012,
for implementation 01 January 2013.

Ref No: Q2647 | Published On: 15-Dec-2012 | Status: Current

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) 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.

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for implementation 01 January 2013.

Ref No: Q2735 | Published On: 15-Dec-2012 | Status: Current

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 Z30.2 *Sterilisation* as an additional diagnosis?

A:

It is correct to assign Z30.2 *Sterilisation* 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.

Published 15 December 2012,
for implementation 01 January 2013.

Coding Rules

Published 15 June 2012

Ref No: Q2712 | Published On: 15-Jun-2012 | Status: Updated | Updated On: 21-Sep-2020

Ultrasound guided compression repair of pseudoaneurysm

Note: This coding rule has been amended for consistency with the guidelines in ACS 0042 Procedures normally not coded and ACS 0016 General procedure guidelines.

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 rules Q3130 CT guided core biopsy of the lung and Q3378 Hookwire localisation of extramammary lesions.

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for implementation 01 July 2012.

Ref No: Q2645 | Published On: 15-Jun-2012 | Status: Updated | Updated On: 15-Jun-2019

Z03 Medical observation and evaluation for suspected diseases and conditions

Q:

Is it appropriate to assign a code from Z03 *Medical observation and evaluation for suspected diseases and conditions, ruled out* according to ACS 1617 *Neonatal sepsis/risk of sepsis* in the following scenarios:

Scenario 1:

Mother has a PPROM, baby is born prematurely and antibiotics are administered. However 'risk of sepsis' is not documented.

Scenario 2:

Mother goes into spontaneous premature labour without PPROM, and baby is born prematurely and antibiotics are administered.

Again, 'risk of sepsis' is not documented.

A:

Clinical coders should not assume 'risk of sepsis' in the scenarios described and should instead seek clinical confirmation that antibiotics are being administered for 'risk of sepsis' in order to assign Z03 *Medical observation and evaluation for suspected diseases and conditions, ruled out*.

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

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for implementation 01 July 2012.

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

Published 15 June 2012,
for implementation 01 July 2012.

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

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: Q2756 | Published On: 15-Jun-2012 | Status: Current

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* - 1 July 2012 revision.

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 Seventh Edition 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

Note: The Seventh Edition Tabular List for codes E1-.22 are inconsistent with the index entries above. The terms ‘fixed’ and ‘persistent’ at the includes term *proteinuria* should be essential (rather than non essential) modifiers. This will be corrected in Eighth Edition.

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for implementation 01 July 2012.

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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Ref No: Q2714 | Published On: 15-Jun-2012 | Status: Current

Foot ulcer/diabetic ulcer with other documented cause

Q:

When a foot ulcer is specified as a venous or pressure ulcer and the patient has diabetes mellitus (DM), can E1-.69 **Diabetes mellitus with other specified complication* be assigned given there is a documented cause other than the diabetes mellitus?

A:

Please refer to ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision. The index pathway *Diabetes, with* does not infer a causal relationship but rather represents conditions (often termed 'complications') which occur commonly with diabetes mellitus. When diabetes mellitus exists with foot ulcer, E1-.69 **Diabetes mellitus with other specified complication* can be assigned following the index pathway *Diabetes, diabetic, with, ulcer, foot*. An appropriate code for the ulcer may also be assigned according to ACS 0401, *Rule 4b*.

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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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for implementation 01 January 2012.

Ref No: Q2627 | Published On: 15-Dec-2011 | Status: Updated | Updated On: 15-Jun-2019

Healthcare associated *Staphylococcus aureus* bacteraemia (HA SAB) (2 of 2)

Q:

Is a condition onset flag (COF) of 1 assigned in the first admitted episode of care where HA SAB is diagnosed and a COF of 2 assigned for any subsequent admitted episode of care relating to the previously diagnosed HA SAB?

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, it is agreed that a condition onset flag of 1 should be assigned in the episode of care where *Healthcare associated Staphylococcus aureus bacteraemia* (HA SAB) first arose and that a condition onset flag of 2 should be assigned in any subsequent episode of care relating to the previously diagnosed HA SAB, as it arose before the current admitted patient episode of care.

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for implementation 01 January 2012.

Ref No: Q2686 | Published On: 15-Dec-2011 | Status: Updated | Updated On: 15-Jun-2019

Clinical diagnosis versus histology

Q:

A patient is admitted for excision of a ‘dermal cyst’ from the arm. The clinician documents ‘dermal cyst’ both pre and post surgery, however, the histology shows the lesion to be an angiomyoma. Should the guideline in ACS 0010 *Clinical documentation and general abstraction guidelines*, be followed, which states, “In the event that an investigation result varies from the clinical documentation, such as a clinical diagnosis of gastric ulcer with ‘no evidence of ulcer’ reported on histopathology, the case should be referred to the clinician.”

Or should the ACS 0010 guideline, be followed, which states, “Laboratory, x-ray, pathological and other diagnostic results should be coded where they clearly add specificity to already documented conditions.”

A:

In the scenario cited, the clinician has documented a clinical diagnosis of ‘dermal cyst’ in the absence of histological examination. However, histology reveals an ‘angiomyoma’, which appears contradictory to the original clinical diagnosis. If the clinician was asked to confirm the diagnosis with the benefit of the histology report, the question is, would the documentation be ‘dermal cyst’ or ‘angiomyoma’? As per the guidelines in ACS 0010 *Clinical documentation and general abstraction guidelines*, “In the event that an investigation result varies from the clinical documentation..., the case should be referred to the clinician.”

ACS 0010 also states, “It is important to seek clinical advice where necessary for clarification of discrepancies between investigation results and clinical documentation.” Therefore, where there is discrepancy between the clinical diagnosis and histology, as cited in this scenario, clinical verification should be sought prior to code assignment.

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

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Ref No: Q2737 | Published On: 15-Dec-2011 | Status: Updated | Updated On: 15-Jun-2019

Morphology of recurrent mediastinal tumour

Q:

What is the appropriate morphology code to assign in the following scenario? Patient admitted with recurrence of mediastinal tumour where original biopsy revealed “malignant cystic histiocytoma - M8830/3”. Supplementary histology report states morphology to be “malignant ossifying fibromyxoid tumour - M8842/3”. Note only /0 and /1 are contained in Appendix A: *Morphology of neoplasms*. Approximately a year later, the recurrence is resected and histology now states “high grade undifferentiated sarcoma - M8805/3”. Clinician states it is a recurrence of original tumour.

A:

Where there is doubt about the correct morphology code to assign due to ambiguous documentation in the clinical record, clinical coders should be guided by the principles in ACS 0010 *Clinical documentation and general abstraction guidelines*, which state:

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

- verification of diagnoses recorded on the front sheet and/or the discharge summary which are not supported in the clinical record, **and**
- clarification of discrepancies between investigation results and clinical documentation”
- For the scenario cited:
- the original morphology code (M8830/3 *Malignant fibrous histiocytoma*) should not be assigned as it appears to have been superseded by the supplementary report.
- in the first instance, confirmation should be sought from the clinician as to the correct morphology code to assign.
- where clinical confirmation is not possible clinical coders should be guided by the histopathology report in the current episode of care and assign M8805/3 *Undifferentiated sarcoma*.

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

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Coding Rules

Published 15 June 2011

Ref No: Q2640 | Published On: 15-Jun-2011 | Status: Updated | Updated On: 16-Dec-2019

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:

"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"*

ACS 0002 also 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, not for epidemiological purposes:

"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

Published 15 April 2011

Ref No: Q2620 | Published On: 15-Apr-2011 | Status: Updated | Updated On: 15-Jun-2019

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:

It is acknowledged there may be inconsistency in the assignment of Z51.4 *Preparatory care for subsequent treatment, not elsewhere classified*.

The issue arises where there is uncertainty as to the correct selection of principal diagnosis. Should Z51.4 be assigned as the principal diagnosis, indicating the episode of care is primarily for preparatory care, or should the condition necessitating the preparatory care be assigned as the principal diagnosis eg the neoplasm?

The answer to this question has wider implications for the assignment of 'Z' codes in other episodes of care. These implications require further analysis and review, which will be considered for a future edition of ICD-10-AM.In the interim follow the principle of the advice issued by the NCCH in Coding Matters, Volume 16, Number 4, March 2010, which states:

> "...assign the condition as the principal diagnosis for brachytherapy planning..."

Therefore, for the scenario cited, assign the condition necessitating the insertion of fiducial markers as the principal diagnosis.

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Ref No: Q2622 | Published On: 15-Apr-2011 | Status: Updated | Updated On: 15-Jun-2019

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*, Definition where it states:

“Note: Prior to the defining of chronic kidney disease, the term ‘chronic renal failure’ described both ‘failing’ and ‘failed’ kidneys and no further description was required when classifying. Under the new 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 glomerular filtration rate (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 GFR (eGFR) 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.

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for implementation 01 May 2011.

Ref No: TN126 | Published On: 15-Apr-2011 | Status: Updated | Updated On: 01-Jul-2017

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

Published 15 October 2010

Ref No: Q2611 | Published On: 15-Oct-2010 | Status: Updated | Updated On: 15-Jun-2019

Open reduction and internal fixation (ORIF) proximal femur

Q:

The index lookup below assigns ORIF femur to 47528-01 *Open reduction of fracture of femur with internal fixation*, which has an excludes note 'for that of proximal femur (47519-00 **[1479]**)'. However, 47519-00 **[1479]** *Internal fixation of fracture of trochanteric or subcapital femur* does not capture that this was an open reduction. Is this excludes in the correct spot? Is it correct that for ORIF of the proximal femur (subcapital, trochanteric etc) that code 47519-00 be assigned instead of 47528-01? The indexing doesn't seem to support the excludes notes as the proximal femur sites are not indexed under the open reduction?

Reduction

- fracture (bone) (with cast) (with splint)
- - femur (closed) 47516-01 **[1486]**
- - - with internal fixation (cross) (intramedullary) 47531-00 **[1486]**
- - - - neck 47519-00 **[1479]**
- - - - pertrochanteric 47519-00 [**1479**]
- - - - proximal 47519-00 **[1479]**
- - - - subcapital 47519-00 **[1479]**
- - - - subtrochanteric 47519-00 [**1479**]
- - - - trochanteric 47519-00 **[1479]**
- - - epiphysis (capital) (slipped) 47525-00 **[1493]**
- - - open 47528-00 **[1486]**
- - - - with internal fixation (cross) (intramedullary) 47528-01 **[1486]**
- - - - epiphysis (capital) (slipped) 47525-01 **[1493]**

A:

This is an example of where the Conventions used in the ACHI Alphabetic Index are applied:

> "PREPOSITIONAL TERMS Wherever a preposition from the list below immediately follows a lead term or subterm, they always take precedence over symbols, numbers and the alphabetic sequence of subterms:

- as
- by
- for
- with
- without"

Therefore, the correct code assignment for ORIF of the proximal femur (subcapital, trochanteric etc) is 47519-00 **[1479]** *Internal fixation of fracture of trochanteric or subcapital femur*, following the prepositional subterm 'with' in the index pathway:

Reduction

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

- - femur (closed) 47516-01 **[1486]**

- - - with internal fixation (cross) (intramedullary) 47531-00 **[1486]**

- - - - proximal 47519-00 **[1479]**

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

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Ref No: TN184 | Published On: 15-Oct-2010 | Status: Updated | Updated On: 15-Jun-2019

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

Published 15 June 2010

Ref No: TN196 | Published On: 15-Jun-2010 | Status: Current | Supersedes: TN171

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*, the correct code to assign is B37.4 *Candidiasis of other urogenital sites* following the index pathway:

Infection

- Candida (albicans) (tropicalis) (see also Candidiasis)

Candidiasis, candidal

- urogenital site NEC B37.4

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: Current | 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. At the lead term fracture in the ICD-10-AM Alphabetic Index the term ‘compression’ is a nonessential modifier while the term ‘crush’ is not listed as either an essential or nonessential modifier.

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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Ref No: TN196 | Published On: 15-Jun-2010 | Status: Current | Supersedes: TN393

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 N05.9and

Infection, infected

- *Streptococcus*, streptococcal NEC

- - Group

- - - A, as the cause of disease classified elsewhere 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.

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Published 15 June 2010,
for implementation 01 July 2010.

Ref No: TN196 | Published On: 15-Jun-2010 | Status: Current | Supersedes: TN393

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)

- - device (related to) NEC

- - - drug delivery or pump (CADD) (external) (implantable spinal) Z45.1

The following advice was provided in 10-AM Commandments Vol 15 No 1: “Where patients are admitted for adjustment, management, fitting or removal of a drug delivery device, (except for loading of a drug delivery device for same-day admission of chemotherapy to treat a neoplasm...) assign: Z45.1 *Adjustment and management of drug delivery device*”

Published 15 June 2010,
for implementation 01 July 2010.

Ref No: TN199 | Published On: 15-Jun-2010 | Status: Updated | Updated On: 30-Jun-2013

Fracture of hip prosthesis due to trauma

Q:

ACS 1309 *Dislocation or complication of hip prosthesis* states:

> 'Assign the code S73.0- *Dislocation of hip* with an additional diagnosis code of Z96.64 *Presence of hip implant* when a patient sustains a dislocation of a hip prosthesis...'

Does this ACS also apply to fractures of hip prostheses due to trauma, ie should an injury code be assigned or is T84.0 *Mechanical complication of internal joint prosthesis* the correct code?

A:

The guidelines in ACS 1309 *Dislocation or complication of hip prosthesis* do apply to fractures of hip prostheses due to trauma. Appropriate injury and external cause of injury codes should be assigned to reflect the trauma.T84.0 *Mechanical complication of internal joint prosthesis* should be assigned where the conditions listed in T82.0 are specified as due to the joint prosthesis, as per the inclusion term at T84.0 and also following the criteria in ACS 1309 *Dislocation or complication of hip prosthesis*.

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

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for implementation 01 July 2010.

Ref No: TN196 | Published On: 15-Jun-2010 | Status: Current | Supersedes: TN393

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.

Published 15 June 2010,
for implementation 01 July 2010.

Coding Rules

Published 15 March 2010

Ref No: TN197 | Published On: 15-Mar-2010 | Status: Current

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.

Published 15 March 2010,
for implementation 01 April 2010.

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.

Published 15 March 2010,
for implementation 01 April 2010.

Ref No: TN197 | Published On: 15-Mar-2010 | Status: Current

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:

The NCCH advises that coders should assign the condition as the principal diagnosis for brachytherapy planning, as 'planning' is considered part of the treatment of the neoplasm. Z51.4 *Preparatory care for subsequent treatment, not elsewhere classified* is a non-specific code and the data collection is better served by coding the condition with the intervention code specifically describing the reason for admission.

Published 15 March 2010,
for implementation 01 April 2010.

Coding Rules

Published 15 December 2009

Ref No: TN198 | Published On: 15-Dec-2009 | Status: Current

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.

Published 15 December 2009,
for implementation 01 January 2010.

Ref No: TN198 | Published On: 15-Dec-2009 | Status: Current

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*.

Published 15 December 2009,
for implementation 01 January 2010.

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.

Published 15 June 2009,
for implementation 01 July 2009.

Ref No: TN200 | Published On: 15-Jun-2009 | Status: Current

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 antiepileptic, sedative-hypnotic and antiparkinsonism drugs, 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.

Published 15 June 2009,
for implementation 01 July 2009.

Coding Rules

Published 15 March 2009

Ref No: TN201 | Published On: 15-Mar-2009 | Status: Current

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.

Published 15 March 2009,
for implementation 01 April 2009.

Coding Rules

Published 15 December 2008

Ref No: TN202 | Published On: 15-Dec-2008 | Status: Current

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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Published 15 December 2008,
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.

Published 15 September 2008,
for implementation 01 October 2008.

Coding Rules

Published 15 June 2008

Ref No: TN204 | Published On: 15-Jun-2008 | Status: Updated | Updated On: 01-Jul-2017

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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Published 15 June 2008,
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-2019

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*, ACS 1316 *Cement spacer/beads* 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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Published 15 September 2007,
for implementation 01 October 2007.

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.)

Published 15 June 2007,
for implementation 01 July 2007.

Ref No: TN208 | Published On: 15-Jun-2007 | Status: Current

Timeframe for Meniscal/Ligament Tears of Knee

Q:

Could the NCCH please consider the institution of a timeframe for meniscal/ligament tears of knee, which defines ‘old’ and ‘current’?

A:

The NCCH has researched this issue, including how injury timeframes are dealt with in other classifications. Unfortunately it is impossible to be definitive in this regard. Each case should be reviewed on its merits and coders should ultimately be guided by documentation and seek clarification from the clinician. To publish timeframes for old and current is extremely difficult due to differences in treatment protocols for these injuries. Some patients with meniscal tears are treated conservatively while others are treated with surgical repair. Some may initially be treated conservatively but then require surgical repair at a later date. Coders should be guided by the definitions in ACS 1906 *Current and Old Injuries*. If it still cannot be determined whether the injury is acute or not, then follow ACS 1319 *Meniscus/Ligament Tear of Knee, NOS* and assume the injury is old.

Published 15 June 2007,
for implementation 01 July 2007.

Coding Rules

Published 15 December 2006

Ref No: TN210 | Published On: 15-Dec-2006 | Status: Current

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. The NCCH received a query asking whether the principal diagnosis in these cases should 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

Published 15 December 2006,
for implementation 01 January 2007.

Ref No: TN210 | Published On: 15-Dec-2006 | Status: Current

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*

Published 15 December 2006,
for implementation 01 January 2007.

Coding Rules

Published 15 March 2004

Ref No: TN221 | Published On: 15-Mar-2004 | Status: Current

Excision of radial head prosthesis

A query was received by the NCCH regarding 'excision of radial head prosthesis'. The operation report for this procedure described, *'right elbow, lateral incision, capsule divided, excision of excessive intracapsular scar tissue and hypertrophic bone, radial head prosthesis excised'*.

Currently there is no code to classify removal of this type of device in ACHI. Clinical advice suggests that the procedure is technically similar to excising bone from the radius.

Classification

Following clinical advice, the NCCH suggests that documentation of 'excision of radial head prosthesis' should be coded as 48406-03 **[1426]** *Ostectomy of radius*.

Published 15 March 2004,
for implementation 01 April 2004.

Ref No: 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.

Published 15 March 2004,
for implementation 01 April 2004.

Frequently Asked Questions (FAQs) – Coronavirus disease 2019 (COVID-19)

COVID-19 FAQs – Admitted care

Published 20 August 2021 – Part 4

Ref No: TN1556 | Published On: 20-Aug-2021 | Status: Current

Code assignment and sequencing for COVID-19 vaccines causing adverse effects in therapeutic use

Q:

What is the correct code assignment and sequencing for a condition documented as an adverse effect of a COVID-19 vaccine?

A:

Minor and unspecified adverse reactions (complications) to non-serum vaccines are classified to T88.1 *Other complications following immunisation, not elsewhere classified*; such as eczema, reaction (allergic) and rash in accordance with the ICD-10-AM Alphabetic Index.

Coding Rule *COVID-19 vaccines causing adverse effects in therapeutic use* provided an example of such an adverse reaction, allergic urticaria, where T88.1 is assigned. In this example, an additional code was added for specificity (L50.0 *Allergic urticaria*).

For other specified adverse effects (complications) of a COVID-19 vaccination, such as pulmonary embolism, assign an appropriate chapter code and appropriate external cause codes.

In all instances of an adverse effect of a COVID-19 vaccination assign U07.7 *Emergency use of U07.7 [COVID-19 vaccines causing adverse effects in therapeutic use]* in addition to appropriate external cause codes where clinical documentation indicates the adverse effect is due to a COVID-19 vaccination.

In the March 2021 Coding Rule, the first example was intended to demonstrate application of U07.7 *Emergency use of U07.7 [COVID-19 vaccines causing adverse effects in therapeutic use]*, and is not a directive that T88.1 is to be assigned as principal diagnosis in all scenarios where an adverse effect of a COVID-19 vaccination is documented.

Improvements to this area of the classification are being progressed for the next edition of ICD-10-AM.

See also Coding Rule *COVID-19 vaccines causing adverse effects in therapeutic use*.

See also Coding Rule *Allergens and anaphylaxis*.

Published 20 August 2021,
for implementation 20 August 2021.

Ref No: TN1556 | Published On: 20-Aug-2021 | Status: Current

Assignment of emergency use code for the need for COVID-19 vaccination

Q:

Why was an emergency use code not implemented for the need for a COVID-19 vaccination?

A:

The World Health Organization (WHO) released two emergency use codes in early 2021 to classify the need for vaccination against Coronavirus disease 2019 (COVID-19) and adverse effects of COVID-19 vaccines.

In March 2021, Coding Rule *COVID-19 vaccines causing adverse effects in therapeutic use* was released to implement U07.7 *Emergency use of U07.7 [COVID-19 vaccines causing adverse effects in therapeutic use]*.

A code to classify the *need for immunisation against COVID-19* was not implemented in Australia following a decision to report COVID-19 vaccinations in the admitted setting as a non-admitted patient service event under COVID-19 vaccination clinic (10.21): https://www.ihpa.gov.au/publications/rules-coding-and-reporting-covid-19-episodes-care.

Published 20 August 2021,
for implementation 20 August 2021.

COVID-19 FAQs – Admitted care

Published 17 September 2020 – Part 3

Ref No: TN1541 | Published On: 17-Sep-2020 | Status: Current

Assignment of symptoms in patients with COVID-19

The COVID-19 pandemic is unprecedented, unique and evolving. Similarly, the classification of COVID-19 is unprecedented, unique and evolving.

At the beginning of the pandemic a decision was made, in Australia, to distinguish the classification of symptomatic COVID-19 admitted episodes from asymptomatic admitted episodes as it was considered this information would be useful in understanding the disease in the future.

Symptoms are not normally coded when a condition has been definitively diagnosed and so the classification of COVID-19 is unique in this respect.

There are complexities in the symptomatic versus asymptomatic nature of COVID-19 presentations, as the type and onset of symptoms are variable and may be related to causes other than COVID-19.

The following principles apply to the classification of symptoms in COVID-19 admitted episodes of care:

Scenario	Classification
COVID-19 has been confirmed and symptoms are present that are attributable to a definitive condition not associated with COVID-19	Codes for symptoms are not assigned, in accordance with normal coding practice
COVID-19 has been confirmed and symptoms are present that are attributable to a definitive condition associated with COVID-19, such as pneumonia or a respiratory tract infection	Codes for symptoms are not assigned, in accordance with normal coding practice
COVID-19 has been confirmed and symptoms are present, that are not attributable to a definitive condition or any other cause	Codes for symptoms are assigned for the classification of COVID-19
COVID-19 has been confirmed and symptoms are present or develop during the episode of care that are not attributable to a definitive condition or any other cause	Codes for symptoms are assigned for the classification of COVID-19

Where a symptom arising during the admitted episode is assigned as a principal diagnosis, follow ACS 0048 *Condition onset flag* to assign a condition onset flag (COF) of 2 *Condition not noted as arising during the current episode of care*, in accordance with *Guide for use point* 3.

Where there is uncertainty as to whether symptoms are attributable to COVID-19, confirmation should be sought from the treating clinician.

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for implementation 17 September 2020.

Ref No: TN1541 | Published On: 17-Sep-2020 | Status: Current

Assignment of COVID-19 emergency use codes in admitted episodes of care for transferred patients

The assignment of the COVID-19 emergency use codes are guided by clinical documentation, and supported by the test results.

Each COVID-19 related admitted episode of care must be reviewed on a case by case basis.

Where COVID-19 is documented as a suspected condition before transfer, apply the guidelines in ACS 0010 *Clinical documentation and general abstraction guidelines/Test results and medication charts* to assign the relevant emergency use code in that episode:

- where the laboratory test confirms a negative COVID-19 result, assign U06.0 *Emergency use of U06.0 [COVID-19, ruled out]*
- where the laboratory test confirms a positive COVID-19 result, assign U07.1 *Emergency use of U07.1 [COVID-19, virus identified]*

See also COVID-19 FAQ Part 3: Clinical documentation to support assignment of U06.0 *Emergency use of U06.0 [COVID-19, ruled out]*.

Published 17 September 2020,
for implementation 17 September 2020.

Ref No: TN1541 | Published On: 17-Sep-2020 | Status: Current

Clinical documentation to support assignment of U06.0 *Emergency use of U06.0 [COVID-19, ruled out]*

Australia enacted U06.0 *Emergency use of U06.0 [COVID-19, ruled out]* to identify activity related to the testing of COVID-19 in accordance with the National Partnership on COVID-19 Response.

Assign U06.0 *Emergency use of U06.0 [COVID-19, ruled out]* where clinical documentation indicates that testing for COVID-19 has occurred but the presence of COVID-19 has been ruled out by virtue of a negative test result for SARS-CoV-2. The specific terminology of 'ruled out' is not required in order to assign this code.

U06.0 *Emergency use of U06.0 [COVID-19, ruled out]* is only assigned in the episode where the laboratory test was performed.

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COVID-19 FAQs – Admitted care

Published 25 May 2020 – Part 2

Ref No: TN1540 | Published On: 25-May-2020 | Status: Current

Application of U06.0 *Emergency use of U06.0 [COVID-19, ruled out]* for admitted patients with a negative test result for SARS-CoV-2 (COVID-19)

Q:

When is U06.0 *Emergency use of U06.0 [COVID-19, ruled out]* assigned?

A:

Health care facilities may routinely test admitted patients for SARS-CoV-2 (eg in the absence of symptoms suggestive of COVID-19).

U06.0 *Emergency use of U06.0 [COVID-19, ruled out]* is assigned where there is clinical documentation that COVID-19 has been ruled out following laboratory testing, irrespective of the indication or whether the patient has been discharged before the test results are received.

U06.0 is not assigned based on observation of a test result alone as per the guidelines in ACS 0010 *Clinical documentation and general abstraction guidelines/Test results and medication charts*:

> *Do not use test result values, descriptions, medication charts, symbols and abbreviations in isolation to inform code assignment.*

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for implementation 25 May 2020.

Ref No: TN1540 | Published On: 25-May-2020 | Status: Current

COVID-19 complicating pregnancy

Q:

What codes are assigned for pregnancy complicated by COVID-19?

A:

Where COVID-19, diagnosed either clinically or by laboratory testing, is complicating pregnancy as per the guidelines in ACS 1521 *Conditions and injuries in pregnancy*, apply the guidelines in the Coding Rule *Coronavirus disease 2019 (COVID-19)*:

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

Example 1:

Admission to hospital for acute lower respiratory tract infection (LRTI) secondary to COVID-19 (laboratory confirmed SARS-CoV-2) complicating pregnancy.

Principal diagnosis:	O99.5 *Diseases of the respiratory system in pregnancy, childbirth and the puerperium*
Additional diagnoses:	J22 *Unspecified acute lower respiratory tract infection*
	O98.5 *Other viral diseases in pregnancy childbirth and the puerperium*
	B97.2 *Coronavirus as the cause of diseases classified to other chapters*
	U07.1 *Emergency use of U07.1 [COVID-19, virus identified]*

Rationale: In this episode, the patient is admitted with a LRTI, secondary to SARS-CoV-2 infection (COVID-19). The principal diagnosis is assigned to O99.5 with J22 reflecting the LRTI complicating pregnancy. The COVID-19 infection is classified in accordance with the COVID-19 coding rule by assigning O98.5 first, followed by B97.2 for the symptomatic COVID-19 and the appropriate emergency use code.

Example 2:

A patient with fever and cough is clinically diagnosed with COVID-19 complicating pregnancy (SARS-CoV-2 testing unavailable).

Principal diagnosis:	O99.8 *Other specified diseases and conditions in pregnancy, childbirth and the puerperium*
Additional diagnoses:	R50.9 *Fever, unspecified*
	R05 *Cough*

O98.5 *Other viral diseases in pregnancy childbirth and the puerperium*

B97.2 *Coronavirus as the cause of diseases classified to other chapters*

U07.2 *Emergency use of U07.2 [COVID-19, virus not identified]*

Rationale: In this episode, the patient is admitted with symptoms and clinically diagnosed as having COVID-19. The principal diagnosis is assigned to O99.8, with R50.9 and R05 to reflect the COVID-19 symptoms complicating pregnancy. COVID-19 is classified in accordance with the COVID-19 coding rule by assigning O98.5 first, followed by B97.2 for the symptomatic COVID-19 and U07.2 to reflect the clinical diagnosis of COVID-19.

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Ref No: TN1540 | Published On: 25-May-2020 | Status: Current

Clinical variation in documentation of COVID-19

Q:

How do variations in clinical terminology and documentation of COVID-19 (eg ‘viral illness – COVID-19’ or ‘Coronavirus infection’) affect code assignment?

A:

Apply the guidelines in the Coding Rule *Coronavirus disease 2019 (COVID-19)*, irrespective of the varying terminology used to describe COVID-19. That is, classify the episode according to the presentation and whether the presentation occurs with a documented clinical manifestation, symptom or is asymptomatic.

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Laboratory tests to identify COVID-19

Q:

Can laboratory tests such as an antibody serology test be used to inform assignment of an emergency use code for coronavirus disease 2019 (COVID-19)?

A:

Testing for COVID-19 can include nucleic acid detection tests, using polymerase chain reaction (PCR) to detect SARS-CoV-2 viral ribonucleic acid, or serology tests to detect human antibodies (ie immunoglobulins or Ig) against SARS-CoV-2 (Therapeutic Goods Administration 2020). Documentation of these tests can include 'swabs', PCR and blood serology tests.

Antibodies are produced after a person is infected with SARS-CoV-2. Serology tests can demonstrate the presence of these antibodies, and therefore whether someone has been infected (Centres for Disease Control and Prevention 2020; Therapeutic Goods Administration 2020).

Clinical advice confirms that documentation of COVID-19 with confirmation from laboratory testing, including antibody serology testing, can be used to assign U07.1 *Emergency use of U07.1 [COVID-19, virus identified]* as these tests specifically identify COVID-19.

Where COVID-19 is ruled out, refer to the guidance in COVID-19 FAQ admitted care Part 2 - *Application of U06.0 Emergency use of U06.0 [COVID-19, ruled out] for admitted patients with a negative test result for SARS-CoV-2 (COVID-19)*.

References:

Centers for Disease Control and Prevention 2020, *Serology Testing for COVID-19*, United States Department of Health & Human Services, viewed 14 May 2020, https://www.cdc.gov/coronavirus/2019-ncov/lab/serology-testing.html.

Therapeutic Goods Administration 2020, *COVID-19 point-of-care tests*, Australian Government Department of Health, viewed 14 May 2020, https://www.tga.gov.au/covid-19-point-care-tests.

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COVID-19 FAQs – Admitted care

Published 01 May 2020 – Part 1

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Application of U06.0 *Emergency use of U06.0 [COVID-19, ruled out]*

Q:

In what circumstances is U06.0 *Emergency use of U06.0 [COVID-19, ruled out]* assigned?

A:

Health care facilities may test inpatients for SARS-CoV-2 where COVID-19 is a differential diagnosis or there is a decision to rule out COVID-19 for other reasons. COVID-19 may be a differential diagnosis in conditions such as influenza, pneumonia and heart failure.

Where laboratory testing for SARS-CoV-2 is negative and COVID-19 has not been clinically diagnosed, assign U06.0 *Emergency use of U06.0 [COVID-19, ruled out]* as an additional diagnosis. Additional codes for observation for suspected conditions or exposure to communicable diseases may be assigned if applicable.

DO NOT assign U06.0 where COVID-19 is clinically ruled out alone (ie not verified by a negative laboratory test result for SARS-CoV-2).

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IHPA

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Transfer for suspected COVID-19

Q:

Where a patient is transferred with multiple suspected conditions and suspected COVID-19 is one of them, is a COVID-19 emergency use code assigned?

A:

Where a patient is transferred for a suspected condition, apply the guidelines in ACS 0012 *Suspected conditions*:

- If a single condition is suspected, assign a code for the suspected condition.
- If **more than one suspected condition** is documented as the differential diagnosis:
  - assign code(s) for the documented symptom(s)

  OR
  - if there are no symptom(s) documented, assign codes for all suspected conditions.

See examples 1 and 2 below.

Transfer for suspected COVID-19, example 1:

Hospital	A	B
Scenario	Patient is admitted with shortness of breath and fever after returning from a cruise where other individuals were known to have COVID-19. Documentation states 'Patient exposed to COVID-19 during recent cruise. ?COVID-19 ?influenza other ?viral infection'. Patient is transferred to Hospital B for laboratory testing to exclude a diagnosis of COVID-19.	Patient is received from Hospital A for investigation of '?COVID-19 ?influenza ?other viral infection'. Laboratory testing is performed to exclude a diagnosis of COVID-19. Test results were negative for SARS-CoV-2. COVID-19 is documented as ruled out and the patient is diagnosed with influenza.
Codes assigned	Principal diagnosis: R06.0 *Dyspnoea* Additional diagnoses: R50.9 *Fever, unspecified* Z03.8 *Observation for other suspected diseases and conditions* Z20.8 *Contact with and exposure to other communicable diseases* Z75.6 *Transfer for suspected condition*	Principal diagnosis: J11.1 *Influenza with other respiratory manifestations, virus not identified* Additional diagnosis: Z20.8 *Contact with and exposure to other communicable diseases* U06.0 *Emergency use of U06.0 [COVID-19, ruled out]*

Rationale	COVID-19 is suspected as one of three differential diagnoses. It is not laboratory confirmed, clinically diagnosed or ruled out; therefore, an emergency use code is not assigned. R06.0 and R50.9 are assigned as there was more than one suspected condition documented as differential diagnoses. Z03.8 is assigned as symptoms suggestive of COVID-19 were documented and it was noted as a possible diagnosis. Z20.8 is assigned to identify exposure to known COVID-19 as documented by the clinician. Z75.6 is assigned as the patient was transferred for investigation of suspected conditions. B97.2 is not assigned as there are multiple suspected conditions so only symptoms are coded.	After study, influenza was determined to be the principal diagnosis. Z20.8 is assigned to identify exposure to known COVID-19 as documented by the clinician. Z03.8 is not assigned as the symptoms were confirmed to be due to influenza and COVID-19 was ruled out. COVID-19 is documented as ruled out; therefore, U06.0 is assigned as an additional diagnosis.

Transfer for suspected COVID-19, example 2:

Hospital	A	B	A
Scenario	Patient is admitted with viral pneumonia due to ?COVID-19. There is no documentation of exposure; however, due to recent travel overseas, patient is transferred to Hospital B specifically for laboratory testing to exclude a diagnosis of COVID-19.	Patient is received from Hospital A with viral pneumonia due to ?COVID-19. Laboratory testing is performed to exclude COVID-19. Test results for SARS-CoV-2 were documented as negative. Patient was transferred back to Hospital A for ongoing care.	Patient is transferred back to Hospital A from Hospital B with a diagnosis of viral pneumonia.
Codes assigned	Principal diagnosis: J12.8 *Other viral pneumonia* Additional diagnoses: B97.2 *Coronavirus as the cause of diseases classified to other chapters* Z75.6 *Transfer for suspected condition*	Principal diagnosis: J12.9 *Viral pneumonia, unspecified* Additional diagnosis: U06.0 *Emergency use of U06.0 [COVID-19, ruled out]*	Principal diagnosis: J12.9 *Viral pneumonia, unspecified*

Rationale	COVID-19 is suspected to have caused the viral pneumonia. B97.2 is assigned to reflect the suspected viral agent. A U07 emergency use code is not assigned as it has not been confirmed by laboratory testing or clinically diagnosed. Z75.6 is assigned to identify that the patient is being transferred for investigation of a suspected condition. Z20.8 is not assigned because only a history of recent overseas travel is documented by a clinician, not a documented history of exposure to a confirmed case of COVID-19.	After study, viral pneumonia was determined to be the principal diagnosis, and COVID-19 was ruled out following laboratory testing; therefore, U06.0 is assigned.	After study, viral pneumonia continues to be the principal diagnosis, with no specific virus identified. COVID-19 was ruled out at Hospital B; therefore, U06.0 is not assigned.

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Assignment of code for exposure to COVID-19

Q:

When is Z20.8 *Contact with and exposure to other communicable diseases* assigned in relation to COVID-19?

A:

Where suspected COVID-19 is ruled out, or the patient is transferred to another facility to undergo testing for SARS-CoV-2, an additional code Z20.8 *Contact with and exposure to other communicable diseases* may be assigned to indicate a documented history of exposure to COVID-19 as determined by a clinician.

For classification purposes, exposure to, or contact with, a confirmed case of COVID-19 must be determined and documented by a clinician. Z20.8 is not assigned in the following scenarios:

- patient-reported exposure to COVID-19 alone
- documentation of recent overseas travel, or contact with individuals that have recently travelled overseas

Where COVID-19 is confirmed, a history of exposure is inherent in the assignment of emergency use codes U07.1 *Emergency use of U07.1 [COVID-19, virus identified]* or U07.2 *Emergency use of U07.2 [COVID-19, virus not identified]*, and an additional code for Z20.8 is not assigned.

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Condition onset flag for COVID-19

Q:

Which condition onset flag (COF) value is applied to the emergency use codes for COVID-19?

A:

ACS 0048 *Condition onset flag* defines COF 2 Condition not noted as arising during the episode of admitted patient care as:

> *A condition previously existing or suspected on admission such as the presenting problem, a comorbidity or chronic disease*

An example is provided:

- *a condition that has not been documented at the time of admission, but clearly did not develop after admission (eg newly diagnosed diabetes mellitus, malignancy and morphology).*

Where a patient is admitted for known or suspected COVID-19, apply COF 2 to the emergency use codes.

However, in the specific circumstance where exposure to COVID-19 is documented as occurring during the episode of admitted care, assign COF 1. For example, assign COF 1 where a patient contracts COVID-19 through exposure to an individual in a health care setting, who has tested positive to SARS-CoV-2.

When it is uncertain whether a condition was present at admission or arose during the episode, assign COF 2 as per ACS 0048 *Condition onset flag/Guide for use*, point 6:

> *When it is difficult to decide if a condition was present at the beginning of the episode of admitted patient care or if it arose during the episode, assign COF 2.*

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Code assignment from Chapter 1 *Certain infectious and parasitic diseases* in episodes of COVID-19

Q:

What is the difference between assignment of B97.2 *Coronavirus as the cause of diseases classified to other chapter*s and B34.2 *Coronavirus infection, unspecified site*?

A:

B97.2 *Coronavirus as the cause of diseases classified to other chapters* is assigned as an additional diagnosis to specify the infectious agent, where documentation indicates that symptom(s) or condition(s) are related to laboratory confirmed, or clinically diagnosed or probable COVID-19. B97.2 is not acceptable as a principal diagnosis (Example 1).

B34.2 *Coronavirus infection, unspecified site* is assigned to classify asymptomatic infection, where documentation indicates a confirmed case of COVID-19 in an asymptomatic patient. B34.2 may be assigned as a principal diagnosis (Example 2).

Example 1:

Patient admitted with shortness of breath and subsequently tested positive for SARS-CoV-2.

Principal diagnosis: R06.0 *Dyspnoea* (as per ACS 0001 *Principal diagnosis*)

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

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

Example 2:

Asymptomatic patient admitted with documented exposure to a confirmed case of COVID-19 and subsequently tested positive for SARS-CoV-2.

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

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

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False negative laboratory test result for SARS-CoV-2 and COVID-19

Q:

Is U07.2 *Emergency use of U07.2 [COVID-19, virus not identified]* assigned for a clinical diagnosis of COVID-19, despite a negative laboratory test result?

A:

In laboratory testing, a negative test result means that the virus causing COVID-19 was not found in the test sample. For many individuals, this means that COVID-19 is not the cause of their symptoms or condition. However, it is possible for some individuals to receive a negative result in error (ie false negative), meaning they may have the virus causing COVID-19 even though it is not detected (Centres for Disease Control and Prevention 2020).

Where COVID-19 is clinically diagnosed, despite a negative laboratory test result, assign U07.2 *Emergency use of U07.2 [COVID-19, virus not identified]*.

Reference:

Centres for Disease Control and Prevention 2020, *Fact sheet for patients: CDC - 2019-nCoV Real-Time RT-PCR Diagnostic Panel*, United States Department of Health & Human Services, viewed 28 April 2020, https://www.cdc.gov/coronavirus/2019-ncov/downloads/Factsheet-for-Patients-2019-nCoV.pdf.

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Assignment of Z11.5 *Special screening examination for other viral diseases* to rule out COVID-19

Q:

What is screening by a mandated authority, and in what circumstance is Z11.5 *Special screening examination for other viral diseases* assigned in the context of screening for COVID-19?

A:

Screening mandated by an authority is performed where an authority, such as a government, compels testing of individuals who:

- are asymptomatic
- have no documented history of exposure.

Assign Z11.5 *Special screening examination for other viral diseases* as a principal diagnosis when screening for COVID-19, as described above, is performed (ie in rare circumstances where the only reason for admission is to screen for the presence of SARS-CoV-2). Screening should not be confused with a decision to routinely test for SARS-CoV-2 during an admitted episode of care.

Where COVID-19 is ruled out on screening (as defined above), assign U06.0 *Emergency use of U06.0 [COVID-19, ruled out]* as an additional diagnosis.

Where COVID-19 has been confirmed as a result of screening (as defined above), assign B34.2 *Coronavirus infection, unspecified site* as the principal diagnosis and U07.1 *Emergency use of U07.1 [COVID-19, virus identified]* as an additional diagnosis.

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Frequently Asked Questions (FAQs) – Eleventh Edition

Frequently Asked Questions (FAQs)

Published 28 June 2019 – Part 1

Ref No: TN1505 | Published On: 28-Jun-2019 | Status: Current

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.

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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.

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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 *Additional diagnoses* to be assigned?

A:

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

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

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

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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).

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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.

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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]**.

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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.-).

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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).

Published 28 June 2019,
for implementation 01 July 2019.

Frequently Asked Questions (FAQs)

Published 16 September 2019 – Part 2

Ref No: TN1502 | Published On: 16-Sep-2019 | Status: Current

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.

Published 16 September 2019,
for implementation 01 October 2019.

Ref No: TN1502 | Published On: 16-Sep-2019 | Status: Current

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*.

Published 16 September 2019,
for implementation 01 October 2019.

Ref No: TN1502 | Published On: 16-Sep-2019 | Status: Current

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.

Published 16 September 2019,
for implementation 01 October 2019.

Ref No: TN1502 | Published On: 16-Sep-2019 | Status: Current

Subject: Eleventh Edition FAQs Part 2:

Use of U91 *Syndrome not elsewhere classified*

Q:

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

A:

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

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

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

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

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

Published 16 September 2019,
for implementation 01 October 2019.

Retired and Superseded Coding Rules

ICD-10-AM/ACHI/ACS Eleventh Edition

The following Coding Rules for ICD-10-AM/ACHI/ACS Eleventh Edition have been removed from the current national coding advice since 1 July 2019.

Ref No: Q3423 | Published On: 16-Dec-2019 | Status: Superseded by Q3685

Adhesions divided during caesarean without labour

Q:

What ICD-10-AM code is assigned for pelvic adhesions, divided during caesarean section?

A:

The ICD-10-AM Alphabetic Index below is inconsistent with other index entries for O65.5 *Labour and deliver affected by abnormality of maternal pelvic organs* that specify conditions complicating 'labour or delivery':

Adhesions, adhesive (postinfective)

- pelvic, pelvis (see also Adhesions/peritoneum)

- peritoneum, peritoneal (male)

- - female pelvic (postpartal) (to uterus)

- - - affecting

- - - - labour and delivery O65.5

- - - - pregnancy O34.8

Classification guidelines in ACS 1506 *Fetal presentation, disproportion and abnormality of maternal pelvic organs* should specify that codes in category O64–O66 may be assigned '**during** labour and/or delivery'.

Therefore, assign O65.5 *Labour and delivery affected by abnormality of maternal pelvic organs* where division of adhesions are required during caesarean section, regardless of when the adhesions are first diagnosed.

ACS 1506 *Fetal presentation, disproportion and abnormality of maternal pelvic organs* and the inconsistent index entry were amended in Eleventh Edition Errata 3.

Published 16 December 2019,
for implementation 01 January 2020.

Ref No: Q3441 | Published On: 22-Jun-2020 | Status: Superseded By: Q3668

Dilation of ileal stricture via colonoscopy

Q:

What code is assigned for dilation of an ileal stricture performed via colonoscopy?

A:

Endoscopic (balloon) dilation of an ileal stricture is a minimally invasive intervention performed as an alternate to surgical interventions such as strictureplasty or resection (Gustavsson 2012).

As there is currently no ACHI code for endoscopic dilation of an ileal stricture, where this procedure is performed via a colonoscopy, assign 32090-00 **[905]** *Fibreoptic colonoscopy to caecum* alone.

Follow the ACHI Alphabetic Index:

Colonoscopy (beyond hepatic flexure) (fibreoptic) (long) (to caecum) 32090-00 **[905]**

Amendments will be considered for a future edition.

References:

Gustavsson, A., Magnuson, A., Blomberg, B., Andersson, M., Halfvarson, J. & Tysk, C. 2012, 'Endoscopic dilation is an efficacious and safe treatment of intestinal strictures in Crohn's disease', *Alimentary Pharmacology and Therapeutics*, vol. 36, issue 2, pp. 151–158, viewed 26 February 2020, https://onlinelibrary.wiley.com/doi/full/10.1111/j.1365-2036.2012.05146.x.

Published 22 June 2020,
for implementation 01 July 2020.

Ref No: Q3339 | Published On: 15-Dec-2018 | Status: Superseded By: Q3668

Dilation of ileocolic anastomotic stricture

Q:

What ACHI code is assigned for dilation of ileocolic anastomotic stricture?

A:

Ileocolic anastomotic strictures may occur after ileocaecal resection or hemicolectomy for conditions such as malignancy of the gastrointestinal tract or Crohn's disease. Endoscopic balloon dilation or surgical resection are performed to treat the ileocolic anastomotic strictures (Ding et al. 2016; Lian et al. 2017).

For dilation of ileocolic anastomotic stricture, assign 32094-00 **[917]** *Endoscopic dilation of colorectal stricture* as a best fit.

Follow the Alphabetic Index:

Dilation

- stricture

- - anastomotic (endoscopic)

- - - colorectal 32094-00 **[917]**

Amendments may be considered for a future edition.

References:

Ding, NS, Yip, WM, Choi, CH, Saunders, B, Thomas-Gibson, S, Arebi, N, Humphries Hart, A 2016, Endoscopic dilatation of Crohn's anastomotic strictures is effective in the long term, and escalation of medical therapy improves outcomes in the biologic era, *Journal of Crohn's and colitis*, vol. 10, no. 10, pp. 1172-1178, viewed 6 November 2018, https://doi.org/10.1093/ecco-jcc/jjw072

Lian, L, Stocchi, L, Remzi, FH Shen, B 2017, Comparison of Endoscopic Dilation vs Surgery for Anastomotic Stricture in Patients with Crohn's Disease Following Ileocolonic Resection, *Clinical Gastroenterology and Hepatology*, vol. 15, no. 8, pp. 1226-1231, viewed 6 November 2018, https://www.clinicalkey.com.au/#!/content/playContent/1-s2.0-S1542356516310011?returnurl=https:%2F%2Flinkinghub.elsevier.com%2Fretrieve%2Fpii%2FS1542356516310011%3Fshowall%3Dtruereferrer=https:%2F%2Fwww.ncbi.nlm.nih.gov%2F

Published 15 December 2018,
for implementation 01 January 2019.

Ref No: Q3013 | Published On: 15-Jun-2016 | Status: Retired | Retired On: 31-Dec-2019

SUBJECT: Cardiac pacemaker and implanted defibrillator status

Q:

When should the pacemaker status code Z95.0 *Presence of cardiac device* be assigned?

A:

Medical equipment and devices which emit electromagnetic interference (EMI) can inhibit pulse generators and pacemakers causing damage to the circuits of the device and placing a patient at risk, so monitoring of the pacemaker function is essential during these procedures. The risk of EMI is high for some procedures, such as monopolar electrocautery.

ACS 0016 *General procedure guidelines states*:

A procedure is defined as “a clinical intervention represented by a code that:

- is surgical in nature, and/or
- ·carries a procedural risk, and/or
- ·carries an anaesthetic risk, and/or
- ·requires specialised training, and/or
- ·requires special facilities or equipment only available in an acute care setting” (METeOR 514040) (Australian Institute of Health and Welfare 2014)

ACS 0936 *Cardiac pacemakers and implanted defibrillators* states:

> Patients with a pacemaker or defibrillator in situ require additional care at the time of procedural interventions, and therefore *Z95.0* Presence of cardiac device should be coded for all procedural cases.

Z95.0 *Presence of cardiac device* is assigned as an additional diagnosis for those patients who have a pacemaker or implanted defibrillator in situ and who undergo a procedure that meets the definition of a procedural intervention as per ACS 0016 *General procedure guidelines*.

Published 15 June 2016,
for implementation 01 July 2016.

Ref No: TN1505 | Published On: 28-Jun-2019 | Status: Retired | Retired On: 30-Sep-2019

ACS 0002 / ACS 0010 Revision

Definition of 'clinical significance' or 'transient' in relation to ACS 0002 *Additional diagnoses*:

ACCD sought input from advisory groups to develop a definition for clinical 'significance' and 'insignificance' of a condition to be included in the review of ACS 0002 for Eleventh Edition. No definition was put forward other than agreement on the criteria in ACS 0002 for qualifying a condition that should be assigned (or not assigned) as an additional diagnosis.

For classification purposes, a transient condition (or an insignificant condition), is a temporary condition that can be treated successfully with administration of medication and does not require:

- further clinical consultation as evidenced by documentation of a clinical assessment
- further investigation specifically to establish a diagnosis or provide greater specificity to an established diagnosis
- a care plan specifically developed for the condition (apart from routine clinical care) within an episode care.

With reference to transient conditions and the significance of them, ACS 0002 *Additional diagnoses* in the section regarding the *Commencement, alteration or adjustment of therapeutic treatment* states:

- Do not assign an additional diagnosis code for a condition that is transient and can be treated successfully with administration of medication without the need for further consultation, investigation or a plan of care (eg Mylanta for heartburn; paracetamol for headache; Sominex for insomnia) (see Examples 1, 2 3).
- An additional diagnosis code can be assigned if a condition requires further assessment (ie the condition is no longer considered transient) by a clinician and
- a diagnostic or therapeutic intervention is undertaken, or
- a care plan is prescribed following clinical consultation

Determining that a condition is transient (insignificant) or significant should be done on a case by case basis within the context of the particular episode of care and with respect to the clinical documentation contained within the episode of care.

It is very difficult for a query to be answered without context or reference to the entire episode of care. For the example of '*Hypokalaemia documented by treating team with a plan for stat dose of potassium replacement*'. In this instance, we are assuming that during the episode of care the patient's electrolytes would require further assessment to ensure that their potassium levels return to the normal range. In this instance the hypokalaemia should be coded as an additional diagnosis.

With regard to the example of '*PPH 500 mls documented by midwife with a stat dose of IM Ergometrine administered*', obstetric episodes of care should be classified utilising the ACS in the specialty Chapter 15 *Pregnancy, childbirth and the puerperium*, as well as the general standards for diseases and interventions.

ACS 1500 *Diagnosis sequencing in obstetric episodes of care/ 080-084 Delivery as a principal diagnosis*, the second dot point states:

- Assign additional diagnoses to indicate the reason for any delivery intervention (eg the reason for induction, use of forceps, caesarean section)

Therefore, the administration of IM Ergometrine is recognised as a delivery intervention for the control of postpartum haemorrhage. 'Postpartum haemorrhage' documented within an episode of obstetric care should be coded regardless of the treatment given or the amount of blood loss. It is a complication of delivery and would require further assessment to ensure that the haemorrhage has been resolved.

During the Eleventh Edition ITG process, examples within the revised ACS 0002 were specifically requested by ITG members, and the examples went through various iterations before being accepted with ITG consensus. ACS 0002 contains examples to demonstrate both when to code and when not to code conditions.

It is impossible to cover every given scenario in examples within the ACS. Clinical coders are required to use the ACS as a guide and the decision to assign additional diagnosis codes should be made on a case by case basis with due consideration to ICD-10-AM convention and the ACS.

Application of ACS 0002 in conjunction with specialty standards and conventions

ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses* are general standards applicable to ICD-10-AM. Unless specifically indicated, the general classification principles in ACS 0001 and ACS 0002 apply to all conditions listed in the specialty standards.

Therefore, after selecting the principal diagnosis, all other conditions documented in an episode of care must meet the criteria in ACS 0002, unless there are specific guidelines in a specialty standard indicating otherwise (eg (condition) "should always be coded").

For example, ACS 0236 *Neoplasm coding and sequencing* provides the following instructions for clinical classification:

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

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

…

In the dot point underlined in the above excerpt from ACS 0236, the primary neoplasm may not meet the criteria for code assignment as per ACS 0002, however as ACS 0236 is a specialty standard, this instruction overrides ACS 0002.

In another example, ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* instructs coders to always code diabetes and its manifestations/complications. In some circumstances, the manifestations will not meet the criteria of ACS 0002, however as ACS 0401 is a specialty standard, its instruction overrides ACS 0002.

Conventions and instructional notes

The ICD employs some special conventions (relating to the use of parentheses, square brackets, colons, etc) as well as use of instructional notes (*Code first, Code also, Use additional code* etc). The conventions and instructional notes of the classification need to be clearly understood both by clinical coders and applied mandatorily.

Published 28 June 2019,
for implementation 01 July 2019.

Ref No: Q3084 | Published On: 15-Sep-2016 | Status: Retired | Retired On: 31-Dec-2019

SUBJECT: Musculoskeletal injury of specified site

Q:

How do you code ‘musculoskeletal injury’ of a specified site?

A:

The musculoskeletal system is comprised of bones, muscles, cartilage, tendons, ligaments, joints and other connective tissue structures. Chapter 13 *Diseases of the musculoskeletal system and connective tissue* includes a list of specific musculoskeletal sites under *Site of Musculoskeletal involvement,* for example:

- Shoulder region (eg clavicle, scapula)
- Upper arm (humerus, elbow joint)
- Forearm (radius, ulna, wrist joint)
- Hand (eg carpus, fingers)
- Pelvic region and thigh (eg femur, pelvis)
- Lower leg (fibula, tibia, knee joint)
- Ankle and foot (eg metatarsus, toes)
- Head/neck/ribs/skull

A ‘musculoskeletal injury’ of a specified site is not a synonymous term for injury of a muscle of that site. The description of an injury as a ‘musculoskeletal injury’ indicates that it is an injury of the musculoskeletal system, rather than another body system (for example soft tissue or skin and subcutaneous tissue).

Chapter 19 *Injury, poisoning and certain other consequences of external causes* classifies injuries of specified body sites to S00-S99.

Where there is documentation of a specified type of injury (eg fracture, sprain, dislocation), refer to the applicable lead term in the Alphabetic Index for the specified injury type (see also the cross reference at *Injury* (*see also specified injury type*)).

Where there is documentation of ‘musculoskeletal injury’ (NOS) of a specified site, assign an appropriate code by following the Alphabetic Index at *Injury/by site*. For example:

Musculoskeletal injury of ankle:

Injury

- ankle

 - specified NEC S99.8

S99.8 *Other specified injuries of ankle and foot*

Musculoskeletal injury of neck:

Injury

- neck

 - specified NEC S19.8

S19.8 *Other specified injuries of neck*

Musculoskeletal injury of shoulder:

Injury

- shoulder

- - specified NEC S49.8

S49.8 *Other specified injuries of shoulder and upper arm*

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

Published 15 September 2016,
for implementation 01 October 2016.

Ref No: Q2905 | Published On: 15-Sep-2015 | Status: Superseded
| Superseded On: 21-Sep-2020 | Superseded By: Q3496

SUBJECT: Coding of allergic reactions NOS and anaphylactic reactions

Q:

How should allergic reactions not otherwise specified (NOS) and anaphylactic reactions be coded? Should symptom codes be assigned for allergic reactions?

A:

The correct code assignment for allergic reactions NOS and anaphylactic reactions are outlined below.

Allergic reaction NOS:

T78.4 *Allergy, unspecified* following the Alphabetic Index:

Allergy, allergic (reaction) T78.4

Allergic reaction NOS to food:

T78.1 *Other adverse food reactions, not elsewhere classified* following the Alphabetic Index:

Allergy, allergic (reaction)

- food (any) (ingested) NEC T78.1

Anaphylaxis / anaphylactic shock due to food:

T78.0 *Anaphylaxis and anaphylactic shock due to adverse food reaction* following the Alphabetic Index:

Anaphylaxis

- due to

- - food reaction T78.0

When assigning a code classified to category T63 *Toxic effect of contact with venomous animals* additional codes should be assigned for any associated allergic reaction as per the instructional note at this category.

Symptoms such as wheeze, urticaria and swelling should not be coded when a diagnosis of allergic reaction or anaphylaxis has been established unless the symptom is significant in its own right and treated independently of the allergic reaction (*see also Note* at the beginning of Chapter18 *Symptoms, signs and abnormal clinical findings, not elsewhere classified*).

Assign external cause codes from Y37 Exposure to or contact with allergens as appropriate.

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

Published 15 September 2015,
for implementation 01 January 2020.

Retired and Superseded Frequently Asked Questions (FAQs)

ICD-10-AM/ACHI/ACS Eleventh Edition

The following Frequently Asked Questions (FAQs) for ICD-10-AM/ACHI/ACS Eleventh Edition have been removed from the current national coding advice since 1 July 2019.

Ref No: TN1504 | Published On: 28-Jun-2019 | Status: Superseded | Superseded On: Sep-2020 | Superseded By: Q3503 Eleventh Edition ACS 1904 *Procedural complications* – due to/related to prosthetic devices, implants or grafts

Eleventh Edition ACS 1904 *Procedural complications* – due to/related to prosthetic devices, implants or grafts

Procedural complications may be classified to either the body system chapters or block *Complications of surgical and medical care, not elsewhere classified* (T80–T88), and the following rules apply:

- 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
    - the complication is not related to a body system, assign an appropriate code from T80–T81 or T86–T88

As per ACS 1904 *Procedural complications/Overview/dot point three*, codes in categories T82–T85 are generally intended to be used for complications specific to prosthetic devices, implants and grafts such as mechanical complication, infection, pain, thrombosis, haemorrhage, mesh erosion and so on.

Therefore, unless there is a specific coding rule or ACS that indicates otherwise (eg complications related to coronary artery bypass graft), a causal relationship does not need to be documented to assign a procedural complication when the condition is classified to categories T82–T85.

Example 1: Patient with a history of endovascular aneurysm repair (EVAR) of an abdominal aortic aneurysm (AAA) with a bifurcated endoprosthesis, was readmitted due to intermittent abdominal pain and progressive dyspnoea. Computed tomography (CT) angiogram of the aorta confirmed endoleaks following EVAR.

Assign:

T82.3 *Mechanical complication of other vascular grafts*

with appropriate external cause codes

Follow the Alphabetic Index:

Leak, leakage

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

- - arterial graft NEC T82.3

Example 2: Patient was admitted for a ruptured anterior cruciate ligament (ACL) graft for which the patient underwent revision of a left knee ACL reconstruction

Assign:

T84.4 *Mechanical complication of other internal orthopaedic devices, implants and grafts*

with appropriate external cause codes

Follow the Alphabetic Index:

Complication(s) (from) (of)

- orthopaedic

- - device, implant or graft *(see also Complication(s)/by site and type)* T84.9

- - - mechanical NEC T84.4

Example 3: A 59-year-old woman was admitted with complaints of pain and loss of mobility of the stump of her left leg. She had a below knee amputation (BKA) of her left lower limb in 2010. She did not wear her prosthesis over the amputated side, because of persistent touch-evoked pain. Physical examination revealed erythema on the stump with cellulitis. She was diagnosed with cellulitis of the amputation stump due to an ill-fitting prosthetic limb.

Assign:

T84.7 *Infection and inflammatory reaction due to other internal orthopaedic prosthetic devices, implants and grafts*

L03.13 *Cellulitis of lower limb*

Z89.5 *Acquired absence of leg at or below knee*

with appropriate external cause codes

Follow the Alphabetic Index:

Complication(s)

- orthopaedic

- - device, implant or graft

- - - infection or inflammation NEC T84.7

Cellulitis (diffuse) (with lymphangitis)

- limb L03.19

- - lower L03.13

Absence

- extremity (acquired) Z89.9

- - lower (above knee) (unilateral) Z89.6

- - - with upper extremity (any level) Z89.8

- - - below knee (unilateral) Z89.5

Example 4: Urethral trauma/injury sustained from displacement of an indwelling catheter

Assign:

T83.0 *Mechanical complication of urinary (indwelling) catheter*

with appropriate external cause codes

Follow the Alphabetic Index:

Displacement, displaced

- device, implant or graft (see also Complication(s)/by site and type/mechanical)
- - catheter NEC
- - - urinary (indwelling) T83.0

It is unnecessary to assign an additional code from Chapter 19 (eg S37.3- *Injury of urethra*) to indicate the site of the post-operative complication. The purpose of S codes in Chapter 19 *Injury, poisoning and certain other consequences of external causes* is to classify injures due to trauma (ie an injury not related to an intervention).

If urethral trauma/injury occurs during removal (accidental or intentional) of an indwelling catheter (IDC) by a patient, ACS 1904 is not applicable as the trauma/injury is not a complication of the device (catheter). Where the urethral trauma/injury meets the criteria in ACS 0002 *Additional diagnoses*, assign:

S37.3- *Injury of urethra*

X58 *Exposure to other specified factors*

with place of occurrence and activity codes as appropriate.

Follow the Alphabetic Index of diseases and nature of injury (Section I):

Injury

- urethra (sphincter) S37.30
- - membranous S37.31
- - penile S37.32
- - prostatic S37.33
- - specified part NEC S37.38

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

Exposure (to)

- factor(s)
- - specified NEC X58

Example 5: Ureteral stricture due to a procedure

Ureteral stricture occurring after insertion of prosthetic devices, implants or grafts is classified as a complication of prosthetic devices, implants or grafts:

Assign:

T83.89 *Other specified complications of genitourinary devices, implants and grafts*

N13.5 *Kinking and stricture of ureter without hydronephrosis*

with appropriate external cause codes.

Follow the Alphabetic Index:

Complication(s) (from) (of**)**

- genitourinary NEC (see also Complication(s)/by site and type)

- - device, implant or graft

- - - specified NEC T83.89

Ureteral stricture due to a procedure with no involvement of prosthetic devices, implants or grafts, is classified to an appropriate code from the end of body system chapter.

Assign:

N99.89 *Other intraoperative and postprocedural disorder of genitourinary system*

N13.5 *Kinking and stricture of ureter without hydronephrosis*

with appropriate external cause codes.

Follow the Alphabetic Index:

Complication(s) (from) (of)

- genitourinary NEC (see also Complication(s)/by site and type)

- - intraoperative or postprocedural

- - - specified NEC N99.89

Stricture

- ureter (postprocedural) N13.5

N13.5 is assigned as an additional diagnosis to provide further specificity of the condition (ie ureteral stricture).

Example 6: Lymphocele following cannulation of the femoral vein

Assign:

T82.89 *Other specified complications of cardiac and vascular prosthetic devices, implants and grafts*

I97.83 *Postprocedural lymphocele, lymphoedema and chylothorax*

with appropriate external cause codes.

Follow the Alphabetic Index:

Complication(s) (from) (of)

- vascular

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

- - - infusion catheter

- - - - specified NEC T82.89

Lymphocele I89.8

- postprocedural I97.83

I97.83 is assigned to provide further specificity of the condition (ie postprocedural lymphocele) (Note: there are no *Excludes* notes to prevent assignment of T82.89 and I97.83 together). However, it is unnecessary to assign I89.8 *Other specified noninfective disorders of lymphatic vessels and lymph nodes* as it does not provide further specificity of the condition.

This content has been adapted and disaggregated from the Clarification on the application of ACS 1904 *Procedural complications* issued 28 June 2019 for implementation 1 July 2019 (updated for 1 October 2019).

Ref No: TN1505 | Published On: 28-Jun-2019 | Status: Superseded
| Superseded On: 15-Mar-2021 | Superseded By: Q3490

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).

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Eleventh Edition FAQs Part 1: Allergens and anaphylaxis

Q:

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

A:

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

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

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

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

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).

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