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Dental filling not otherwise specified

Q:
What procedure code is assigned for dental restoration/filling not otherwise specified?

A:
Where there is no documentation on to the type of material used for dental restoration (filling), seek clarification from the treating clinician. When this is not possible, assign:

97511-01 [465] Metallic restoration of tooth, 1 surface, direct as per the Inclusion term in the ACHI Tabular List.

ACCD acknowledges that the above code is not listed as the default in the ACHI Alphabetic Index. Amendments to this section in ACHI have been undertaken for Eleventh Edition.

Published 15 December 2018,
for implementation 01 January 2019.
Anticoagulants not requiring INR level monitoring.

Q:
Do the guidelines in ACS 0303 Abnormal coagulation profile due to anticoagulants apply to Novel/Non-vitamin K Oral Anticoagulants (NOAC) (ie anticoagulants that do not require INR level monitoring)?

A:
The guidelines in ACS 0303 Abnormal coagulation profile due to anticoagulants apply to abnormal INR (ie abnormal coagulation profile) due to anticoagulant use; therefore, if INR monitoring is not required, ACS 0303 does not apply to the episode of care.

Note also that antiplatelets are not anticoagulants, and INR monitoring is not required when these agents are administered.

ACS 0303 states:
Patients taking oral anticoagulants may require bridging anticoagulant therapy prior to a planned procedure. This involves replacing their usual oral anticoagulant (eg warfarin) with a short action agent such as Clexane or heparin until the patient can resume their usual anticoagulant therapy. The intention of bridging therapy is to minimise the risk of developing a thromboembolic event after a procedure.

CLASSIFICATION
If patients on long term anticoagulants require anticoagulant level monitoring during an episode of care and the INR level is within the target therapeutic range (ie no supratherapeutic or subtherapeutic INR is documented), assign Z92.1 Personal history of long term (current) use of anticoagulants as an additional diagnosis.

ACS 0303 has been amended for Eleventh Edition. In the interim, apply the following guidelines to clarify the assignment of Z92.1:

Assign Z92.1 Personal history of long term (current) use of anticoagulants as an additional diagnosis if a patient is on long term anticoagulants and:

- bridging anticoagulant therapy is administered prior to or following a planned procedure, or
- anticoagulant therapy is withheld because the patient has a medical condition that contraindicates the continued use of anticoagulants, or
- anticoagulant level monitoring is undertaken during an episode of care and the INR level is within the target therapeutic range (ie no supratherapeutic or subtherapeutic INR is documented)

Published 15 December 2018, for implementation 01 January 2019.
Anaphylaxis due to latex

Q:
What codes are assigned for anaphylaxis due to latex exposure?

A:
A wide range of commercial and medical equipment products contain natural latex. In people who have developed sensitivity to natural latex proteins, direct contact (eg from wearing latex (rubber) gloves or blowing up balloons) or inhalation (eg via powdered lubricant from latex gloves), may result in minor conditions such as urticaria or allergic rhinitis, or a more severe reaction such as anaphylaxis (ASCIA 2015). For anaphylaxis due to latex, regardless of the latex source or exposure setting, assign T78.2 Anaphylactic shock, unspecified with X58 Exposure to other specified factors.

Follow the Alphabetic Index Section I:

Anaphylaxis T78.2

Follow the External causes of injury Alphabetic Index Section II:

Exposure (to)
- specified factors NEC X58

Also assign place of occurrence and activity codes as appropriate

Amendments have been undertaken for Eleventh Edition.

References:

Published 15 December 2018,
for implementation 01 January 2019.
Nonendoscopic replacement of urinary catheter

Q:

What ACHI codes are assigned for nonendoscopic replacement of IDC?

A:

Assign the following codes for nonendoscopic replacement of an indwelling urinary catheter (IDC) following an admission for trial of void (TOV) that was unsuccessful:

92119-00 [1902] Removal of other urinary drainage device

and

36800-00 [1090] Bladder catheterisation

Follow the ACHI Alphabetic Index:

Removal — see also Excision
- catheter
  - - bladder (endoscopic) (indwelling)
  - - - nonoperative (nonendoscopic) NEC 92119-00 [1902]

Insertion
- catheter
  - - bladder, indwelling 36800-00 [1090]

Amendments have been undertaken for Eleventh Edition.

Published 15 December 2018,
for implementation 01 January 2019.
Pregnancy complicated by diseases of the genitourinary system

The ICD-10-AM Alphabetic Index at Pregnancy/complicated by/conditions in/N00-N99 and Pregnancy/complicated by/diseases of genitourinary system has been updated for Eleventh Edition.

In the interim, assign the following for pregnancy complicated by:

diseases of the genital organs NEC, assign O99.8 Other specified diseases and conditions in pregnancy, childbirth and the puerperium

infection of the genital organs or genitourinary system, assign:

a code from category O23 Infections of genitourinary tract in pregnancy or

O98.0 Tuberculosis in pregnancy, childbirth and the puerperium or

O98.1 Syphilis in pregnancy, childbirth and the puerperium or

O98.2 Gonorrhoea in pregnancy, childbirth and the puerperium or

O98.3 Other infections with a predominantly sexual mode of transmission in pregnancy, childbirth and the puerperium

diseases of the genitourinary system NEC, assign O26.81 Kidney disorders in pregnancy, childbirth and the puerperium

See also condition/in pregnancy or Pregnancy/complicated by/abnormal, abnormality/by site:

Pregnancy (single) (uterine) — see also condition/in pregnancy

- complicated by

  - abnormal, abnormality

  - - broad ligament O34.8

  - - cervix O34.4

  - - fallopian tube O34.8

  - - ovary O34.8

  - - pelvic organs or tissues O34.9

  - - - specified NEC O34.8

  - - pelvis, with disproportion (bony) (major) NEC O33.0

  - - perineum O34.7

  - - uterus NEC O34.5

  - - - congenital O34.0

  - - - vagina O34.6

  - - - vulva O34.7

Published 15 December 2018, for implementation 01 January 2019.
Debridement in the oral cavity

Q:
What code is assigned for debridement of tooth, with or without repair of the oral cavity?

A:
Clinical advice confirms that debridement during a tooth extraction involves removing tooth, bone fragments or necrotic tissue in the tooth socket, and is regarded as an inherent part of the procedure; therefore a code for the debridement is not required as per ACS 0016 General procedure guidelines which states:

Do not code procedures which are individual components of another procedure. These components would usually be considered a routine or inherent part of the more significant procedure being performed.

Assign a code for debridement of the oral cavity only when it is performed in isolation to treat a specific condition (eg infection of tooth socket).

For oral cavity debridement performed in isolation (ie not in conjunction with another dental procedure), assign 97281-00 [456] Nonsurgical periodontal treatment, not elsewhere classified.

Follow the Alphabetic Index:
**Treatment**
- dental
  - - periodontal, nonsurgical 97281-00 [456]

For debridement and repair of the mucosa of the oral cavity, such as the cheek (buccal mucosa), assign 45676-00 [406] Other repair of mouth.

Follow the Alphabetic Index:
**Repair**
- mouth NEC 45676-00 [406]

Amendments have been undertaken in regard to dental interventions for Eleventh Edition.

Published 15 September 2018, for implementation 01 October 2018.
Platelet rich plasma injection into joint

Q:
What is the correct procedure code for platelet rich plasma injection into a joint?

A:
Autologous platelet-rich plasma (PRP) is blood plasma enriched with platelets. PRP contains increased concentration of proteins called growth factors that promote wound healing and bone growth. Autologous PRP is used in many fields including sports medicine, orthopaedics, cosmetics, fasciomaxillary and urology.

Intra-articular injection of autologous PRP is performed for conditions such as cartilage degeneration and osteoarthritis. The procedure involves injection of approximately 3 - 8 ml of PRP with a 21-22 gauge needle into the joint. The aim of intra-articular autologous PRP injection is to promote healing of damaged cartilage, tendons, ligaments, muscles and bones to improve joint function (Sanchez et al. 2011; Wilson 2014; Xing et al. 2017).

Assign 50124-01 [1552] Administration of agent into joint or other synovial cavity, not elsewhere classified for intra-articular PRP injection.

Follow the Alphabetic Index:
Administration
- specified site
- - joint NEC 50124-01 [1552]

Note: Interventions classified in block [1893] Administration of blood and blood products are assigned for transfusion of blood and blood products to improve circulation and replace low or missing blood components.

Amendments will be considered for a future edition.

References:


Published 15 September 2018,
for implementation 01 October 2018.
Chewing tobacco

Q:
Are codes for ‘current use’, ‘history of’ or ‘tobacco use disorder’ applicable to ‘chewing tobacco’?

A:
Chewing tobacco (a form of smokeless tobacco use) is detrimental to health and can cause a variety of health problems such as nicotine addiction, cancer of the mouth, oesophagus and pancreas, oral leucoplakia and increased risk of early delivery and still birth when used during pregnancy. The level of nicotine absorbed through the tissues of the mouth from chewing tobacco can be equivalent to or greater than that found in cigarette smokers (Centers for Disease Control and Prevention 2016, Product Safety Australia n.d.).

Research has indicated that mental and behavioural disorders (harmful use, dependence) from smoking tobacco can also occur with chewing tobacco.

Therefore, where use of chewing tobacco is documented in the record assign:

Z72.0 Tobacco use, current
or
F17.- Mental and behavioural disorders due to use of tobacco
or
Z86.43 Personal history of tobacco use disorder

Follow the Alphabetic Index:

Tobacco (nicotine)
- dependence F17.2
- harmful use F17.1
- hazardous use Z72.0
- intoxication F17.0
- maternal use, affecting fetus or newborn P04.2
- use NEC Z72.0
- - counselling and surveillance Z71.6
- withdrawal state F17.3

History (of) (personal)
- tobacco use disorder Z86.43

Amendments will be considered for a future edition.

References:

Published 15 September 2018,
for implementation 01 October 2018.
Brachioplasty

Q:
What is the correct code to assign for brachioplasty?

A:
Brachioplasty, also known as arm lift, is the removal of excess skin and fat from the under surface of the upper arms and contouring the remaining skin resulting in a smooth, toned appearance. It is usually performed for cosmetic reasons, where there is significant skin excess and looseness, after weight loss or due to ageing (Australian Society of Plastic Surgeons 2018).

Assign:
30168-00 [1666] Lipectomy, 1 excision for unilateral brachioplasty
Or
30171-00 [1666] Lipectomy, 2 or more excisions for bilateral brachioplasty

Follow the Alphabetic Index:

Lipectomy
- arm
  - 1 excision 30168-00 [1666]
  - 2 excisions 30171-00 [1666]

Amendments will be considered for a future edition.

References:
Australian Society of Plastic Surgeons 2018, Arm lift, Australian Society of Plastic Surgeons, viewed 11 May 2018,

Published 15 September 2018,
for implementation 01 October 2018.
Postural Orthostatic Tachycardia Syndrome (POTS)

Q:
What code is assigned for Postural orthostatic tachycardia syndrome?

A:
Postural orthostatic tachycardia syndrome (POTS) is due to dysfunction of the autonomic nervous system that controls the heart rate, blood pressure, gastrointestinal motility and other autonomic functions of the body. Symptoms include headaches, fatigue, lightheadedness, sweating, nausea, fainting, dizziness, gastroparesis or rapid gastric emptying and orthostatic tachycardia. The current diagnostic criteria for POTS is an increase in heart rate greater than 30 beats per minute from the lying to upright position, or greater than 120 beats per minute within 10 minutes of standing. The cause of POTS is not known (Dysautonomia International 2012; Raj 2013).

Assign G90.8 Other disorders of autonomic nervous system for postural orthostatic tachycardia syndrome (POTS).

Follow the Alphabetic Index:
Disorder (of) — see also Disease
- autonomic nervous system G90.9
- - specified NEC G90.8

Amendments will be considered for a future edition.

References:

Published 15 September 2018,
for implementation 01 October 2018.
Transcranial magnetic stimulation

Q:
What ACHI code is assigned for transcranial magnetic stimulation (TMS)?

A:
Transcranial magnetic stimulation (TMS) involves stimulation of a small area on the surface of the brain through magnetic fields, generated from a coil placed on the head. TMS is performed using pulses of various intensities or frequencies administered repeatedly, for treatment of major depressive and other mental disorders. A session of TMS typically takes 10-30 minutes and is performed daily.

After a patient has responded to treatment, maintenance TMS may be implemented by gradually reducing the number of treatment sessions to prevent a relapse of depression (Rachid 2018).

Assign 96155-00 [1880] Stimulation therapy, not elsewhere classified

Follow the Alphabetic Index:

Therapy
- stimulation (using electrophysical agent) NEC 96155-00 [1880]

Amendments for the classification of TMS have been made in ACHI Eleventh Edition.

References:

Published 15 September 2018, for implementation 01 October 2018.
Spontaneous/nontraumatic perinephric haematoma

Q:
What code is assigned for a spontaneous/nontraumatic perinephric haematoma with no identified cause of bleeding?

A:
The retroperitoneum is divided into anterior pararenal space, perirenal space, posterior pararenal space and the great vessel space containing the aorta and inferior venacava (Hacking & Jones 2017).

For spontaneous/nontraumatic perinephric haematoma (ie no identified cause of bleeding), assign K66.1 Haemoperitoneum.

Follow the Alphabetic Index:

Haematoma
- retroperitoneal (nontraumatic) K66.1

Amendments will be considered for a future edition.

References:

Published 15 September 2018,
for implementation 01 October 2018.
Debridement of wound outside of theatre

Q:
When non viable skin is debrided outside of theatre, is it considered excisional or nonexcisional debridement?

A:
ACCD acknowledges ACS1203 Debridement is ambiguous for classification of debridement and wound management outside of theatre, with regard to the debridement being classified as excisional or nonexcisional.

Clinical coders cannot assume the debridement is either excisional or nonexcisional based upon the use of a sharp surgical instrument, as this does not necessarily indicate the debridement is excisional if only loose fragments of tissue were removed (Chand 2014).

Clinical coders should always be guided by clinical documentation. Follow the guidelines in ACS 1203 Debridement which states:

...most debridements are excisional
check with the clinician if unsure
use the nonexcisional code if documentation/clinical advice supports its use

Note: a review of the ACHI debridement codes and the relevant ACS are in progress for Eleventh Edition.

In the interim:

where the term ‘excisional’ is documented by a clinician (eg specialist nurse or medical professional) for the debridement outside of theatre, assign a code for excisional debridement.

where wound debridement is performed in an operating theatre using cerebral anaesthesia, assign 90665-00 Excisional debridement of skin and subcutaneous tissue if there is no documentation or clinical advice to the contrary.

where documentation is unclear, seek clinical clarification to determine if the debridement is excisional or nonexcisional. Assign a code for nonexcisional debridement if documentation or clinical advice supports its use.

Note: Amendment made, however this coding advice remains effective as at July 1, 2018

References:

Published 15 June 2018, for implementation 01 July 2018.
Discharge home, or transfer in labour for administrative purposes

Q:
If a patient with a pregnancy complication is discharged home or transferred in labour for administrative purposes, is a code from Chapter 15 Pregnancy, childbirth and the puerperium assigned OR a code from category Z34 Supervision of normal pregnancy?

A:
A patient in the early stages of labour, may be discharged home to await more established labour before being readmitted for the delivery episode. Alternatively, a patient in the first stage of labour may be transferred to another facility for administrative reasons.
Guidelines regarding discharge home/transfer in labour for administrative purposes are included in ACS 1550 Discharge/transfer in labour. Although not explicit, the current guidelines are intended for ‘uncomplicated’ cases (that is, where there is no ‘complication of pregnancy’ code assigned from Chapter 15 Pregnancy, childbirth and the puerperium).

ACS 1550 Discharge/transfer in labour is under review for Eleventh Edition. In the interim, apply the following guidelines:
Where a patient in labour is discharged home or transferred to another facility for administrative reasons in the first stage of labour, and is ≥37 completed weeks of gestation, assign as principal diagnosis:

- a code from category Z34 only if there is no code from Chapter 15 assigned for the episode of care

OR
- a code from Chapter 15 for any documented complication of pregnancy.

Published 15 June 2018, for implementation 01 July 2018.
Administration of misoprostol

Q:

What code is assigned for administration of misoprostol to induce abortion/terminate pregnancy?

A:

Misoprostol is a prostaglandin E1 synthetic analogue that may be administered to induce abortion/terminate pregnancy. It is usually administered orally (e.g., buccally) following ingestion of mifepristone. Misoprostol causes softening and opening of the cervix, and uterine contractions (i.e., it induces labour) (Alfirevic, Aflaifel & Weeks 2014, NPS Medicinewise 2017; The Royal Hospital for Women 2013).

ACS 1511 Termination of pregnancy states:

**PROCEDURES FOR TERMINATION OF PREGNANCY**

Termination of pregnancy may be performed by:

- extraction (e.g., dilation and curettage/evacuation (DC/DE) or suction curettage). Assign an appropriate code from [1265] Curettage and evacuation of uterus.

- induction of labour. Assign a code from block [1334] Medical or surgical induction of labour regardless of the duration of pregnancy and outcome

- other methods (e.g., insertion of prostaglandin suppository). Code specific procedure(s) performed (see ACHI Alphabetic Index).

Therefore, where Misoprostol is administered to induce labour for abortion/termination of pregnancy, assign 90465-01 [1334] Medical induction of labour, prostaglandin by following the Alphabetic Index:

**Induction**

- labour

  - medical (administration of pharmacological agent)

  - prostaglandin 90465-01 [1334]

Amendments to ACHI Obstetric interventions are in progress for Eleventh Edition.

References:


Published 15 June 2018, for implementation 01 July 2018.
Transfer in third stage of labour

Q:

What codes are assigned when a patient delivers a baby at one facility, and is transferred to another facility to deliver the placenta?

A:

The third stage of labour is defined as the time between the birth of the baby and delivery of the placenta (and membranes), and is usually 10 to 30 minutes in duration. A third stage longer than 30-60 minutes is generally considered prolonged, and is associated with a significant risk of postpartum haemorrhage. Prolonged third stage may be due to a complication such as retained or adherent placenta, requiring manual or surgical removal of the placenta. (Arulkumaran S, n.d; National Institute for Health and Care Excellence 2017; Women and Newborn Health Service, King Edward Memorial Hospital 2017).

Delivery of a baby at one facility, with delivery of the placenta at another facility is not usual practice, due to the limited time between these two events (unless there is a condition that delays delivery of the placenta). ACCD acknowledges that in this unusual scenario, the intent was to complete the delivery at the first facility, but this was not possible due to unforeseen circumstances. Assigning delivery codes (O80-O84) at both facilities is not supported by ACCD.

Therefore, if a baby and placenta are delivered at different facilities:

First facility – where the baby is delivered, assign:

- a code for the delivery (O80-O84) (see also ACS 1500 Diagnosis sequencing in delivery episodes of care)
- a code from category Z37 Outcome of delivery
- Z75.3 Unavailability and inaccessibility of health-care facilities, if applicable
- an ACHI code for the delivery procedure

Second facility – where the placenta is delivered, assign:

- as principal diagnosis, a code for the condition that necessitated the patient’s transfer (eg retained/adherent placenta)
  
  OR
  
  if there is no condition documented as the reason for transfer, assign O63.9 Long labour, unspecified
- Z39.01 Postpartum care after hospital delivery as an additional diagnosis
• an appropriate ACHI code (eg from block [1345] *Postpartum evacuation of uterus*), if applicable. Do not assign an ACHI delivery procedure code ([1336]–[1340] *Delivery procedures*).

Amendments to the ACS Chapter 15 *Pregnancy, childbirth and the puerperium* are in progress for Eleventh Edition.

References:


Published 15 June 2018, for implementation 01 July 2018.
Chemical peritonitis

Q:

What code is assigned for chemical peritonitis that is not due to a complication of a procedure?

A:

Chemical peritonitis is a type of secondary peritonitis, due to irritants such as bile, blood, or foreign substances in the peritoneal cavity (Blum, n.d.; WebMD n.d.).

Splenic injury is a common result of blunt abdominal trauma. Haemorrhage into the peritoneum (haemoperitoneum) from splenic injury may result in chemical peritonitis.

The indexing and classification of chemical peritonitis to T81.6 Acute reaction to foreign substance accidentally left during a procedure originates from ICD-10 WHO. This is inappropriate for chemical peritonitis that is not a complication of a procedure.

Assign K65.8 Other peritonitis for chemical peritonitis that is not documented as due to a foreign substance accidently left in the peritoneal cavity during a procedure.

Amendments will be considered for a future edition.

References:


Published 15 June 2018, for implementation 01 July 2018.
Corneal collagen cross-linking (CXL) for keratoconus

Q:
What code is assigned for corneal collagen cross-linking (CXL), performed for keratoconus?

A:
Keratoconus or conical cornea is thinning of the central zone of the cornea. As the disease progresses, normal eye pressure causes the round shape of the cornea to distort developing an irregular cone-like bulge, resulting in significant visual impairment.

Corneal collagen cross-linking, also known as corneal crosslinking (CXL), is a relatively new procedure that slows or halts progression in keratoconus. It achieves this through a chemical reaction using a combination of riboflavin (vitamin B2) and ultraviolet (UVA) light to strengthen the crosslinks between the collagen fibres within the stroma layer of the cornea.

There are two protocols of CXL, the epithelium-off and epithelium-on methods. In the epithelium-off protocol, the outermost layer (epithelium) of the cornea is removed and the eye is soaked in riboflavin drops for 30 minutes. The cornea is then irradiated with ultraviolet A (UVA) light for 30 minutes with riboflavin drops inserted regularly during this stage. The epithelium-on method leaves the epithelium intact to lower the risk of infection and reduce the post-operative pain and healing period for the patient (Keratoconus Australia n.d., MSAC 2017).

Assign 90066-00 [174] Other repair of cornea for corneal collagen cross-linking.

Follow the Alphabetic Index:
Repair
- cornea, corneal (laceration) NEC 90066-00 [174]

Amendments will be considered for a future edition.

References:

Published 15 March 2018, for implementation 01 April 2018.
Cerebral infarction with haemorrhagic transformation

Q:

What code is assigned for cerebral infarction with haemorrhagic transformation?

A:

Cerebral (ischaemic) infarction may be complicated by haemorrhagic transformation (HT) (also known as haemorrhagic conversion). There are two main types of HT:

- haemorrhagic infarction (HI); petechial haemorrhages at the infarct margins or throughout the infarct, without mass effect. HI occurs commonly in the natural evolution of an acute embolic stroke and is usually asymptomatic.

- parenchymal haematoma (PH); (secondary) intracerebral haematoma with mass effect (ie. ischaemic infarct with superimposed cerebral haemorrhage). PH is less common, but is symptomatic due to extension and mass effect beyond the original infarct territory.

Haemorrhagic transformation may occur spontaneously, or as a complication of anticoagulant/thrombolytic therapy (Gaillard 2017; The Internet Stroke Center 2017; Zhang et al. 2014).

In the absence of a precoordinated code for cerebral infarction with haemorrhagic transformation, assign codes from categories I63 Cerebral infarction and I61 Intracerebral haemorrhage as per the guidelines in the Conventions used in the Tabular List of Diseases/Multiple condition coding:

In Australia, multiple condition coding (meaning that multiple conditions may be assigned in an episode of care) is used to provide the necessary specificity to fully describe the episode of care.

Follow the Alphabetic Index and select an appropriate code from the subterms:

**Infarct, infarction (of)**
- cerebral I63.9
  - - due to
  - - - cerebral venous thrombosis, nonpyogenic I63.6
  - - - embolism
  - - - - cerebral arteries I63.4
  - - - - precerebral arteries I63.1
  - - - - occlusion NEC
  - - - - cerebral arteries I63.5
  - - - - precerebral arteries I63.2
  - - - - stenosis NEC
  - - - - cerebral arteries I63.5
  - - - - precerebral arteries I63.2
  - - - - thrombosis
  - - - - cerebral arteries I63.3
  - - - - precerebral arteries I63.0
  - - - specified NEC I63.8

**Haemorrhage, haemorrhagic**
- cerebellar, cerebellum (nontraumatic) I61.4
- cerebral, cerebrum (see also Haemorrhage/intracerebral) I61.9
- - lobe I61.1
- intracerebral (nontraumatic) I61.9
- - deep I61.0
- - in
- - - - brain stem I61.3
- - - cerebellum I61.4
- - - hemisphere I61.2
- - - - cortical I61.1
- - - - subcortical I61.0
- - intraventricular I61.5
- - multiple localised I61.6
- - specified NEC I61.8
- - superficial I61.1

See also ACS 0303 Abnormal coagulation profile due to anticoagulants and ACS 1902 Adverse effects.

Amendments will be considered for a future edition.

References:


Published 15 March 2018,
for implementation 01 April 2018.
Non-malignant stromal endometriosis

Q:
What code is assigned for non-malignant stromal endometriosis?

A:
Stromal endometriosis, presenting usually in the form of superficial nodules or plaques, is a relatively common form of endometriosis. It typically occurs in association with classic endometriosis but occasionally occurs on its own (Boyle McCluggage, 2009).

Where there is documentation of stromal endometriosis with no evidence of malignancy, follow the Alphabetic Index at the lead term Endometriosis and select a subterm for the specific site.
For example:
Peritoneal biopsy of endometriosis deposits.
Histopathology report states: stromal endometriosis; no atypia or evidence of malignancy seen.
Assign: N80.3 Endometriosis of pelvic peritoneum
Follow the Alphabetic Index:
Endometriosis
- peritoneal (pelvic) N80.3
Amendments will be considered for a future edition.

References:

Published 15 March 2018,
for implementation 01 April 2018.
Benign juvenile granulosa cell tumour (JGCT) of the testis

Q:
What codes are assigned for benign juvenile granulosa cell tumour (JGCT) of the testis?

A:
Granulosa cell tumours are types of stromal cell tumours. There are two types of granulosa cell tumours; adult or juvenile. Juvenile granulosa cell tumours (JGCT) of the testis are rare, benign tumours that present most commonly in the perinatal period (Bulotta et al 2012; Rane 2017).

ICD-10-AM Appendix A Morphology of neoplasms contains a table correlating behaviour codes with Chapter 2 Neoplasms categories. As indicated by the table, /1 behaviour codes are usually assigned with D37-D48 Neoplasms of uncertain or unknown behaviour. There are, however, exceptions where behaviour codes are assigned that do not correlate with the listed Chapter 2 topography codes (see Note at D45 Polycythaemia vera, D46 Myelodysplastic syndromes and D47 Other neoplasms of uncertain or unknown behaviour of lymphoid, haematopoietic and related tissue).

Juvenile granulosa cell tumours are classified as per ICD-O Third Edition with behaviour code /1 Uncertain whether benign or malignant. ICD-10-AM does not list a morphology code for JGCT with benign behaviour. Therefore, assign as a best fit for benign JGCT of the testis:

- D29.2 (Benign neoplasm of) Testis
- M8622/1 Granulosa cell tumour, juvenile

Follow the Alphabetic Index:

Neoplasm, neoplastic
- testis (Benign) D29.2

Tumour
- granulosa cell
- - juvenile (M8622/1)

Amendments will be considered for a future edition.

References:


Published 15 March 2018, for implementation 01 April 2018.
Ligament pain in pregnancy

Q:
What code is assigned for ligament pain (eg broad ligament, round ligament) in pregnancy?

A:
Ligament (eg broad ligament, round ligament) pain is common in pregnancy, usually due to stretching as the uterus expands.

Where there is documentation of ‘broad ligament pain’, ‘round ligament pain’, or ‘ligament pain’ NOS (not otherwise specified) in pregnancy, meeting the criteria in ACS 0001 Principal diagnosis or ACS 0002 Additional diagnoses, assign O34.8 Maternal care for other abnormalities of pelvic organs.

Follow the Alphabetic Index:

**Pregnancy** (single) (uterine)
- complicated by
  - - abnormal, abnormality
  - - - pelvic organs or tissues
  - - - - specified NEC O34.8

Amendments are being considered for ICD-10-AM Eleventh Edition.

*Published 15 March 2018,*
*for implementation 01 April 2018.*
Genital herpes in pregnancy

Q: What codes are assigned for genital herpes in pregnancy?

A: Genital herpes is a common sexually transmitted infection (STI).

Assign the following codes for genital herpes in pregnancy:

O98.3 Other infections with a predominantly sexual mode of transmission in pregnancy, childbirth and the puerperium

A60.0 Herpesviral infection of genitalia and urogenital tract

N77.0* Ulceration of vulva in infectious and parasitic diseases classified elsewhere

OR

N77.1* Vaginitis, vulvitis and vulvovaginitis in infectious and parasitic diseases classified elsewhere

Follow the Alphabetic Index:

Pregnancy (single) (uterine) — see also condition/in pregnancy
- complicated by
  - - conditions in
    - - A55–A64 O98.3

Herpes, herpetic

... 
- genital, genitalis
  - - female A60.0† N77.-*

See also the Inclusion term at A60.0 Herpesviral infection of genitalia and urogenital tract.

Amendments are being considered for ICD-10-AM Eleventh Edition.

Published 15 March 2018,
for implementation 01 April 2018.
Additional diagnoses in delivery episodes of care

Q:
Do the guidelines in ACS 1521 *Conditions and injuries in pregnancy* apply to complications of labour and delivery?

A:
ACS 1521 *Conditions and injuries in pregnancy* was updated for Tenth Edition to provide comprehensive guidelines for nonobstetric conditions complicating pregnancy. The Tenth Edition amendments to ACS 1521 built upon the logic contained in previous versions of the ACS (previously titled *Conditions complicating pregnancy*).

The guidelines in ACS 1521 have never been applied to labour and delivery episodes of care.

The *Conventions used in the Tabular List of Diseases/Multiple condition coding* state:

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

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

- Assign codes for other conditions/complications (pregnancy, childbirth, puerperal or nonobstetric) that meet the criteria for an additional diagnosis in ACS 0002 *Additional diagnoses*.

For example, to classify *maternal exhaustion complicating labour*, if the exhaustion meets the criteria in ACS 0002, follow the Alphabetic Index:

**Exhaustion** (physical) NEC R53
- maternal, complicating delivery O75.8

Assign:

O75.8 *Other specified complications of labour and delivery*
R53 *Malaise and fatigue*

This is consistent with coding practice in previous editions of ICD-10-AM.

Amendments to the classification and ACS for obstetrics are continuing for Eleventh Edition.

Published 15 March 2018,
for implementation 01 April 2018.
Z38 Liveborn infants according to place of birth

Q:
In ACS 1607 Newborn/neonate, what is the definition of ‘immediately post delivery’ in regards to admission of babies born outside the hospital?

A:
ACS 1607 Newborn/neonate defines a neonate as “a liveborn who is less than 28 days old”. Therefore, neonate (newborn) is synonymous with liveborn infant.

The Classification points in ACS 1607 provide (sequencing) guidelines regarding assignment of codes from category Z38 Liveborn infants according to place of birth:

1. A code from category Z38 Liveborn infants according to place of birth should be sequenced as the principal diagnosis only when the newborn is completely well (including those babies who have had a circumcision performed). This category includes babies born:
   - in hospital
   - outside the hospital and admitted immediately post delivery.

2. Any morbid condition arising during the birth episode should be sequenced before Z38 Liveborn infants according to place of birth.

3. A code from category Z38 Liveborn infants according to place of birth is not required when coding second or subsequent admissions.

ACCD acknowledges that there are no criteria for “immediately post delivery” with regards to neonates. Applying the above definition and guidelines in ACS 1607, assign a code from category Z38 for an infant less than 28 days old (i.e. a newborn/neonate) who is admitted to hospital for the first time after birth outside of hospital.

Follow the Alphabetic Index:

Newborn (infant) (liveborn) (singleton)
- born
  - - outside hospital Z38.1
- multiple (delivery)
  - - born
  - - - outside hospital Z38.7
- twin
- - born
  - - - outside hospital Z38.4

It should be noted that classification advice is provided independent of admitted patient care types, unless specifically stated otherwise.

See also Coding Rule: Assigning Z38. - as the principal diagnosis.
Published 15 December 2017,
for implementation 01 January 2018.
DVT of the iliofemoral vein

Q:

What code is assigned for a DVT of the iliofemoral vein?

A:

Tenth Edition FAQs Part 1: *Deep Venous Thrombosis (DVT)* provides advice with regard to documentation of DVT at multiple levels:

There is nothing to preclude assignment of multiple codes from category I80 *Phlebitis and thrombophlebitis*, as there is no hierarchy within the category.

Therefore, for a DVT of the iliofemoral vein, assign:

I80.21 *Phlebitis and thrombophlebitis of iliac vein*
I80.1 *Phlebitis and thrombophlebitis of femoral vein*

The following amendments to the Alphabetic Index are included in Errata 3 to Tenth Edition, for implementation 1 January 2018:

**Phlebitis** (infective) (pyaemic) (septic) (suppurative) (ulcerative) NEC
- iliofemoral — see *Phlebitis/lower extremity/femoral AND Phlebitis/lower extremity/iliac*
- lower extremity (vessels) NEC I80.3
  - - femoral I80.1
  - - iliac I80.21

**Thrombophlebitis**
- iliofemoral — see *Thrombophlebitis/lower extremity/femoral AND Thrombophlebitis/lower extremity/iliac*
- lower extremity (vessels) NEC I80.3
  - - femoral I80.1
  - - iliac I80.21

**Thrombosis, thrombotic** (multiple) (progressive) (septic) (vein) (vessel)
- iliofemoral — see *Thrombosis, thrombotic/lower extremity/femoral AND Thrombosis, thrombotic/lower extremity/iliac*
- lower extremity NEC I80.3
  - - femoral I80.1
  - - iliac I80.21

Published 15 December 2017, for implementation 01 January 2018.
SVD in multiple delivery by combination of methods

Q:

Can an ACHI code for spontaneous vertex delivery (SVD) be assigned in a multiple delivery, if one (or more) of the infants is delivered by SVD but the remaining infants are delivered following an assistance procedure?

A:

Advice was published in September 2017 as part of the Tenth Edition QAs:

As per the table in ACS 1505 Delivery and assisted delivery codes, codes for spontaneous delivery (90467-00 [1336] Spontaneous vertex delivery and 90470-00 [1339] Spontaneous breech delivery) are assigned with O80 Single spontaneous delivery or O84.0 Multiple delivery, all spontaneous.

Note that for classification purposes, once a delivery is ‘assisted’ it is no longer ‘spontaneous’.

In addition to the above advice, the ACHI codes for spontaneous delivery may be assigned with O84.82 Multiple delivery by combination of methods, when at least one of the infants is delivered vaginally without assistance (ie spontaneously).

For example:

Twin 1 delivered by spontaneous vertex delivery. Twin 2 delivered vaginally following breech extraction.

Assign:

O84.82 Multiple delivery by combination of methods
O30.0 Twin pregnancy
O64.1 Labour and delivery affected by breech presentation
Z37.2 Twins, both liveborn
90467-00 [1336] Spontaneous vertex delivery
90470-03 [1339] Breech extraction

Published 15 December 2017,
for implementation 01 January 2018.
Respiratory epithelial adenomatoid hamartoma (REAH)

Q:
What codes are assigned for a respiratory epithelial adenomatoid hamartoma?

A:
A hamartoma is a benign neoplasm that results from overgrowth of glands indigenous to a particular site. Hamartomas tend to originate from the lung, liver, spleen, kidney, intestine and the upper aerodigestive tract.

Respiratory epithelial adenomatoid hamartoma (REAH) (also referred to as glandular hamartoma and seromucinous hamartoma), is a benign lesion of the nasal cavity, paranasal sinuses and nasopharynx. They often arise in the context of inflammatory polyps within the nasal cavity and are usually diagnosed on pathology in patients undergoing endoscopic sinus surgery (Barnes et al. 2005; Davison et al. 2016; Fitzhugh Mirani 2008).

Assign a topography (site) code for benign neoplasm from the subterms listed at Neoplasm, neoplastic (e.g. nasal cavity, paranasal sinus or nasopharynx).

ICD-10-AM does not list a morphology code for epithelial adenomatoid hamartoma. Assign M8010/0 Epithelial tumour, benign as a best fit by following the Alphabetic Index:

Tumour
- epithelial
- - benign (M8010/0)

Amendments will be considered for a future edition.

References:


Published 15 December 2017,
for implementation 01 January 2018.
Transarterial chemoembolisation of the liver

Q:
What is the correct code to assign for a transarterial chemoembolisation (TACE) of the liver?

A:
Transarterial chemoembolisation (TACE) is a combination of chemotherapy (pharmacotherapy) and embolisation.

Embolisation involves injecting soft, gelatinous sponges, or tiny plastic beads into a blood vessel via a catheter. This material blocks or slows down the blood supply to an organ, causing any tumours within to shrink and/or die.

Chemoembolisation involves administration of chemotherapeutic agents within the beads used in the embolisation procedure (Canadian Cancer Society 2017, Cancer Council NSW 2016).

For transarterial chemoembolisation (TACE) of the liver (ie the chemotherapeutic agent is administered locally) assign:

35321-05 [768] Transcatheter embolisation of blood vessels, abdomen

and

35317-02 [741] Peripheral arterial or venous catheterisation with administration of other therapeutic agent

Follow the Alphabetic Index:

Embolisation
- blood vessel, transcatheter
- - liver 35321-05 [768]

and

Chemotherapy
- for local effect (open) (percutaneous) (via peripheral arterial or venous catheterisation) 35317-02 [741]

References:


Published 15 December 2017,
for implementation 01 January 2018.
Assigning multiple manifestation (asterisk) codes paired with the same aetiology (dagger) code

Q:
Can multiple manifestation (asterisk) codes be assigned when paired with the same aetiology (dagger) code?

A:
Where multiple manifestation (asterisk) codes are paired with the same aetiology (dagger) code, assign the aetiology code once only, as per the guidelines in ACS 0025 Double coding.

Example 1:
Systemic lupus erythematosus with nephritis, pleuritis and pericarditis
Assign:
M32.1† Systemic lupus erythematosus with organ or system involvement
J99.1* Respiratory disorders in other diffuse connective tissue disorders
N08.5* Glomerular disorders in systemic connective tissue disorders
I32.8* Pericarditis in other diseases classified elsewhere

Example 2:
Lewy body disease with dementia and Parkinson’s disease
Assign:
G31.3† Lewy body disease
F02.8* Dementia in other specified diseases classified elsewhere
G22* Parkinsonism in diseases classified elsewhere

Assign and sequence codes as per the guidelines in ACS 0001 Principal diagnosis and ACS 0002 Additional diagnoses.
Amendments will be considered for a future edition.
Radiofrequency ablation of the nasal turbinates

Q: What code is assigned for radiofrequency ablation (RFA) of the nasal turbinates?

A: Radiofrequency ablation is a minimally invasive destruction technique using radiofrequency energy, rather than electrical energy used in diathermy, to heat the soft tissue to a temperature that induces cell death. It is used in patients with hypertrophy of the nasal turbinates to reduce the bulk of the nasal turbinates and reduce nasal obstruction (HealthPACT, 2016).

Assign 41674-00 [374] Cauterisation or diathermy of nasal turbinates as a best fit for radiofrequency ablation of the nasal turbinates by following the Alphabetic Index:

Diathermy
- nose, nasal
- - turbinates 41674-00 [374]

Amendments will be considered for a future edition.

References:

Published 15 December 2017,
for implementation 01 January 2018.
Acanthoma

Q:
What codes are assigned for an acanthoma of the skin, with no evidence of malignancy?

A:
Acanthomas are benign tumours of epidermal keratinocytes (Le Boit et al, 2016).

Malignant clear cell acanthomas, which are rare, are classified morphologically to M8070/3 Squamous cell carcinoma NOS as per the Alphabetic Index.

Where there is documentation of acanthoma of the skin with no evidence of malignancy, assign as a best fit:

D23.- Other benign neoplasm of skin
M8000/0 Neoplasm, benign

Follow the Alphabetic Index:

Neoplasm, neoplastic
- skin (nonmelantoic)/by site/benign

and

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

Amendments will be considered for a future edition.

Reference:

Published 15 December 2017, for implementation 01 January 2018.
Deroofing of a blister

Q:

What code is assigned for deroofing of a blister?

A:

Deroofing a blister involves removing the top layer of skin from the blister. This is performed for a number of reasons including to remove non-viable tissue, to assess the wound bed, to ease the pain of the blister, and to reduce the risk of infection (North Bristol NHS 2016).

Deroofing of blisters is often undertaken with a dressing change or debridement, and may be performed on the ward with no anaesthesia. In this case the blister deroofing is an inherent component of the dressing or debridement, and is not coded as per ACS 0016 General Procedure Guidelines, Procedure Component.

Where blister ‘deroofing’ is performed in an operating theatre under anaesthesia without any other intervention for the blister site (ie changing of dressing or debridement), assign 90665-00 [1628] Excisional debridement of skin and subcutaneous tissue by following the Alphabetic Index:

Debridement

- skin

- - excisional 90665-00 [1628]

As blisters may be nontraumatic or due to an external cause such as burns, see also ACS 1203 Debridement and ACS 1911 Burns/Dressing/debridement of burns, if applicable.

See also Coding Rule: Debridement of burn performed with change of dressing and Coding Rule: Wound debridement.

Improvements to the classification of wound management is currently under review for Eleventh Edition.

References:


Published 15 December 2017,
for implementation 01 January 2018.
Replacement of cochlear implant magnet

Q:
What code is assigned for replacement of a cochlear implant magnet?

A:
Cochlear implants contain internal and external magnets. The external (sound processor) magnet maintains the position of the sound processor (the device component that receives sound) over the internal (implant) magnet. The main component of the device is implanted into the inner ear (cochlear).

Internal magnets may require temporary removal in order for an MRI (magnetic resonance imaging) to be performed; the magnet is reinserted following the MRI. Internal magnets may also be replaced due to a complication (for example, dislodgement) (Cochlear Ltd 2017).

ACHI contains codes for implantation and removal of cochlear prosthetic devices in block [329] Application, insertion or removal procedures on inner ear:

41617-00 [329] Implantation of cochlear prosthetic device
41617-01 [329] Removal of cochlear prosthetic device

Assign both of the above codes for replacement of the entire cochlear implant device (that is, both the magnets and the cochlear component). It is not appropriate to assign these codes for replacement of the internal magnet alone.

Block [1870] Interventions involving assistive or adaptive device, aid or equipment includes auditory aid [cochlear implant] [hearing aid]. Therefore, where a cochlear implant magnet is replaced, assign 96092-00 [1870] Application, fitting, adjustment or replacement of other assistive or adaptive device, aid or equipment as a best fit by following the Alphabetic Index:

Replacement

- assistive or adaptive device, aid or equipment NEC 96092-00 [1870]

Amendments will be considered for a future edition.

References:


Published 15 December 2017,
for implementation 01 January 2018.
Immunisation in a delivery episode of care

Q:
Is a code required when a patient receives immunisation during a delivery episode of care?

A:
Immunisation is not routinely provided to all patients following delivery. Women who are under immunised (that is, have a suboptimal level of immunisation) against certain infectious diseases during pregnancy, may receive immunisation in the postpartum period (Australian Government Department of Health 2016; Farlex, Inc 2017).

ACS 1500 Diagnosis sequencing in delivery episodes of care states:

Assign codes for other conditions/complications (pregnancy, childbirth, puerperal or nonobstetric) that meet the criteria for an additional diagnosis in ACS 0002 Additional diagnoses.

Where there is documentation identifying that a patient requires, and is provided with immunisation in the delivery episode, assign an appropriate code for Need for immunisation... by following the Alphabetic Index at the lead term Vaccination, by type of vaccination.

Assign an ACHI code by following the Alphabetic Index at the lead term Vaccination/by type.

For example, if a patient is immunised with measles-mumps-rubella (MMR) vaccine in the delivery episode, assign Z27.4 Need for immunisation against measles-mumps-rubella [MMR] and 92156-00 [1882] Administration of measles-mumps-rubella vaccine by following the Alphabetic Indexes:

ICD-10-AM Alphabetic Index

Vaccination
- prophylactic (against)
  - measles-mumps-rubella (MMR) Z27.4

ACHI Alphabetic Index

Vaccination (against) (prophylactic)
- measles
  - with mumps and rubella combined 92156-00 [1882]

Amendments will be considered for a future edition.

References:


Published 15 December 2017, for implementation 01 January 2018.
MonaLisa™ Touch procedure

Q:

What code is assigned for MonaLisa™ Touch procedure?

A:

MonaLisa Touch™ is a new treatment for vaginal atrophy (and its symptoms such as vaginal dryness, irritation and fissures). MonaLisa Touch™ uses a carbon dioxide laser to deliver a precise amount of heat to the vaginal wall, stimulating regeneration of the vaginal tissue, promoting proliferation of the cells, and restoration of vaginal wall strength and blood supply. This action causes micro-lesions, triggering the process of collagen reproduction, which in turn re-balances vaginal mucosa, and re-establishes the correct vaginal pH (High Tech Laser Australia 2017; MonaLisa Touch™ 2017).

Assign 35539-01 Laser destruction of lesion of vagina for MonaLisa Touch™ by following the Alphabetic Index:

Laser therapy
- vagina 35539-01

Amendments will be considered for a future edition.

References:


Published 15 December 2017,
for implementation 01 January 2018.
HELPP syndrome

Q:
When both pre-eclampsia and HELLP syndrome are documented in the clinical record, are two codes assigned?

A:
In ICD-10-AM HELLP syndrome is classified as a type of pre-eclampsia, as per ICD-10. The codes listed in category O14 Pre-eclampsia represent a continuum of pre-eclampsia severity; mild/moderate, severe, and HELLP syndrome. This is highlighted in a number of other international classifications:

- ICD-11 (Beta) describes HELLP syndrome as: Severe preeclampsia associated with hemolysis, elevated liver enzymes, or low platelets

- ICD-10-CM (USA) lists an Inclusion term at O14.2 HELLP syndrome: Severe pre-eclampsia with hemolysis, elevated liver enzymes and low platelet count

- SNOMED CT lists HELLP syndrome as a subclassification of severe pre-eclampsia (disorder)

Therefore, for classification purposes (severe) pre-eclampsia is inherent in O14.2 HELLP syndrome. Amendments will be considered for a future edition.

Published 15 December 2017,
for implementation 01 January 2018.
Acute kidney injury with chronic kidney disease (stage 3-5)

Q:
When a patient is admitted with acute kidney injury (AKI) on a background of chronic kidney disease (CKD) stage 3-5, but only the AKI is actively managed, is U87.1 Chronic kidney disease, stage 3-5 or N18.3-N18.5 Chronic kidney disease assigned with the AKI code?

A:
ACS 0001 Principal diagnosis/Acute and chronic conditions states:

If a condition is described as both acute (subacute) and chronic and separate subterms exist in the Alphabetic Index at the same indentation level, code both and sequence the acute (subacute) code first.

Therefore, where a patient is admitted with acute kidney injury (AKI) on a background of chronic kidney disease (CKD), assign codes for both conditions.

Follow the Alphabetic Index:

Injury
- kidney
  - nontraumatic — see Failure/kidney

Failure, failed
- kidney N19
  - acute N17.9
  - with
    - - cortical necrosis N17.1
    - - medullary necrosis N17.2
    - - tubular necrosis N17.0
  - - puerperal, postpartum O90.4
  - - specified NEC N17.8
  - - chronic — see Disease/kidney/chronic
    - - end-stage (CKD stage 5) N18.5
    - - hypertensive (see also Hypertension/kidney) I12.0

See also ACS 1438 Chronic kidney disease.

References:

Published 15 December 2017,
for implementation 01 January 2018.
Placental site nodule

Q:
What code is assigned for placental site nodule?

A:
A placental site nodule (PSN) is a rare, benign, nonmolar nonneoplastic lesion that may be identified months or years following delivery. Patients present with abnormal vaginal bleeding (e.g., menorrhagia, intermenstrual bleeding) or an abnormal Pap smear. PSN is usually a histological finding, not a clinical diagnosis (Jacob & Mohapatra 2009; Pramanick et al. 2014). Because of their small size and circumscription, they are usually completely removed by the surgical procedure (e.g., dilation and curettage) that led to their discovery (Shih, 2009).

Assign O90.8 Other complications of the puerperium, not elsewhere classified for placental site nodules meeting the criteria in ACS 0002 Additional diagnoses (except for same-day endoscopy – see below).

Follow the Alphabetic Index:
Puerperal, puerperium
- complications
- - specified NEC O90.8
ACS 0051 Same-day endoscopy – Diagnostic/Classification states:

1. **Symptom/condition documented as the indication for endoscopy:**
   
   **1.1 If a causal link is documented** between the indication/symptom and any of the findings, that is, either the clinician documents the link, or the classification directs clinical coders to assume a link:

   • assign as principal diagnosis a code for the finding identified as the cause of the indication and do not assign a code for the indication/symptom (see also Note at the beginning of Chapter 18 Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified)

   • assign codes for all other findings as additional diagnoses (note these findings do not need to meet the criteria in ACS 0002 Additional diagnoses).

   **1.2 If no causal link is documented** between the indication/symptom and any of the findings:

   • assign a code for the indication/symptom as the principal diagnosis

   • assign codes for all findings as additional diagnoses.
Therefore, assign O90.8 for a histological finding of placental site nodule following same-day endoscopy (ie hysteroscopy), and sequence as per the above guidelines. Do not assign Z39.0- *Postpartum care and examination immediately after delivery* unless the episode of care is within the puerperal period (see ACS 1548 *Puerperal/postpartum condition or complication/ Postpartum care and examination immediately after delivery*). Amendments will be considered for a future edition.

References:


Published 15 December 2017, for implementation 01 January 2018.
Preparatory care for dialysis code

Q:
Is supplementary code U87.1 *Chronic kidney disease, stage 3–5* or N18.5 *Chronic kidney disease, stage 5* assigned when a patient is admitted for creation of an AV fistula for haemodialysis?

A:

ACS 1438 *Chronic kidney disease/Classification* states:

*Chronic kidney disease* (N18.-) must be assigned in all episodes of care when a diagnosis of chronic kidney disease (or chronic renal failure) is documented and meets the criteria for an additional diagnosis (see ACS 0002 *Additional diagnoses*).

When a patient with chronic kidney disease (CKD) is admitted for creation of an AV fistula for haemodialysis, do not assign a code for CKD unless it meets the criteria in ACS 0002 *Additional diagnoses*. Note that creation of the AV fistula is to obtain vascular access for haemodialysis, and is not a therapeutic treatment for CKD, and thus cannot be used as a criterion for assignment of CKD as per ACS 0002.

In this scenario assign:

Z49.0 *Preparatory care for dialysis*

U87.1 *Chronic kidney disease, stage 3–5*

Assign ACHI codes as appropriate.

Published 15 December 2017, for implementation 01 January 2018.
Pathology and other test results reproduced or copied into electronic documents

Q:
Can pathology and other test results reproduced or copied into electronic documents be used for code assignment?

A:
ACS 0010 General abstraction guidelines/Test results states:
...
Before coding any diagnosis/procedure recorded, the clinical coder must verify information recorded on the front sheet and/or the discharge summary by reviewing pertinent documents in the body of the clinical record.
...
Laboratory, x-ray, pathological and other diagnostic results should be coded where they clearly add specificity to already documented conditions that meet the criteria for a principal diagnosis (see ACS 0001 Principal diagnosis) or an additional diagnosis (see ACS 0002 Additional diagnoses).
The Introduction of the Australian Coding Standards states:
...
coding decisions are not made solely based on information provided on clinical record front sheet and/or the discharge summary (or a copy of the same) but that analysis of the entire clinical record is performed before code assignment. ...
and
...
When a diagnosis is recorded for which there is no supporting documentation in the body of the clinical record, it may be necessary to consult with the clinician before assigning a code.
The access to or inclusion of test results in an electronic medical record is no different to a printed result within a paper-based record. Therefore, apply the above guidelines where test results are included in an electronic medical record.
See also ACS 0010 General abstraction guidelines and Coding Rule: Coding from test results and findings on radiological reports.

Published 15 December 2017,
for implementation 01 January 2018.
Pressure injury with diabetes mellitus

Q: Is a pressure injury classified as a complication of diabetes mellitus?

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

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

Rule 3.

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

None of the synonyms listed above for pressure injury are listed in the Alphabetic Index under Diabetes, with. Therefore, the guidelines in ACS 0401 for ‘complications’ of diabetes mellitus do not apply to pressure injury in a patient with diabetes mellitus, unless the criteria for diabetic foot are met.

See also ACS 0401 Diabetes mellitus and intermediate hyperglycaemia/6. Diabetic foot.

Published 15 December 2017,
for implementation 01 January 2018.
Tenth Edition FAQs Part 3: Same-day endoscopy

Q:
Why does ACS 0052 Same-day endoscopy – surveillance instruct that Z codes for follow-up or screening are not assigned as an additional diagnosis? Where a second endoscopic procedure is performed in the same episode for screening and nothing is found, this instruction means a diagnosis code for that particular endoscopy is unable to be assigned.

A:
This instruction was added into the standard due to the fact that there is inconsistent use of the terminology ‘follow-up’ and ‘screening’, and therefore the addition of these codes provides little value in the data. However, this has been reconsidered in the context of multiple endoscopies performed in the one operative episode, and is amended in Tenth Edition Addenda to Errata 2, for implementation 1 October 2017, to allow assignment of these codes as additional diagnoses, as appropriate.

Q:
Why is the code for liver cirrhosis sequenced as principal diagnosis in ACS 0052 Surveillance Example 13?

A:
Example 13 has been reviewed and is amended in Tenth Edition Addenda to Errata 2, for implementation 1 October 2017, to sequence the varices as the principal diagnosis. It’s acknowledged that in that scenario there would be no surveillance of the liver cirrhosis (chronic incurable condition).

Q:
Why has a personal history code been assigned in ACS 0052 Surveillance Example 11?

A:
The assignment of the personal history code in this scenario was seen as relevant to the episode. However, upon review it is acknowledged that it is not consistent with the guidelines in ACS 2112 Personal history which states:

These codes would only be assigned as additional diagnoses where the condition is completely resolved yet the history is directly relevant to the current episode of care.

The personal history code will be removed from example 11 in Tenth Edition Addenda to Errata 2, for implementation 1 October 2017. A task has been created to review ACS 2112 Personal history for a future edition.

Published 29 September 2017, for implementation 01 October 2017.
Q:
What code is assigned for a patient admitted five months post delivery with low milk supply?

A:
Where a patient has a condition relating to lactation, assign a code from category O91 *Infections of breast associated with childbirth* or O92 *Other disorders of breast and lactation associated with childbirth*, regardless of whether the condition occurs in the delivery episode, within the puerperium or beyond the puerperium.

**Scenario:** Breastfeeding patient admitted 5 months post delivery with a nonobstetric condition. Patient commenced on Domperidone for low milk supply. No attachment difficulties documented. Assign:

PDx for the nonobstetric condition as per the criteria in ACS 0001 *Principal diagnosis*

O92.40 *Hypogalactia, without mention of attachment difficulty* as an additional diagnosis

This question highlighted a logic error in the guidelines in ACS 1548 *Puerperal/postpartum condition or complication/Conditions relating to lactation*. Amendments are included in Tenth Edition Addenda to Errata 2, for implementation 1 October 2017.

Published 29 September 2017,
for implementation 01 October 2017.
Subject Tenth Edition FAQs Part 2: Obstetrics

Q:

Should ACS 1505 *Delivery and assisted delivery codes* refer to ‘ACHI code(s)’?

A:

ACS 1505 *Delivery and assisted delivery codes* states:

Where a patient delivers during an episode of care, assign:

a code from O80–O84 *Delivery and*  

an ACHI code from [1336] – [1340] *Delivery procedures or other procedure(s) to assist delivery*

The above statement means that at least one ACHI code (delivery or other procedure to assist delivery) is assigned for every episode of care where a patient delivers. Assign multiple ACHI codes, if applicable, based on documentation in the clinical record.

Q:

Is it correct that 90467-00 [1336] *Spontaneous vertex delivery* is assigned once only for a twin delivery where both infants are delivered by spontaneous vertex delivery?

A:

ACS 1505 *Delivery and assisted delivery codes* states:

In a multiple delivery, if the babies are delivered by different methods, ACHI codes for all of the delivery methods must be assigned.

Therefore, if the same delivery method is used for all the infants, only one ACHI code is assigned.

That is:

O84.0 *Multiple delivery, all spontaneous* – assign one spontaneous delivery code if all infants delivered by the same method

O84.1 *Multiple delivery, all by forceps and vacuum extractor* – assign one forceps or vacuum code if all infants are delivered by the same method

O84.2 *Multiple delivery, all by caesarean section* – assign one caesarean section code if all infants are delivered by the same method

Scenario: Healthy twins both delivered by spontaneous vertex delivery.

Assign:

O84.0 *Multiple delivery, all spontaneous*

O30.0 *Twin pregnancy*

Z37.2 *Twins, both liveborn*

90467-00 [1336] *Spontaneous vertex delivery*  

(anaesthesia code if applicable)

Q:
What codes are assigned for spontaneous vertex delivery with McRoberts manoeuvre?

**A:**

As per the table in ACS 1505 Delivery and assisted delivery codes, codes for spontaneous delivery (90467-00 [1336] Spontaneous vertex delivery and 90470-00 [1339] Spontaneous breech delivery) are assigned with O80 Single spontaneous delivery or O84.0 Multiple delivery, all spontaneous.

Note that for classification purposes, once a delivery is ‘assisted’ it is no longer ‘spontaneous’.

<table>
<thead>
<tr>
<th>ICD-10-AM CODE</th>
<th>ACHI CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>O80 Single spontaneous delivery</td>
<td>90467-00 [1336] Spontaneous vertex delivery</td>
</tr>
<tr>
<td>90470-00 [1339] Spontaneous breech delivery</td>
<td></td>
</tr>
<tr>
<td>O84.0 Multiple delivery, all spontaneous</td>
<td>90467-00 [1336] Spontaneous vertex delivery</td>
</tr>
<tr>
<td>90470-00 [1339] Spontaneous breech delivery</td>
<td></td>
</tr>
</tbody>
</table>

**Scenario:** Single delivery; McRoberts manoeuvre performed, followed by vertex delivery of healthy infant.

Assign:

O83 Other assisted delivery

Z37.0 Single live birth

90477-00 [1343] Other procedures to assist delivery

See also Coding Rule: SVD in multiple delivery by combination of methods.

**Q:**

What codes are assigned for fetal death in utero (FDIU)/missed abortion before fetal viability, with induction of labour?

**A:**

ACS 1511 Termination of pregnancy states:

For delivery episodes of care following fetal death in utero (intrauterine death) (not induced), follow the Alphabetic Index at Death/fetus, fetal and the guidelines in ACS 1500 Diagnosis sequencing in delivery episodes of care.

... PROCEDURES FOR TERMINATION OF PREGNANCY

induction of labour. Assign a code from block [1334] Medical or surgical induction of labour regardless of the duration of pregnancy and outcome

**Scenario:** FDIU/missed abortion before fetal viability (14/40). Patient induced with prostaglandin suppository. Documentation: “IOL – Misoprostol 400mg inserted PV”.

Assign:
002.1 Missed abortion

009.2 14–19 completed weeks

90465-01 [1334] Medical induction of labour, prostaglandin

Follow the Alphabetic Index:

Death
- fetus, fetal (cause not stated) (intrauterine)
  - - before fetal viability, with retention (< 20 completed weeks (140 days) gestation and/or fetal weight < 400g) O02.1

Induction
- labour
  - - medical (administration of pharmacological agent)
  - - - prostaglandin 90465-01 [1334]

Note that an ACHI code for induced abortion is not assigned as the fetus is already deceased.

Q:

Is the assignment of codes from categories E09-E14 with codes from category O24 Diabetes mellitus in pregnancy contradictory to ACS 0401 Diabetes mellitus and intermediate hyperglycaemia/General classification rules/Rule 6?

A:

ACS 0401 Diabetes mellitus and intermediate hyperglycaemia/Specific classification principles for DM and IH/DM and IH in pregnancy, childbirth and the puerperium states:

Assign codes for DM or IH (E09–E14) as per the Instructional notes (code also) at O24-.

The above specific classification principle and the Instructional notes at category O24 Diabetes mellitus in pregnancy take precedent over the General classification rules for DM and IH in ACS 0401.

Scenario: Pregnant patient with type 2 diabetes mellitus; diabetes diagnosed two years ago. Patient does not have any diabetes complications; diabetes managed by diet.

Assign:

O24.14 Pre-existing diabetes mellitus, Type 2, in pregnancy, other

E11.9 Type 2 diabetes mellitus without complication

Q:

Are the guidelines in ACS 0104 Viral hepatitis and ACS 0505 Mental illness in pregnancy, childbirth and the puerperium sequencing directives?

A:

ACS 0104 Viral hepatitis/Classification point 2. Viral hepatitis in pregnancy, childbirth and the puerperium states:

Where viral hepatitis is documented in pregnancy, childbirth or the puerperium, assign:

a code for the specific type of viral hepatitis (B15–B19)
O98.4 Viral hepatitis in pregnancy, childbirth and the puerperium

ACS 0505 Mental illness in pregnancy, childbirth and the puerperium states:

Where a mental disorder is documented in pregnancy, childbirth or the puerperium, assign:

a code from Chapter 5 Mental and behavioural disorders for the specific type of mental illness

O99.3 Mental disorders and diseases of the nervous system in pregnancy, childbirth and the puerperium.

The above guidelines are not sequencing directives. Both ACS 0104 and ACS 0505 contain cross references to standards where sequencing guidelines are provided for conditions/complications in pregnancy and the puerperium:

See ACS 1521 Conditions and injuries in pregnancy and ACS 1548 Puerperal/postpartum condition or complication.

Note: Viral hepatitis is always coded as per the guidelines in ACS 0104, but the general classification principles in ACS 0001 Principal diagnosis and ACS 0002 Additional diagnoses apply to mental health conditions.

Q:

Does “including delivery of placenta” as a definition of delivery mean whole placenta? If there are retained portions of placenta, is the delivery considered incomplete?

A:

ACS 1548 Puerperal/postpartum condition or complication states:

The puerperium is defined as the period of 42 days following delivery (including delivery of placenta).

Delivery of placenta means expulsion of the whole placenta, excluding any retained portions that are expelled or require removal post delivery (see also ACS 1548 Example 7).

Scenario: Patient delivered (baby and placenta) at home (planned home birth). She is admitted to hospital four hours later due to postpartum haemorrhage, and is taken to theatre for removal of retained portions of placenta by dilation and curettage (D&C).

Assign:

O72.2 Delayed and secondary postpartum haemorrhage

Z39.02 Postpartum care after planned, out of hospital delivery

16564-00 [1345] Postpartum evacuation of uterus by dilation and curettage

(anaesthesia code)

Note: It is acknowledged that there are issues with the indexing and classification of postpartum haemorrhage and underlying causes (eg atonic uterus, retained portions/fragments of placenta). These issues are under review for ICD-10-AM/ACHI/ACS Eleventh Edition.

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Subject Tenth Edition FAQs Part 2: Procedural complications

Q:
Which complication code is assigned when a postoperative complication is not classified to T82-T85 *Complications of prosthetic devices, implants and grafts* but the complication is documented as due to a prosthetic device, graft or implant?

A:
Classifying of procedural complications is a complex area. Complications may be non-specific or specific to a particular procedure (e.g., prosthetic devices, graft or transplantation). ICD-10-AM, based on ICD-10, is not a multi-axial diagnostic classification; it is inflexible to incorporate all types of complications into the classification consistently.

Codes in the categories of T82-T85 are generally intended to be used for complications specific to prosthetic devices, grafts and implants such as mechanical complication, infection, pain, thrombosis, haemorrhage, mesh erosion and so on. Other conditions may occur when a prosthetic device, graft or implant is present but they are more general complications non-specific to the procedure itself (e.g., implantation of a prosthetic device). It is therefore considered more correct to classify these conditions to an appropriate body system chapter, unless documentation in the clinical record specifies that the procedural complication is ‘secondary to’ or ‘due to’ a prosthetic device, implantation or graft, for which an appropriate code from T82-T85 is assigned, followed by a code from the body system chapter.

**Scenario 1:**
Lymphocele following radical prostatectomy
Assign:
I97.83 *Postprocedural lymphocele, lymphoedema and chylothorax*

**Scenario 2:**
Lymphocele due to cannulation of the femoral vein
Assign:
T82.89 *Other specified complications of cardiac and vascular prosthetic devices, implants and grafts*
I97.83 *Postprocedural lymphocele, lymphoedema and chylothorax*

Q:
What code is assigned for peritonitis in a peritoneal dialysis patient when there is no documentation that the complication is due to the device?

A:
Peritonitis is a medical condition that may occur in the postoperative period. It may or may not be related to the procedure performed. Peritonitis is not classified as a procedural complication unless the causal relationship is clearly documented.

However, when peritonitis occurs in a peritoneal dialysis (PD) patient, clinical advice from the Australia and New Zealand Dialysis and Transplant Registry (ANZDATA) indicates that it is considered PD related peritonitis.

Therefore, for peritonitis in a peritoneal dialysis patient without further specification assign:
T85.71 *Infection and inflammatory reaction due to peritoneal dialysis catheter*
K65.- *Peritonitis*
Y84.1  Kidney dialysis  
Y92.23  Place of occurrence, health service area, not specified as this facility  
or  
Y92.24  Place of occurrence, health service area, this facility  
Where another cause of the peritonitis is specified, such as perforated diverticulum, assign codes following the guidelines in ACS 0001 Principal diagnosis/Problems and underlying conditions, and ACS 0002 Additional diagnoses.  

**Note:** This advice defaults the classification of peritonitis in PD patients. It should not be applied to other medical conditions occurring postoperatively.  

**Q:**  
What code is assigned for postoperative pain following insertion of prosthetic devices, grafts or implants?  

**A:**  
A code for postoperative pain is only assigned when there is no underlying cause of the pain specified in the clinical record, and it meets the criteria in ACS 0001 Principal diagnosis/Problems and underlying conditions or ACS 0002 Additional diagnoses.  
If the cause of pain is specified in the clinical record, an appropriate code for the underlying cause is assigned, not postoperative pain.  

**Scenario 1:**  
A patient readmitted with persisting pain after a recent left hip replacement. Extensive investigations, including CT of the hip were conducted, but did not reveal the cause of the pain.  
Assign:  
T84.83  Pain following insertion of internal orthopaedic prosthetic devices, implants and grafts  
(external cause codes as appropriate)  

**Scenario 2:**  
A patient admitted with chronic hip pain 12 months after a left hip replacement. A radiograph showed loosening of the prosthesis at the bone–cement interface and a revision of hip replacement was carried out.  
Assign:  
T84.0  Mechanical complication of internal joint prosthesis  
M25.55  Pain in joint, pelvic region and thigh  
R52. 2  Chronic pain  
(external cause codes as appropriate)  

**Q:**  
Could postoperative anaemia be assumed as posthaemorrhagic anaemia in the absence of any documented cause?  

**A:**  
The overall concept of procedural complications has been reviewed for ICD-10-AM Tenth Edition. This clarifies that conditions that arise during a procedure, or in the postoperative period are not considered as procedural complications unless a causal relationship is documented in the clinical record. However, for
certain conditions, the causal relationship is assumed, i.e. a cause and effect relationship does not have to be documented to assign a procedural complication code. These conditions include:

- Certain conditions where the relationship is inherent in the diagnosis (e.g. acute blood loss anaemia during a procedure or from a surgical wound)
- Conditions classified to T82–T85 for complications related to prosthetic devices, implants or grafts
- Conditions that are a direct consequence of a procedure, resulting in an unintended event

These conditions may or may not be documented as ‘secondary to’ or ‘due to’ the procedure performed, however they are classified as procedural complications. ICD-10-AM Tenth Edition Alphabetic Index has been updated to reflect these changes. For example:

Haemorrhage
- due to or associated with
- - device, implant or graft NEC (see also Complication(s)/by site and type) T85.83

**Scenario:**

A tracheoesophageal fistula formed following tracheostomy

Assign:

J95.04 Tracheo-oesophageal fistula following tracheostomy

**Scenario:**

Acute blood loss anaemia post ORIF for femoral fracture, without further specification as to cause of the anaemia.

Assign:

T84.81 Haemorrhage and haematoma following insertion of internal orthopaedic prosthetic devices, implants and grafts

D62 Acute posthaemorrhagic anaemia

(external cause codes as appropriate)

If the cause of anaemia other than acute haemorrhage is specified in the clinical record (e.g. pre-existing anaemia, malignancy or other chronic diseases during postoperative recovery), classify the anaemia as per the documented cause, not acute posthaemorrhagic anaemia.

**Q:**

What is the correct place of occurrence code to assign when the patient is registered in the hospital system, but care is delivered by a private provider on behalf of the hospital?

**A:**

The note at Y92.23 Health service area, not specified as this facility and Y92.24 Health service area, this facility states:

- 'This facility' includes satellite units managed and staffed by the same health care provider. These units may be located on the hospital campus or off the hospital campus and treat movements of patients between sites as ward transfers'

Where complications occurred at a unit or centre external to the admitting facility, and the movement of patients is regarded as an internal transfer with intention of resuming care when patients return (i.e. continuation of the same admission), it is classified as ‘this facility’. This includes transferring patients to a department or centre where the care is provided by a subcontractor.

If the movement of patients is regarded as an external transfer (i.e. the patient is discharged from the admitting facility and admitted to another facility under a contractual agreement), it is regarded as another facility (i.e. not specified as this facility).

**Scenario 1:**
Patient admitted for chest pain and transferred to the radiology department (privately owned, contracting to the facility) for a coronary angiogram. A haematoma at the arterial puncture site was identified the next day while the patient was still admitted at the hospital.

Assign:

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

Scenario 2:

Patient admitted to Hospital A for treatment of sepsis. During the admission, he slipped on the hospital floor and suffered a fracture of neck of femur (NOF). This was surgically treated and eventually he was transferred to Hospital B for rehabilitation of the fracture and deconditioning. During his stay at Hospital B he developed pneumonia and was transferred back to Hospital A where he continued physiotherapy for the fractured NOF.

Assign:

Hospital A: Y92.24 Place of occurrence, health service area, this facility (with COF=1)
Hospital B: Y92.23 Place of occurrence, health service area, not specified as this facility (with COF=2)
Hospital A: Y92.24 Place of occurrence, health service area, this facility (with COF=2)

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Tenth Edition FAQs Part 2: Same-day endoscopy

Q:
Where an endoscopy incorporates both diagnostic and surveillance components or where a diagnostic endoscopy and a surveillance endoscopy are performed in the same episode, should the diagnostic findings be sequenced before the surveillance diagnoses?

A:
There is no hierarchy for assignment of the principal diagnosis in the above scenario. Follow the guidelines in ACS 0051 Same-day endoscopy – diagnostic and ACS 0052 Same-day endoscopy – surveillance where there are both diagnostic and surveillance endoscopies in the one episode. Then, apply the general principles in ACS 0001 Principal diagnosis to determine the principal diagnosis. This has always been the case in these scenarios and has not changed with Tenth Edition.

Published 22 September 2017, for implementation 01 October 2017.
Tenth Edition FAQs Part 1: Difficult intubation

Q:
What codes (including external cause codes) are assigned for difficult intubation?
A:
Assign:
T88.42 Difficulty intubation
Y84.8 Other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of unintentional events at the time of the procedure
Y92.24 Health service area, this facility

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Tenth Edition FAQs Part 1: Revision of Type 1 and Type 2 Excludes notes

Key points

The structure of ICD-10-AM has not changed.

Some Excludes notes have been removed due to redundancy, but chapter structure has not changed.

As per the Reference to Changes document, a high level review at chapter level was undertaken to remove redundancy. In the review, it was noted that Excludes notes served a multitude of purposes, including (but not limited to) addition during development of ICD-10 (to enable tabular browsing during development), and to support mortality single condition coding purposes (ie direct the coder to the underlying cause).

Australia (ICD-10-AM) utilises the multiple condition coding convention to identify both the underlying cause and manifestation(s), and as such a number of Excludes notes were determined to be redundant. It was also noted that some Alphabetic Index entries supported the mortality coding purpose (ie single condition coding).

As a result, Excludes notes (at the chapter level) identified as redundant for ICD-10-AM purposes were removed for Tenth Edition.

The review of Excludes notes at the category and code level will continue for Eleventh Edition.

The areas of pre-coordination (ie mortality direction for underlying cause coding) in the Alphabetic Index and Tabular List have been highlighted, and as work continues on this topic for Eleventh Edition, the indexing and tabular Inclusion terms will be assessed and amended (where appropriate).

Problems and Underlying conditions

The ICD-10-AM Conventions used in the Tabular List of diseases/Multiple condition coding state:

In classifying a condition with an underlying cause, if the Alphabetic Index or Excludes note... results in a code for one of the clinical concepts not being assigned, follow the guidelines in ACS 0001 Principal diagnosis/Problems and underlying conditions and ACS 0002 Additional diagnoses and assign codes for both the condition and the underlying cause.

Scenario:

Neurogenic bladder due to cauda equina syndrome

Assign:

N31.9 Neuromuscular dysfunction of bladder, unspecified

G83.4 Cauda equina syndrome

* Sequence codes as per the guidelines in ACS 0001 and ACS 0002.

Note:

ICD-10-AM Conventions used in the Tabular List of diseases/Multiple condition coding state:

If, by following the Alphabetic Index, a residual code is assigned (ie other or unspecified), do not assign an additional code to further classify the condition unless directed by an Instructional note in the Tabular List or an Australian Coding Standard.
Tenth Edition FAQs Part 1: Abnormal coagulation profile due to anticoagulants

Q:
Are Z92.1, R79.83 and D68.3 mutually exclusive?

A:
Z92.1 Personal history of long term (current) use of anticoagulants, R79.83 Abnormal coagulation profile and D68.3 Haemorrhagic disorder due to circulating anticoagulants are mutually exclusive, as evidenced by the Excludes notes at R79.83 and D68.3. Long term use of anticoagulants is inherent in D68.3 and R79.83.

Q:
Does INR monitoring need to be documented to assign Z92.1 and R79.83?

A:
INR/anticoagulant level monitoring is required to assign Z92.1 Personal history of long term (current) use of anticoagulants and R79.83 Abnormal coagulation profile, as per the guidelines in ACS 0303 Abnormal coagulation profile due to anticoagulants/Classification which states:

If patients on long term anticoagulants require anticoagulant level monitoring during an episode of care and the INR level is within the target therapeutic range (ie no supratherapeutic or subtherapeutic INR is documented), assign Z92.1 Personal history of long term (current) use of anticoagulants as an additional diagnosis

If the INR value is outside the patient’s normal/usual therapeutic range (eg supratherapeutic or subtherapeutic INR is documented) but no bleeding occurs, assign R79.83 Abnormal coagulation profile together with appropriate external cause codes to indicate that the abnormal coagulation profile is related to the administration of an anticoagulant.

Note: The second dot point infers that the INR level (value) is being monitored during an episode of care, as multiple values are required to demonstrate a trend.

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Tenth Edition FAQs Part 1: Use of definitional information

A clinical coder **cannot** use definitional information contained in any ACS for classification purposes.

This information is provided for coder education only.

For example:

- ACS 0533 *Electroconvulsive therapy (ECT)* includes definitional information regarding pulse width such as percentages and duration periods.
- ACS 1807 *Acute and chronic pain* includes definitional information for neoplastic (cancer), neuropathic and nociceptive pain types.

If documentation is lacking in specific detail, this should be discussed with the clinicians involved.

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for implementation 01 October 2017.
Tenth Edition FAQs Part 1: ACS mutual exclusivity

Mutual exclusivity does not apply to coding standards; however, multiple standards may apply to a particular case.

Apply first the general standards for diseases and interventions.

For example, ACS 0001 Principal diagnosis, ACS 0002 Additional diagnoses, ACS 0010 General abstraction guidelines (see also the list of General standards for diseases in the ACS) and ACS 0042 Procedures normally not coded.

Apply the guidelines in the specialty standards on a case by case basis.

For example, ACS 0051 Same-day endoscopy – diagnostic and ACS 0052 Same-day endoscopy – surveillance may apply to the same episode of care, in addition to the general standards for diseases.

**Note:** There may be a See instruction within an ACS to indicate that there may be applicable guidelines in another ACS.

For example, ACS 0001 Principal diagnosis/Residual condition or nature of sequela includes a cross reference to ACS 0008 Sequelae and ACS 1912 Sequelae of injuries, poisoning, toxic effects and other external causes.

Published 15 September 2017, for implementation 01 October 2017.
Tenth Edition FAQs Part 1: Chronic pain

Q: Will there be amendments to chronic pain in Errata 2?
A: Errata 2 incorporates amendments to ICD-10-AM code R52.2 *Chronic pain* and ACS 1807 *Acute and chronic pain* with regard to the classification of chronic pain.

Q: What codes are assigned for chronic pain with underlying conditions?
A: The ICD-10-AM *Conventions used in the Tabular List of diseases/Multiple condition coding* state:

In classifying a condition with an underlying cause, if the Alphabetic Index or *Excludes* note... results in a code for one of the clinical concepts not being assigned, follow the guidelines in ACS 0001 *Principal diagnosis/Problems and underlying conditions* and ACS 0002 *Additional diagnoses* and assign codes for both the condition and the underlying cause.

ACS 1807 *Acute and chronic pain* states:

To classify chronic pain with a documented underlying cause and/or site:

- code first the underlying cause and/or site and,
- assign R52.2 *Chronic pain* as an additional diagnosis

*Note:* the amendments made to ACS 1807 in Errata 2 are included in the text above

Scenario:

Chronic low back pain due to bone metastases

Assign:  

- **C79.5 Secondary malignant neoplasm of bone and bone marrow** (ie the underlying cause of the chronic low back back)
- **M54.5 Low back pain** (ie the site of the chronic pain)
- **R52.2 Chronic pain** (ie to identify the chronicity)

*Note:* R52.2 *Chronic pain* is always where there is underlying cause and/or site documented.

R52.2 Chronic pain may be assigned as a principal diagnosis if there is no documentation of an underlying cause or site.

* Sequence codes as per the guidelines in ACS 0001 and ACS 0002.

Q: What documentation of terminology for chronic pain is used for code assignment?
A: To assign R52.2 *Chronic pain*, documentation within the clinical record must state any of the following terms:

- neoplastic (or cancer) pain
- neuropathic pain
- nociceptive pain
- chronic pain

*Notes:* ‘Nerve pain’ is not synonymous with ‘neuropathic pain’
The guidelines under the Classification section in ACS 1807 are applicable for code assignment. The remaining information/definitions contained within ACS 1807 is provided for clinical coder reference only.

**Scenario:**

Pain due to osteoarthritis of the hip.

**Assign:** M16.1 *Other primary coxarthrosis*

**Note:** * R52.2 is not assigned as there is no documentation of ‘chronic pain’ or ‘nociceptive pain’

**Q:**

What codes are assigned for chronic pain with external causes?

**A:**

Where chronic pain is the sequelae of an external cause, follow the guidelines in ACS 0008 *Sequelae* or ACS 1912 *Sequelae of injuries, poisoning, toxic effects and other external causes* as appropriate to the case.

Published 15 September 2017, for implementation 01 October 2017.
Tenth Edition FAQs Part 1: Multiple condition coding convention

The concept of ‘translate medical statement into code’ in the classification and coding standards has been revised to ‘classify the clinical concept’ in line with the purpose of ICD-10 as a classification.

Key points regarding the multiple condition coding convention are highlighted below:

The ICD-10-AM Conventions used in the Tabular List of diseases/Multiple condition coding state:

- In Australia, multiple condition coding (meaning that multiple conditions may be assigned in an episode of care) is used to provide the necessary specificity to fully describe the episode of care. **This does not mean multiple codes are assigned to describe a single condition (unless otherwise instructed).**
- It is unnecessary for conditions to be explicit in a code title or *Inclusion* term to be correctly classified. **Do not assign an additional code to further classify a condition unless directed by an Instructional note in the Tabular List or an Australian Coding Standard.**
- If, by following the Alphabetic Index, a residual code is assigned (ie other or unspecified), **do not assign an additional code to further classify the condition unless directed by an Instructional note in the Tabular List or an Australian Coding Standard.**
- In classifying a condition with an underlying cause, if the Alphabetic Index or *Excludes* note... results in a code for one of the clinical concepts not being assigned, follow the guidelines in ACS 0001 *Principal diagnosis/Problems and underlying conditions* and assign codes for **both** the condition and the underlying cause.

Published 15 September 2017,
for implementation 01 October 2017.
Tenth Edition FAQs Part 1: Administration of agents (Alphabetic Index)

Q:
Is there a hierarchy at the lead term Administration for the subterms indication, specified site and type of agent?

A:
There is no hierarchy for Administration/indication, Administration/specifed site and Administration/type of agent. Cross-references are included to direct clinical coders to other subterms, as appropriate.

For example, to classify steroid injection into a joint (NOS), assign 50124-01 [1552] Administration of agent into joint or other synovial cavity, not elsewhere classified, follow the Alphabetic Index:

Administration
- specified site
  - joint NEC 50124-01 [1552]
...
- type of agent
  - steroid NEC — code to block [1920] with extension -03 (see also Administration/specifed site)

Published 15 September 2017, for implementation 01 October 2017.
Tenth Edition FAQs Part 1: ACS deleted for Tenth Edition

A coding standard is evaluated for clinical and classification currency or redundancy before the decision is made to delete it from the ACS.

When a coding standard is deleted from the ACS, the content is relocated to either another standard or incorporated into the Tabular List and/or Alphabetic Index, as applicable.

In some instances, a specialty standard is considered redundant if the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses* (or other general/specialty standards) are applicable to the topic.

For example, ACS 1436 *Admission for trial of void* was deleted for Tenth Edition as the following principles apply:

- Follow the Alphabetic Index: *Trial of void/admission for*
- Assign a code for urinary retention when it meets the criteria in ACS 0002
- Assign codes for intervention(s) as per the guidelines in ACS 0042 *Procedures normally not coded/Classification/Dot point 2*)

Note: Information regarding ACS deletion is documented in the *Chronicle* available on the ACCD website (https://www.accd.net.au/Downloads.aspx).

Published 15 September 2017, for implementation 01 October 2017.
Tenth Edition FAQs Part 1: Mental health interventions

Q:
Are mental health intervention codes mandatory?

A:
ACS 0534 *Specific interventions related to mental health care services* states:

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

This applies the same logic as in ACS 0032 *Allied health interventions* which states:

For inpatient coding it is only necessary to assign the general code(s) from block **[1916] Generalised allied health interventions.** **However, clinical coders are encouraged to use the more specific codes for allied health interventions to better represent the interventions performed.**

Published 15 September 2017,
for implementation 01 October 2017.
Tenth Edition FAQs Part 1: Application of ACS 0001 and ACS 0002 in conjunction with specialty standards

ACS 0001 Principal diagnosis and ACS 0002 Additional diagnoses are general standards applicable to ICD-10-AM. Unless specifically indicated, the general classification principals in ACS 0001 and ACS 0002 apply to all conditions listed in the specialty standards.

ACS 0002 lists a number of specialty standards that include guidelines to assign codes for certain conditions as additional diagnoses, regardless of whether or not they meet the criteria (see ACS 0002 Additional diagnoses/Additional diagnosis reporting referred to in other standards). Note that the list in ACS 0002 is not exhaustive as standards are added or changed over time, and not all applicable specialty standards may be contained in this list.

Therefore, after selecting the principal diagnosis, all other conditions documented in an episode of care must meet the criteria in ACS 0002, unless there are specific guidelines in a specialty standard indicating otherwise (eg (condition) “should always be coded”).

Published 15 September 2017, for implementation 01 October 2017.
Tenth Edition FAQs Part 1: Adoption

Q:
Is Z76.22 Health supervision and care of other infant/child NEC assigned for babies/infants when a Family and Community Services (FACS) evaluation is undertaken?

A:
Assign Z76.22 Health supervision and care of other infant/child NEC for infants receiving care or assessment for the purposes of adoption, foster placement, or family supervision.

Published 15 September 2017, for implementation 01 October 2017.
Tenth Edition FAQs Part 1: Deep Venous Thrombosis (DVT)

Q:
What code is assigned when there is documentation of DVT at multiple levels? For example, DVT extending inferiorly into the popliteal and posterior tibial veins.

A:
There is nothing to preclude assignment of multiple codes from category I80 Phlebitis and thrombophlebitis, as there is no hierarchy within the category. Therefore, where the site of a DVT is documented as ‘extending inferiorly into the popliteal and posterior tibial veins, assign:

I80.22 Phlebitis and thrombophlebitis of popliteal vein
and
I80.23 Phlebitis and thrombophlebitis of tibial vein.

Published 15 September 2017, for implementation 01 October 2017.
Tenth Edition FAQs Part 1: Passive smoking

Q:
Does passive smoking need to meet the criteria in ACS 0002 Additional diagnoses, or is it assigned whenever documented similar to Z72.0 Tobacco use, current?

A:
ACS 2118 Exposure to tobacco smoke states:
Assign Z58.7 Exposure to tobacco smoke when exposure to secondhand tobacco smoke is documented by a clinician, except if the patient is a current or ex-smoker.
Therefore, exposure to secondhand tobacco smoke (passive smoking) does not have to meet the criteria in ACS 0002 Additional diagnoses to assign Z58.7 Exposure to tobacco smoke.
See also Tenth Edition FAQs Application of ACS 0001 and ACS 0002 in conjunction with specialty ACS

Published 15 September 2017,
for implementation 01 October 2017.
Tenth Edition FAQs Part 1: FFR (Fractional Flow Reserve)

Q:
Is Fractional flow reserve (FFR) assigned with a cardiac catheterisation with angiogram code OR coronary angiogram only (ie no catheterisation) code?

A:
In previous editions, FFR was inherent in codes from block [668], as it was commonly performed in conjunction with coronary interventions and there was no appropriate ACHI code. A unique code for FFR was created for Tenth Edition.

The code also instruction at 38241-00 [668] states:

- **Code also when performed:**
  - coronary:
    - angiography (38215-00, 38218-00, 38218-01, 38218-02 [668])
    - angioplasty (see blocks [669], [670] and [671])

Therefore, assign 38241-00 [668] Coronary artery blood flow measurement (for FFR) in addition to any other procedures listed in the code also instruction, as appropriate to the documented case.

Published 15 September 2017,
for implementation 01 October 2017.
Q: What code is assigned for obesity without a BMI documented?
A: For obesity NOS, assign E66.90 *Obesity, not elsewhere classified, body mass index [BMI] not elsewhere classified.*

Follow the Alphabetic Index:

**Obesity** (morbid) (simple) E66.9-

Assign a fifth character by referring to the Tabular List:

<table>
<thead>
<tr>
<th>Fifth Character</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>body mass index [BMI] not elsewhere classified</td>
</tr>
<tr>
<td>1</td>
<td>body mass index [BMI] &gt;= 30 kg/m² to &lt;= 34.99 kg/m² (Obese class I)</td>
</tr>
<tr>
<td>2</td>
<td>body mass index [BMI] &gt;= 35 kg/m² to &lt;= 39.99 kg/m² (Obese class II)</td>
</tr>
<tr>
<td>3</td>
<td>body mass index [BMI] &gt;= 40 kg/m² (Clinically severe obesity)</td>
</tr>
</tbody>
</table>

Note: The terms ‘not elsewhere classified’ apply to residual or unspecified categories; ‘not otherwise specified’ means unspecified or unqualified. Where there is no information regarding the BMI, assign the fifth character ‘0’.

With reference to E66 *Obesity and overweight*, where there is no documentation of a BMI applicable to the fifth characters 1, 2, or 3 then 0 serves as the default character to assign.

Q: Can a code from category E66 *Obesity and overweight* be assigned for a patient with a documented body mass index of 28, but no documentation of ‘obese’ or ‘overweight’?
A: As per the ICD-10-AM Alphabetic index:

**BMI (body mass index)**
- >= 25 kg/m² to <= 29.99 kg/m² E66.3
- >= 30 kg/m² — see *Obesity*
The Alphabetic Index under the lead term *BMI (body mass index)* indicates that the terms obesity and overweight do not need to be documented for a code from category E66 *Obesity and overweight* to be assigned.

**Q:**
Can coders use documentation of a patient’s height and weight to calculate BMI when there is documentation such as "increased BMI"?

**A:**
There are no index entries for increased BMI:

**BMI (body mass index)**
- \( \geq 25 \text{ kg/m}^2 \text{ to } \leq 29.99 \text{ kg/m}^2 \) E66.3
- \( \geq 30 \text{ kg/m}^2 \) — see Obesity

The terms obesity or overweight, or specific BMI values must be documented to assign a code from category E66 *Obesity and overweight*. It is not the responsibility of the clinical coder to calculate the BMI. Where documentation is incomplete (eg documentation of increased BMI without specific values), seek clarification from the clinician.

*Published 15 September 2017, for implementation 01 October 2017.*
Administration of Albumex or plasma with plasmapheresis

Q.
Is a code for administration of albumin (Albumex) or (fresh frozen) plasma assigned in addition to 13750-00 [1892] Therapeutic plasmapheresis?

A.
‘Plasmapheresis’ refers to a range of procedures in which extracorporeal separation of blood components results in a filtered plasma product. In therapeutic plasmapheresis, filtered plasma is discarded and red blood cells with donor plasma or albumin are returned to the patient (Stieglitz 2016).

ACS 0016 General procedure guidelines/Procedure components states:

Do not code procedures which are individual components of another procedure. These components would usually be considered a routine or inherent part of the more significant procedure being performed.

Therefore, an additional ACHI code is not required for the administration of Albumex (albumin) or plasma, as it is a component of therapeutic plasmapheresis.


Published 15 September 2017, for implementation 01 October 2017.
Breast carcinoma no specific/special type (NST)

Q:
What is the correct morphology code to assign where there is documentation of breast carcinoma of no specific/special type (NST)?

A:
Breast carcinoma of no specific/special type (NST), also known as ductal carcinoma NST, is an invasive (infiltrating) breast tumour where the cells are not able to be identified as a specific histological type.

Where there is documentation of breast carcinoma NST, assign M8500/3 *Infiltrating duct carcinoma NOS* or M8500/6 *Infiltrating duct carcinoma NOS, metastatic* as appropriate.

Amendments to the Alphabetic Index will be considered for a future edition.

Published 15 September 2017, for implementation 01 October 2017.
Admission for induction following termination of pregnancy at another facility.

Q:
What abortion code is assigned when a patient is admitted following intra-amniotic injection for termination of pregnancy (TOP) at another facility?

A:
Historically, patients were admitted to a facility for a medical abortion (termination of pregnancy (TOP)), and the procedure completed within the episode of care. A change of practice means that some patients present to one facility for intra-amniotic TOP (as outpatients), and are admitted to another facility the following day for induction to expel the dead fetus.

Assign codes for medical abortion for the admitted episode of care, as per the guidelines in ACS 1511 Termination of pregnancy.

Amendments will be considered for a future edition.

Published 15 September 2017,
for implementation 01 October 2017.
Total laparoscopic abdominal hysterectomy with removal of adnexa, and pelvic lymph node dissection

Q:
What codes are assigned for total laparoscopic abdominal hysterectomy with removal of adnexa (fallopian tube(s) and/or ovary(ies)), and pelvic lymph node dissection?

A:
Where total laparoscopic abdominal hysterectomy with removal of adnexa (fallopian tube(s) and/or ovary(ies)) and pelvic lymph node dissection is documented, assign:

35670-00 [1268] Abdominal hysterectomy with radical excision of pelvic lymph nodes
30390-00 [984] Laparoscopy

Follow the Alphabetic Index:

Hysterectomy
- abdominal (total)
  - - with
    - - - dissection of pelvic lymph nodes 35670-00 [1268]

Assign the code for laparoscopy as per the guidelines in ACS 0023 Laparoscopic/arthroscopic/endoscopic surgery.

Amendments are in progress for ACHI Eleventh Edition.

Published 15 June 2017, for implementation 01 July 2017.
Alcoholic cirrhosis of liver and alcoholic liver failure

Q:
Can K70.3 *Alcoholic cirrhosis of liver* and K70.4 *Alcoholic hepatic failure* be assigned together in an episode of care?

A:
K70.3 *Alcoholic cirrhosis of liver* and K70.4 *Alcoholic hepatic failure* are not mutually exclusive. Therefore, both codes can be assigned for these conditions if they meet the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*.

Published 15 June 2017, for implementation 01 July 2017.
Hepatic encephalopathy and alcoholic hepatic encephalopathy

Q:

What codes are assigned for hepatic encephalopathy and alcoholic hepatic encephalopathy?

A:

**Hepatic encephalopathy** is a complication of severe hepatic failure or cirrhosis where the liver can no longer adequately remove toxins from the blood resulting in a build-up of toxins in the bloodstream that may lead to confusion, strange behaviours or mood changes and in severe cases leads to brain damage.

**Alcoholic hepatic encephalopathy** is the above condition due to alcohol use/abuse.

Note also that **alcoholic encephalopathy** (classified to G31.2 *Degeneration of nervous system due to alcohol*) is encephalopathy caused by alcohol toxicity, or thiamine deficiency due to the effects of alcohol, but without liver disease (Canadian Liver Foundation 2016, Wolf 2017).

The ICD-10-AM Conventions used in the Tabular List of diseases/Multiple condition coding state:

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

Therefore:

- for **hepatic encephalopathy** not otherwise specified (NOS) assign:

  G93.4 *Encephalopathy, unspecified*

  And

  K72.9 *Hepatic failure, unspecified*

- for **alcoholic hepatic encephalopathy**, follow the cross reference in the Alphabetic Index:

  *Encephalopathy* G93.4
- hepatic (see also Failure/hepatic)

Failure, failed

- hepatic

- alcoholic (acute) (chronic) (subacute) (with or without hepatic coma) K70.4

assign:

G93.4 Encephalopathy, unspecified

and

K70.4 Alcoholic hepatic failure

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

References:

Canadian Liver Foundation, Hepatic Encephalopathy 2016, liver.ca, Markham, viewed 9 June 2016 http://www.liver.ca/liver-disease/types/cirrhosis/hepatic-encephalopathy.aspx


Published 15 June 2017, for implementation 01 July 2017.
T-cell therapy

Q:
How do you code T-cell therapy?

A:
T-cells are a type of white blood cell that play an essential role in cell-mediated immunity.

T-cell therapy, also known as chimeric antigen receptor (CAR) T-cell therapy or adoptive cell transfer (ACT) immunotherapy, involves collecting T-cells via apheresis and genetically modifying them in a laboratory to produce chimeric antigen receptors (CARs) on their surface. CARs are proteins that allow T-cells to recognise a specific protein (antigen) on tumour cells.

When infused back into the patient’s bloodstream, the reengineered CAR T-cells destroy tumour cells that contain the antigen on their surfaces. CAR T-cells may remain in the body long after the infusion has been completed, and may protect the patient against cancer recurrence, resulting in long-term remissions.

For collection of T-cells via apheresis, assign 13750-01 [1892] Therapeutic leukopheresis by following the Alphabetic Index:

Leukopheresis, therapeutic (leukocytapheresis) 13750-01 [1892]

For infusion of the reengineered CAR T-cells (T-cell therapy), assign 13706-04 [1893] Administration of leukocytes by following the Alphabetic Index:

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

- type of agent

- - white cells (donor leukocytes) 13706-04 [1893]

Amendments to ACHI will be considered for a future edition.

Published 15 June 2017, for implementation 01 July 2017.
Fetal scalp blood sampling (for lactate or pH)

Q:
What code is assigned for fetal scalp lactate or fetal scalp pH?

A:
Fetal scalp lactate is a blood sample taken from the fetal scalp vessels during labour to measure lactate levels. Blood lactate levels are used to predict intrapartum fetal hypoxia (hypoxic ischaemic encephalopathy (HIE)) in conjunction with electronic fetal monitoring.

Fetal blood sampling may also be performed to measure blood pH levels.

Assign 16606-00 [1330] Fetal blood sampling by following the Alphabetic Index:

Sampling
- fetal blood 16606-00 [1330]

Amendments to ACHI will be considered for a future edition.

Published 15 June 2017, for implementation 01 July 2017.
Unintentional event (misadventure) code for ‘failed intubation’

Q:
What is the external cause code (unintentional event/misadventure) for failed intubation?

A:

It is acknowledged that the indexing and classification of *unintentional event/misadventure due to endotracheal tube* is inconsistent and confusing.

Documentation of ‘failed intubation’ indicates that the external cause is due to complication/unintentional event (misadventure) due to endotracheal intubation. The absence of an endotracheal tube during general anaesthesia is equivalent to ‘failure to intubate/failure to introduce an endotracheal tube’

The indexing and classification of Y65.3 and Y65.4 is based on ICD-10. Both codes are listed in the same rubric; Y65.3 is a more specific option:

Y65.3 *Endotracheal tube wrongly placed during anaesthetic procedure*

Y65.4 *Failure to introduce or to remove other tube or instrument*

‘Failure to introduce endotracheal tube (failed intubation) during anaesthetic procedure’ is classified to Y65.3, as indicated by the NEM in the Alphabetic Index:

**Failure**

- to

- - introduce tube or instrument *(except endotracheal tube during anaesthesia)* Y65.4

... 

- - remove tube or instrument *(except endotracheal tube during anaesthesia)* Y65.4

Therefore, when:

‘failed intubation during anaesthetic procedure’ is documented, assign Y65.3 *Endotracheal tube wrongly placed during anaesthetic procedure* as the external cause

‘failed intubation’ is documented, but it is not during an anaesthetic procedure, assign Y65.4 *Failure to introduce or to remove other tube or instrument* as the external cause.

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

Published 15 June 2017, for implementation 01 July 2017.
Carrier of drug resistant microorganisms

Q:

What codes are assigned for carrier of/colonisation with drug resistant microorganisms such as Vancomycin Resistant *Enterococcus* (VRE) or Methicillin Resistant *Staphylococcus aureus* (MRSA), without current infection?

A:

Where a patient is a carrier of a drug resistant microorganism, and it meets the criteria in ACS 0002 *Additional diagnoses*, assign a code from Z22 *Carrier of infectious disease* and apply the *Instructional note* (*Use additional code to identify resistance to antimicrobial drugs* (Z06.5–Z06.7-)).

For example:

For carrier of Vancomycin Resistant *Enterococcus* (VRE), such as a patient with VRE positive urine without documentation of a urinary tract infection (UTI), requiring full contact precautions and reviews by the Infection Control team, assign:

*Z22.3 Carrier of other specified bacterial diseases*

and

*Z06.61 Resistance to vancomycin.*

For carrier of Methicillin Resistant *Staphylococcus aureus* (MRSA), such as a patient with a groin swab positive for MRSA, requiring full contact precautions and isolation, assign:

*Z22.3 Carrier of other specified bacterial diseases*

and

*Z06.52 Resistance to methicillin.*

Published 15 June 2017,
for implementation 01 July 2017.
Laparoscopic biopsy of uterine serosa

Q:
What code is assigned for laparoscopic biopsy of lesion (eg granulation or cyst) of uterine serosa?

A:
There are three uterine layers; endometrium (inner layer), myometrium (middle/muscle layer), and perimetrium/serosa (outer layer that covers the uterus).

For laparoscopic biopsy of uterine serosa, assign 90452-00 [1266] **Excision of other lesion of uterus** as a best fit, by following the Alphabetic Index:

**Excision** — see also Removal
- lesion(s) — see also Excision/tumour AND Excision/cyst AND Excision/polyp
- - uterus 90452-00 [1266]

Assign 30390-00 [984] **Laparoscopy** as per the guidelines in ACS 0023 **Laparoscopic/arthroscopic/endoscopic surgery**.

Amendments to ACHI will be considered for a future edition.

Published 15 June 2017,
for implementation 01 July 2017.
Socket moulding

Q:
What code is assigned for socket moulding post enucleation of the eye?

A:
Socket moulding is an impression of the eye socket taken to create a permanent artificial eye following enucleation of the eyeball. The mould is used to match the colour, appearance, shape and thickness of the other eye. Socket moulding may be performed at a clinic or in the hospital, and general anaesthesia is usually required when performed for children.

Assign 96091-00 [1870] Manufacture of assistive or adaptive device, aid or equipment, following the Alphabetic Index:

Casting
- assistive or adaptive device, aid or equipment 96091-00 [1870]

Amendments to ACHI will be considered for a future edition.

Published 15 March 2017,
for implementation 01 April 2017.
Gestational diabetes mellitus with hypoglycaemia

Q:
How do you code gestational diabetes mellitus with hypoglycaemia?

A:
The guidelines in ACS 0401 Diabetes mellitus and intermediate hyperglycaemia/Gestational diabetes mellitus (GDM) indicate that GDM is classified to O24.4- Diabetes mellitus arising during pregnancy. Follow the Alphabetic Index:

Hypoglycaemia (spontaneous) E16.2
- with diabetes (mellitus) — see Diabetes, diabetic

Diabetes, diabetic
- gestational O24.4-

OR

Pregnancy
- complicated by
  - - diabetes (mellitus)
  - - - gestational O24.4-

There is no subcategory for GDM with hypoglycaemia as there is for diabetes mellitus type 1, type 2, other, and unspecified (E1-.64 *diabetes mellitus with hypoglycaemia), therefore assign:

O24.4- Diabetes mellitus arising during pregnancy

E16.2 Hypoglycaemia, unspecified

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

Published 15 March 2017,
for implementation 01 April 2017.
Goldilocks mastectomy

Q:

How do you code Goldilocks mastectomy?

A:

Goldilocks mastectomy is a procedure that uses autologous cutaneous mastectomy tissue to form a mound, negating the need for an additional flap or insertion of an implant.

Assign a code for subcutaneous mastectomy as a best fit by following the Alphabetic Index:

Mastectomy
- subcutaneous (unilateral) 31524-00 [1747]
- - bilateral 31524-01 [1747]
31524-00 [1747] Subcutaneous mastectomy, unilateral
31524-01 [1747] Subcutaneous mastectomy, bilateral

 Amendments to ACHI will be considered for a future edition.

Published 15 March 2017, for implementation 01 April 2017.
Place of occurrence, water NOS

Q:

What place of occurrence code is assigned for water NOS?

A:

Place of occurrence codes for specific types of water are located in Y92.8 Other specified place of occurrence:

Y92.80  Area of still water
Y92.81  Stream of water
Y92.82  Large area of water
Y92.83  Beach

Assign Y92.88 Other specified place of occurrence for water NOS by following the External Causes of Injury Alphabetic Index:

Place of occurrence of external cause Y92.9

- specified NEC Y92.88

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

Published 15 March 2017, for implementation 01 April 2017.
Single delivery assisted by forceps and McRoberts manoeuvre

Q:
How do you code a single delivery where forceps and McRoberts manoeuvre are used to assist the delivery? For example, forceps delivery of head followed by delivery of shoulder and arm via McRoberts manoeuvre.

A:
The following is of note when selecting an appropriate code from O80-O84 Delivery:

Each of the above categories are mutually exclusive

O80 Single spontaneous delivery is never assigned if a delivery assistance procedure has been performed

O81 Single delivery by forceps and vacuum extractor is assigned if delivery is completed using forceps or vacuum extractor. The exception is where forceps are used to rotate the fetal head only, but delivery is not completed using forceps

O82 Single delivery by caesarean section is assigned if delivery is completed by caesarean section, regardless of whether forceps or a vacuum extraction has been attempted, or any other assistance procedure has been performed

O83 Other assisted single delivery is assigned if delivery is assisted by any method other than by forceps or vacuum extractor (assign O81) or caesarean section (assign O82). This includes where forceps are used but fail, or are used to rotate the fetal head only, but delivery is not completed using forceps.

In the cited scenario (forceps delivery of head followed by delivery of shoulder and arm via McRoberts manoeuvre) the delivery was assisted using forceps.

Assign O81 Single delivery by forceps and vacuum extractor by following the ICD-10-AM Alphabetic Index:

Delivery
- assisted
  - by
    - forceps or vacuum extractor O81

Published 15 December 2016, for implementation 01 January 2017.
Respiratory Distress, unspecified

Q:
Does the statement in ACS 1614 Respiratory distress syndrome/hyaline membrane disease/surfactant deficiency regarding unspecified respiratory distress mean that P22.9 Respiratory distress of newborn, unspecified should never be assigned?

A:
Respiratory distress in newborns may have many causes including transient tachypnoea of the newborn, respiratory distress syndrome (RSD)/hyaline membrane disease, meconium aspiration syndrome, infections or underlying congenital heart defects.

ACS 1614 Respiratory distress syndrome/hyaline membrane disease/surfactant deficiency states:

*The term 'respiratory distress unspecified' should not be coded as such, as it is considered a symptom not a diagnosis. Further information regarding a definitive diagnosis should be sought from the clinician.*

That is, where documentation or clinical advice is available to identify the cause of the symptom ‘respiratory distress’, assign a code for the underlying cause (see examples above). Where there is no confirmation of an underlying cause, assign P22.9 Respiratory distress of newborn, unspecified as a last resort by following the Alphabetic Index:

**Distress**

- respiratory

- - newborn P22.9

*Published 15 December 2016, for implementation 01 January 2017.*
Drainage of parapharyngeal abscess

Q:
What is the correct code to assign for drainage of parapharyngeal abscess?

A:
In the absence of a specific code or index entries for drainage of parapharyngeal abscess, clinical advice supports the assignment of either of the following codes (as appropriate) as a best fit:

31409-00 [421] Excision of parapharyngeal lesion by cervical approach

31412-00 [421] Excision of recurrent or persistent parapharyngeal lesion by cervical approach

Amendments to ACHI will be considered for a future edition.

Published 15 December 2016,
for implementation 01 January 2017.
Stretta procedure

Q:
What code is assigned for Stretta procedure?

A:
Stretta procedure is performed for the treatment of gastro-oesophageal reflux disease (GORD). It involves radiofrequency (thermal) ablation of the lower oesophageal sphincter (LOS) and gastric cardia, via endoscopy. The thermal energy creates a lesion in the oesophagus, causing the treated area to swell and stiffen as it heals, resulting in an increased thickening of the LOS. The altered LOS, when closed, prevents stomach acid and contents from flowing back up to the oesophagus, thus eliminating GORD symptoms.

Assign 30478-22 [856] Endoscopic destruction of lesion or tissue of oesophagus for Stretta procedure by following the Alphabetic Index:

Oesophagoscopy

- with
  - - radiofrequency (Halo) ablation 30478-22 [856]

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

Published 15 December 2016,
for implementation 01 January 2017.
TransPyloric Shuttle insertion

Q:
What procedure code is assigned for TransPyloric Shuttle insertion?

A:
The TransPyloric Shuttle (TPS®) is a device used to treat obesity. The device is inserted endoscopically into the stomach and consists of a large spherical bulb connected by a silicone tether that passes through the pylorus to a smaller cylindrical bulb in the duodenum. The large bulb prevents the device from migrating out of the stomach, and intermittently creates a seal at the pylorus to delay partially digested food and gastric juices from flowing into the duodenum. This device causes the stomach to fill up faster, and prolongs appetite satiety which reduces the overall calorie intake resulting in weight loss.

Assign 90950-02 [889] *Endoscopic insertion of device into stomach* for the endoscopic insertion of a TransPyloric Shuttle for the treatment of obesity by following the Alphabetic Index:

**Insertion**
- device
- stomach, for obesity (endoscopic) *(see also Banding/gastric, for obesity)* 90950-02 [889]

Amendments to ACHI will be considered for a future edition.

*Published 15 December 2016,*
*for implementation 01 January 2017.*
Removal of a bone anchored hearing aid (BAHA) implant

Q: What is the correct ACHI code to assign for the removal of BAHA titanium implants?

A: The removal of bone anchored hearing aids (BAHA) is usually performed due to skin reactions, for example flap necrosis, granulation or hyperplasia of skin around the implant site, or infection.

Assign 92202-00 [1908] Removal of therapeutic device, not elsewhere classified as a best fit, by following the Alphabetic Index:

Removal — see also Excision
- device
  - therapeutic NEC 92202-00 [1908]

A review of the classification of BAHA will be considered for a future edition of ACHI.

Published 15 December 2016,
for implementation 01 January 2017.
Candidiasis of vulva and/or vagina complicating pregnancy

Q:
What is the correct code to assign from Chapter 15 *Pregnancy, childbirth and the puerperium* for candidiasis of vulva and/or vagina complicating pregnancy?

A:
Assign the following codes for candidiasis of vulva or vagina:

*O23.5 Infections of the genital tract in pregnancy*
*B37.3† Candidiasis of vulva and vagina*
*N77.1* Vaginitis, vulvitis and vulvovaginitis in infectious and parasitic diseases classified elsewhere

as per the Alphabetic Index:

**Pregnancy** (single) (uterine)

...-

- complicated by
- - infection(s)
- - - genital organ or tract O23.5

**Candidiasis, candidal** B37.9

...

- vagina B37.3† N77.1*
- vulva B37.3† N77.1*
- vulvovaginitis B37.3† N77.1*

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

Published 15 September 2016,
for implementation 01 October 2016.
Check cystoscopy for transitional cell carcinoma (TCC) of the bladder

Q:
What codes are assigned where a different site of the bladder or a different morphological behaviour of TCC in the bladder is found at check cystoscopy?

A:
Transitional cell carcinoma (TCC) of the bladder is a cancer that forms in the lining or urothelium of the bladder. The tumours are commonly superficial with a tendency to recur anywhere in the bladder; therefore surveillance of the bladder (check cystoscopy) is performed regularly after the initial diagnosis.

Follow the guidelines in:

ACS 0052 *Same-day endoscopy – Surveillance*:

Assign as principal diagnosis:

- the condition under surveillance (follow-up/screening) if detected at screening

and

ACS 0237 *Recurrence of malignancy*:

If the primary malignancy previously eradicated has recurred, assign a code for the original primary site using the appropriate code from C00-C75.

Therefore, where a check cystoscopy is performed for previous TCC (M8120/3) of the bladder, and a TCC with the same morphology (M8120/3), but of a different site of the bladder is found, assign as principal diagnosis TCC of the original primary site, with morphology M8120/3.

For example:

TCC of dome of bladder diagnosed six months ago. TCC of bladder wall found at check cystoscopy. Assign:

C67.1 *Malignant neoplasm of dome of bladder*

M8120/3 *Transitional cell carcinoma NOS*

Where a check cystoscopy is performed for previous TCC (M8120/3) of the bladder, and an in situ TCC (M8120/2) of (any site within) the bladder is found, this is also considered a recurrence of the malignancy (that is, the morphology is the same, only the behaviour is different). Therefore, assign as principal diagnosis TCC of the original primary site, with morphology M8120/3.

For example:

TCC of dome of bladder diagnosed six months ago. In situ TCC of bladder wall found at check cystoscopy. Assign:

C67.1 *Malignant neoplasm of dome of bladder*

M8120/3 *Transitional cell carcinoma NOS*

Note: if a neoplasm is found at check cystoscopy with a different histological type/morphology (eg. previous TCC (M8120/3) with a papillary in situ TCC (M8130/2) found at follow-up), this is not considered a recurrence of the original neoplasm. In this scenario assign the appropriate in situ codes.
The classification and sequencing of neoplasms will be reviewed for a future edition.

See also, Coding Rule, *Recurrence of transitional cell carcinoma (TCC) of the bladder*, published 15 December, 2011 - note ‘recurrence’ does not need to be specifically documented to follow the advice in this Coding Rule.

Published 15 September 2016,
for implementation 01 October 2016.
Coronary angiogram following failed initial access

Q:

What codes are assigned for a coronary angiogram where initial arterial access is abandoned and another artery must be used to complete the procedure?

A:

There are a number of vascular access options for coronary angiography (eg femoral, radial, brachial arteries). Right transfemoral approach is often utilised due to the large diameter of the artery. An alternative to the selected approach is necessary if difficulties with access are encountered.

Failure of one access site and hence use of an alternative site (eg failure to advance the guidewire following needle puncture of the right femoral artery with subsequent successful performance of the procedure via the left femoral artery) is considered routine practice for percutaneous coronary interventions (see ACS 0016 General procedure guidelines/Procedure components).

In the above scenario, it is not the angiogram that is abandoned, just the approach. Therefore, ACS 0019 Procedure not completed or interrupted does not apply.

Assign ACHI codes only for the successful procedure performed.

Published 15 September 2016, for implementation 01 October 2016.
Intra-tympanic dexamethasone (IT dexa)

Q:
What is the appropriate code for intra-tympanic administration of dexamethasone or other pharmacological agent?

A:
Intra-tympanic (IT) administration of pharmacological agents such as dexamethasone and gentamicin are used in the treatment of inner ear disorders such as Meniere’s disease and autoimmune or sensorineural hearing loss.

Administration is a simple injection via myringotomy, tympanostomy tube or microwick, which delivers the pharmacological agent directly to the middle ear (round window membrane).

For IT administration of pharmacological agents to the middle ear (round window membrane) assign 90114-00 [316] Other procedures on eardrum or middle ear following the Alphabetic Index:

Procedure
- ear
  - - middle NEC 90114-00 [316]

Amendments to ACHI will be considered for a future edition.

Published 15 June 2016,
for implementation 01 July 2016.
Implantation of bone conduction hearing devices

Q:
What codes should be assigned for implantation of bone conduction hearing devices?

A:
A bone conduction hearing aid consists of a hearing aid worn behind the ear coupled with an electromagnetic bone conductor/vibrator. These devices are not bone anchored.

Bone conduction aids may be the best option for children who cannot wear a conventional aid due to the following:

- ear/s have not developed normally and parts of the outer or middle ear are missing or too small to fit the device,
- constantly discharging ears,
- severe irritation or inflammation in the external canal.

A bone conduction hearing aid is classified to 41557-02 [321] Implantation of electromagnetic hearing device by following the Alphabetic Index:

Insertion
- hearing device
  - - bone conduction 41557-02 [321]
  ...
  - - electromagnetic 41557-02 [321]

The bone anchored hearing aid or ‘BAHA’ system utilises a titanium implant which is placed in the skull bone behind the non-functioning ear. An abutment connects the sound processor with the implant in the bone. This creates direct (percutaneous) bone conduction.

BAHA may be performed as a one stage or two stage surgery. This decision is based on several factors including the thickness and quality of the cortical bone as well as the patient’s age. Generally, for patients with good bone quality and thickness greater than 3 mm, surgery in a single operative episode is recommended. However, in patients with compromised or soft bone, irradiated bone, bone thickness less than 3 mm, special needs patients (e.g. mentally or physically compromised) or in conjunction with other surgery (e.g. acoustic neuroma removal) two stages is generally recommended.

As per ACS 1220 Extraoral osseointegrated implants:

Stage one BAHA surgery is classified to 45794-00 [1698] Osseointegration procedure, implantation of titanium fixture for attachment of bone anchored hearing aid [BAHA] by following the Alphabetic Index:

Osseointegration
- extraoral
  - - implantation of titanium fixture (1st stage)
  - - - for
  - - - - attachment of
- - - - - bone anchored hearing aid (BAHA) 45794-00 [1698]

Stage two BAHA surgery is classified to 45797-00 [1697] Osseointegration procedure, fixation of transcutaneous abutment for attachment of bone anchored hearing aid [BAHA] by following the Alphabetic Index:

**Osseointegration**

- extraoral

- - fixation of transcutaneous abutment (2nd stage)

- - for attachment of

- - - - bone anchored hearing aid (BAHA) 45797-00 [1697]

Where both ‘stages’ of the BAHA are completed in one operative visit assign both codes. Do not assign 41557-02 [321] Implantation of electromagnetic hearing device with BAHA surgery.

Clinical coders should be guided by the entire operation report, not abbreviations or brand names.

Improvements to the classification of bone conduction and bone anchored hearing aids will be considered for a future edition of ACHI.

Published 15 June 2016, for implementation 01 July 2016.
Endotracheal administration of surfactant

Q:
Should endotracheal intubation be assigned when surfactants, such as Curosurf, are administered via an endotracheal tube?

A:
Curosurf is a natural surfactant, prepared from porcine lungs and used in the treatment of respiratory distress syndrome (RDS) in premature babies. Surfactants are wetting agents that coat the surface of the air sacs (alveoli) and reduce surface tension in the lungs which assists the air sacs to inflate and expand during breathing and stops them sticking together. Administration of surfactants helps premature neonates breathe until their lungs have developed enough to produce their own surfactant.

Surfactants, such as Curosurf, may be given directly into the lungs via an endotracheal tube in a ventilated neonate, or administered prophylactically through an endotracheal tube without ventilation. ACS 1614 Respiratory distress syndrome/hyaline membrane disease/surfactant deficiency states:

Surfactant is administered routinely for the treatment of respiratory distress syndrome of the newborn and should not be coded (see ACS 0042 Procedures normally not coded, point 8).

Endotracheal intubation as the route of administration for a surfactant is not coded unless it proceeds to ventilation.

Published 15 June 2016, for implementation 01 July 2016.
Turbinoplasty

Q: What is the correct code to assign for a turbinoplasty?

A: During a turbinoplasty, the turbinates are reshaped either by outfracturing or submucosal resection or a combination of the two methods. Both involve removal of turbinate tissue (ie a partial turbinectomy) via different mechanisms.

ACHI does not have a specific code for turbinoplasty, therefore assign code(s) according to the documentation within the operation report:

- 41692-00 [376] Submucous resection of turbinate, unilateral
- 41692-01 [376] Submucous resection of turbinate, bilateral
- 41686-00 [381] Surgical fracture of nasal turbinates, unilateral
- 41686-01 [381] Surgical fracture of nasal turbinates, bilateral
- 41689-00 [376] Partial turbinectomy, unilateral
- 41689-01 [376] Partial turbinectomy, bilateral

If outfracturing (surgical fracture) or submucous resection is not specified assign 41689-00 [376] Partial turbinectomy, unilateral or 41689-01 [376] Partial turbinectomy, bilateral following the Alphabetic Index:

Turbinectomy

- partial (unilateral) 41689-00 [376]
- - bilateral 41689-01 [376]

However, if a turbinoplasty (by any method) is performed in conjunction with a septoplasty assign 41671-02 [379] Septoplasty or 41671-03 [379] Septoplasty with submucous resection of nasal septum; as turbinectomy is included within these codes as per the Includes notes.
Amendments to ACHI will be considered for a future edition.

Published 15 June 2016,
for implementation 01 July 2016.
**Excision of umbilicus**

**Q:**
What is the correct code to assign for excision of the umbilicus?

**A:**
As ACHI classifies other procedures on the umbilicus to the *Abdomen, Peritoneum and Omentum* assign 90331-00 [1004] *Other procedures on abdomen, peritoneum or omentum* following the Alphabetic Index:

**Procedure**
- abdomen NEC 90331-00 [1004]

Amendments for excision of umbilicus will be considered for a future edition of ACHI.

*Published 15 June 2016, for implementation 01 July 2016.*
Lipiodol (poppy seed oil) tubal flushing

Q:
What procedure code should be assigned for Lipiodol flush?

A:
Lipiodol tubal flushing is a procedure that bathes the fallopian tubes (and uterus) in Lipiodol (poppy seed oil) (Repromed 2016).

Several theories exist on how Lipiodol is thought to enhance pregnancy rates, including flushing of non-occlusive but pregnancy-hindering debris from fallopian tubes; positively influencing the intraperitoneal environment; improving either the environment in which eggs mature or the sperm-egg interaction; or by enhancing implantation through a direct effect on the endometrium (Reilly Johnson 2010).

The correct code to assign for Lipiodol tubal flushing is 35703-01 [1248] Therapeutic hydrotubation by following the Alphabetic Index:

Hydrotubation
- fallopian tube
  - therapeutic 35703-01 [1248]

If Lipiodol flushing is conducted with other gynaecology procedures e.g. hysteroscopy, code other procedures as appropriate.

Improvements will be considered for a future edition of ACHI.

References:


Published 15 June 2016, for implementation 01 July 2016.
Endometrial Scratch

Q:

What is the correct code to assign for an endometrial scratch?

A:

Research suggests that by ‘scratching’ the endometrium the chemical conditions in the endometrium are more beneficial to an implanting embryo. It is thought that a repair process begins and this allows the release of a group of chemicals called growth factors in the endometrium, and it is these chemicals that increase the chances of a pregnancy (Woodhead 2014).

Assign 13215-03 [1297] Other reproductive medicine procedure for endometrial scratch by following the Alphabetic index:

Procedure

- for

- - reproductive medicine (in vitro fertilisation) NEC 13215-03 [1297]

Amendments to ACHI will be considered for a future edition.

References:


Published 15 June 2016,
for implementation 01 July 2016.
Wound debridement

Q:
Can a debridement of a wound in theatre be coded as a soft tissue debridement?

A:

ACS 1203 Debridement, states:

- *most debridements are excisional*
- *check with the clinician if unsure*
- *use the nonexcisional code if documentation/clinical advice supports its use*

Therefore, a wound taken to theatre for debridement is assumed to be excisional unless there is documentation or clinical advice that supports assignment of a code for nonexcisional debridement. The advice in ACS 1203 effectively defaults classification of wound debridement to excisional. However, there is no default position as to whether the excisional debridement is of soft tissue or skin and subcutaneous tissue.

ACS 1916 Superficial and soft tissue injuries defines soft tissue (deep tissue) as tissue that:

> connects, supports or surrounds other structures and organs of the body. Soft tissue includes muscles, nerves, tendons, fat, blood or lymph vessels, fasciae and tissue around joints (synovial tissue) (that is, all tissue excluding skin, subcutaneous tissue, cartilage and bone).

Where documentation in the clinical record, in particular the operation report, states that debridement was of ‘soft tissue’, ‘deep tissue’ or soft tissue structures assign 30023-00 [1566] Excisional debridement of soft tissue by following the Alphabetic Index:

**Debridement**
- soft tissue, excisional NEC 30023-00 [1566]

In the absence of documentation to support that any deep or soft tissue structures have been debrided, or if only subcutaneous tissues are documented as having been debrided (and there is no indication it is nonexcisional), assign 90665-00 [1628] Excisional debridement of skin and subcutaneous tissue by following the index pathway:

**Debridement**
- skin
  - - excisional 90665-00 [1628]

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

Published 15 March 2016, for implementation 01 April 2016.
Traumatic neuroma due to surgery

Q:
What is the correct diagnosis code to assign for a traumatic neuroma due to surgery?

For example, a patient was admitted post brow lift with wound swelling. The wound was excised and the histopathology report found traumatic neuroma.

A:
The correct code to assign for traumatic neuroma due to surgery in the scenario cited is G97.8
Other intraoperative and postprocedural disorders of the nervous system following the index pathway:

Complication(s)
- nervous system
  - - intraoperative or postprocedural
    - - - specified NEC G97.8

ACS 1904 Procedural complications states:

An additional code from Chapters 1 to 19 should be assigned where it provides further specificity.

In the scenario cited, no additional code provides further specificity and thus no additional code is assigned.

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

Published 15 March 2016,
for implementation 01 April 2016.
ACS 0002 Additional diagnoses and alteration to treatment - Part 2

Q:

Should a condition be assigned as an additional diagnosis whenever medication is altered or only when the medication is altered for management of that condition (ie not management of a side effect). The Coding Rules Anticoagulation monitoring (15 June 2010) and ACS 0002 Additional diagnoses and alteration to treatment (15 June 2015) appear to contradict.

A:

The advice published 15 June 2010, Anticoagulation monitoring, is still current and should be followed i.e. assign Z92.1 Personal history of long term (current) use of anticoagulants to reflect alteration to anticoagulants as detailed in the Coding Rule. However, the advice is specific to anticoagulants and should not be applied to other conditions or scenarios. Changes to the classification of anticoagulation therapy are being implemented for Tenth Edition when this advice will be retired.

Where medication to treat a specific condition is altered during an episode of care, assign an additional diagnosis code for the condition by following the criteria in ACS 0002 Additional diagnoses, dot point 1, which states:

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

- commencement, alteration or adjustment of therapeutic treatment

Although alteration to medication may be related to management of a side effect of the medication, the therapeutic treatment of the condition is still being altered and so meets the criterion above to be assigned as an additional diagnosis.

A review of the criteria for assignment of additional diagnoses in ACS 0002 is planned for the future, following analysis of the Supplementary codes for chronic conditions (U codes) data.

Published 15 March 2016,
for implementation 01 April 2016.
Chondroplasty of wrist

Q:
What is the correct code to assign for chondroplasty of the wrist?

A:
There is no specific code in ACHI for chondroplasty of the wrist, however ACHI classifies chondroplasty of other sites to blocks for ‘other repair procedures’.
Therefore assign 90542-00 [1468] Other repair of wrist following the index pathway:

Repair
- wrist NEC 90542-00 [1468]

Where chondroplasty of the wrist is performed arthroscopically, also assign 49218-00 [1443] Arthroscopy of wrist, as per ACS 0023 Laparoscopic/arthroscopic/endoscopic surgery.

Amendments to ACHI Alphabetic Index will be considered for a future edition of ACHI

Published 15 March 2016, for implementation 01 April 2016.
ACS 0011 Admission for surgery not performed

Q:
What is the principal diagnosis for a same day episode of care, where the procedure is cancelled due to another condition, and that condition is investigated or treated, but the patient is still discharged that same day?

A:

ACS 0011 Admission for surgery not performed lists three examples with codes for conditions that are the reason for cancellation of an elective procedure:

- In examples 2 and 4 the conditions listed as the reason for cancellation do not meet the criteria in either ACS 0001 Principal diagnosis or ACS 0002 Additional diagnoses, as they do not require admitted patient care. These conditions are coded to indicate the reason for the cancellation of the procedure and are sequenced after the relevant code from category Z53 Persons encountering health services for specific procedures, not carried out.

- Example 5 differs in that the pneumonia meets the criteria for assignment in ACS 0001 Principal diagnosis. That is, the pneumonia is chiefly responsible for occasioning the episode of admitted patient care.

Other examples include:

- Patient with osteoarthritis admitted for arthroscopy of the knee. The procedure is cancelled when the patient complains of chest pain on admission. The patient was seen by a cardiologist, and blood tests and ECG were performed, but no cause was found for the chest pain. The patient was discharged later in the day and the arthroscopy was rescheduled. Assign:
  R07.4 Chest pain, unspecified
  M17.1 Other primary gonarthrosis
  Z53.0 Procedure not carried out because of contraindication

- Patient with breast cancer was admitted for same-day chemotherapy. The chemotherapy session was cancelled as the patient was anaemic. The patient was transfused with two units of packed cells and discharged home that afternoon. Assign:
  D64.9 Anaemia, unspecified
  Z51.1 Pharmacotherapy session for neoplasm
  C50.9 Breast, unspecified
  M8000/3 Neoplasm, malignant
  Z53.0 Procedure not carried out because of contraindication

See also ACS 0002 Additional diagnoses/Additional diagnosis reporting referred to in other standards.

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

Published 15 December 2015,
for implementation 01 January 2016.
Prematurity and documentation of gestational age

Q:

Does ‘prematurity’ need to be documented in the clinical record or is documentation of gestational age sufficient to assign codes from P07.2 Extreme immaturity or P07.3 Other preterm infants? Should these codes be routinely assigned or do they need to meet ACS 0002 Additional diagnoses?

A:

Prematurity is a significant indicator of neonatal morbidity and mortality and as such should be documented in the clinical record. However clinicians may use the gestational age to reflect this, particularly for those closer to 37 completed weeks, and not specifically document the term premature.

The Tabular note at P07 Disorders related to short gestation and low birth weight, not elsewhere classified, also reinforces the importance of gestational age by the instruction to give priority of assignment to gestational age over birth weight.

Codes from P07.2- Extreme immaturity and P07.3- Other preterm infants should always be assigned for neonates with a gestational age documented as less than 37 completed weeks.

ACS 1618 Low birth weight and gestational age has been flagged for review for a future edition.

Published 15 December 2015,
for implementation 01 January 2016.
Vacuum assisted wound closure (VAC) Dressings

Q:
Where multiple VAC dressings are applied in an episode, how many times should the code be assigned?

A:
Vacuum assisted wound closure (VAC) is a type of wound dressing which uses negative pressure to promote wound healing. The wound is covered with open cell foam or gauze dressing that moulds to the wound bed. A drainage tube is attached, the wound is then sealed and vacuum or negative pressure is applied via a pump. The suction pressure removes or 'debrides' loose tissue and has been shown to reduce swelling, aid wound closure and promote formulation of granulation tissue.

Dressings are routine treatment for burns, wounds and ulcers, however vacuum dressings are not, nor are they a routine part of any significant procedure being performed. ACHI classifies vacuum dressings as nonexcisional debridement:

90686-01 [1628] Nonexcisional debridement of skin and subcutaneous tissue

or

90686-00 [1627] Nonexcisional debridement of burn.

Do not apply the guidelines in ACS 0020 Bilateral /multiple procedures, ACS 1203 Debridement or ACS 1911 Burns when coding vacuum dressings, instead apply the following guidelines for their application or replacement (change):

• when performed with cerebral anaesthesia (including that with excisional debridement), assign once for each operating theatre session.
  
  For example:
  
  o Day 1 - excisional debridement of soft tissue of ulcer and application of vacuum dressing performed in theatre under general anaesthetic, assign:

  90665-00 [1628] Excisional debridement of skin and subcutaneous tissue

  and

  90686-01 [1628] Nonexcisional debridement of skin and subcutaneous tissue

  and the appropriate anaesthetic code.

  o Day 5 – change of vacuum dressing performed in theatre under general anaesthesia, assign:

  90686-01 [1628] Nonexcisional debridement of skin and subcutaneous tissue and the appropriate anaesthetic code.

• when performed without cerebral anaesthesia, assign once only for the episode of care
  
  For example:
  
  o Day 1 – patient transferred with vacuum dressing in situ:

  No code is assigned.

  o Day 2 – change of vacuum dressing performed on the ward, assign:
90686-01 [1628] Nonexcisional debridement of skin and subcutaneous tissue, once only.

- **Day 4** – change of vacuum dressing performed on the ward.

  As 90686-01 [1628] Nonexcisional debridement of skin and subcutaneous tissue has already been assigned for this episode, no additional code is required.

- when vacuum dressings are performed with cerebral anaesthesia in an operating theatre and without cerebral anaesthesia on the ward in the same episode of care, assign once for each operating theatre session.

  A code for any change of dressings undertaken on the ward is not required.

  For example:

  - **Day 1** – vacuum dressing applied in operating theatre under general anaesthetic, assign:

    90686-01 [1628] Nonexcisional debridement of skin and subcutaneous tissue

    and the appropriate anaesthetic code.

  - **Day 3** – change of vacuum dressing undertaken on the ward.

    As 90686-01 [1628] Nonexcisional debridement of skin and subcutaneous tissue has already been assigned for this episode, no additional code is required.

  - **Day 5** – change of vacuum dressing undertaken on the ward.

    As 90686-01 [1628] Nonexcisional debridement of skin and subcutaneous tissue has already been assigned for this episode, no additional code is required.

  - **Day 6** – excisional debridement and application of new vacuum dressing in operating theatre under general anaesthetic, assign:

    90665-00 [1628] Excisional debridement of skin and subcutaneous tissue and

    90686-01 [1628] Nonexcisional debridement of skin and subcutaneous tissue

    and the appropriate anaesthetic code.

  - **Day 9** – change of vacuum dressing undertaken on the ward.

    As 90686-01 [1628] Nonexcisional debridement of skin and subcutaneous tissue has already been assigned for this episode, no additional code is required.

As VAC dressings are classified to nonexcisional debridement, ACS 0042 Procedures normally not coded, point 7 – Dressings, does not apply.

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

Published 15 December 2015,
for implementation 01 January 2016.
Debridement of burn performed with change of dressing

Q:
Should debridement, trimming of skin and de-roofing of blisters performed with change of burn dressings be coded?

A:
ACCD considers the statement in ACS 1203 Debridement, ‘most debridements are excisional’ refers to debridements performed in an operating room, as per the reference to ‘surgeon’. ACS 1911 Burns/Dressing/debridement of burns refers to these procedures being performed in the ‘operative episode’ and refers clinical coders to the excisional debridement codes in block [1627] Debridement of burn.

Clinical advice confirms that debridement, de-roofing of blisters and trimming of skin during a change of burn dressing, performed on the ward with no anaesthesia, is nonexcisional debridement. This type of nonexcisional debridement is an inherent component of changing a burn dressing and is not to be coded as per ACS 0016 General Procedure Guidelines, Procedure Component.

Note: This advice is specific to the classification of debridement of burn with change of dressing; do not apply to other scenarios for debridement.

Improvements to the classification of wound management have been flagged for review in a future edition of ACHI.

Published 15 December 2015,
for implementation 01 January 2016.
Injection of markers into lesions of the gastrointestinal tract

Q:
What is the correct procedure code for injection of markers such as lipoidol/ histoacryl markers into gastrointestinal tract lesions?

A:
Endoscopic tattooing or marking is a commonly used method for marking lesions of the gastrointestinal tract (oesophageal, gastric, colonic).

There are different types of markers used for different purposes:

- Radiolucent markers such as carbon particles (SPOT) or India ink, are primarily used to mark a lesion to facilitate location of the lesion in subsequent surgery or follow up.
- Radio-opaque markers such as Lipoidol, are used to demarcate lesion margins for precise delivery of image guided radiotherapy. Demarcation of the lesion in the gastrointestinal tract is usually performed endoscopically. Markers are injected into the normal mucosa around the circumference of the lesion, outlining its margin.

For injection of tattooing markers (of any type) into lesions of the oesophagus, stomach or intestine, assign an appropriate code for the type of endoscopy with injection/administration of tattooing agent using the following index pathways as appropriate:

Oesophagoscopy (flexible)
- with
  - - administration of tattooing agent 30473-07 [1005]

OR

Administration
- type of agent
  - tattoo, tattooing
    - by
      - - - colonoscopy (to caecum) 32090-02 [905]
      - - - - to hepatic flexure 32084-02 [905]
      - - - - panendoscopy (to duodenum) 30473-07 [1005]
      - - - - - to ileum 30473-08 [1005]

Appropriate codes are:

30473-07 [1005] Panendoscopy to duodenum with administration of tattooing agent
30473-08 [1005] Panendoscopy to ileum with administration of tattooing agent
32084-02 [905] Fibreoptic colonoscopy to hepatic flexure with administration of tattooing agent
32090-02 [905] Fibreoptic colonoscopy to caecum with administration of tattooing agent

Improvements to ACHI will be considered for a future edition.

Reference:

Published 15 December 2015, for implementation 01 January 2016.
Clinical update: The spine – Part B

See The spine – Part A for information on the anatomy, diseases and conditions of the spine

**SPINAL FUSION AND INTERNAL FIXATION**

The spinal fusion surgical procedure is designed to abolish motion between the vertebrae. It is believed that elimination of motion will relieve pain caused by conditions such as degenerative disc disease, prolapsed intervertebral disc, spondylolisthesis, spinal stenosis and a weak or unstable spine from fractures or tumours. Spinal fusion is also performed to correct scoliosis, to prevent the progression of scoliosis and to stabilise the spine particularly in neuromuscular disorders.

Spinal fusion involves joining or fusing two or more vertebra together in order to stabilise the spine. **Bone graft** is packed between the vertebrae to promote growth of new bone and over time fuses bone together.

<table>
<thead>
<tr>
<th>Bone graft type</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autograft</td>
<td>Bone from patient’s body, e.g. harvested from iliac crest, spine or ribs during fusion surgery</td>
</tr>
<tr>
<td>Allograft</td>
<td>Donor bone, e.g. from bone bank</td>
</tr>
<tr>
<td>Bone graft substitutes/stimulators</td>
<td>Man-made or manipulated natural bone, e.g.</td>
</tr>
<tr>
<td></td>
<td>• Bone morphogenetic protein (BMP), e.g. ‘Infuse’</td>
</tr>
<tr>
<td></td>
<td>• Ceramic-based Bone Graft Extenders</td>
</tr>
<tr>
<td></td>
<td>• Demineralized Bone Matrix (DBM)</td>
</tr>
<tr>
<td></td>
<td>• Autologous growth factor (AGF)</td>
</tr>
</tbody>
</table>

A combination of bone graft types may be used in the one procedure, e.g. iliac crest bone (autograft), allograft and Infuse (bone graft substitute).

**Common spinal fusion procedures** are:

- Anterior cervical discectomy and fusion (ACDF)
- Anterior lumbar interbody fusion (ALIF)
- Posterior lumbar interbody fusion (PLIF)
- Transforaminal lumbar interbody fusion (TLIF)
- Direct lateral interbody fusion (DLIF)
- Extreme lateral interbody fusion (ELIF or XLIF)
- Posterolateral fusion (PLF)

Access is anterior (front of body), posterior or posterolateral (rear of body, requiring a laminectomy or foramenotomy to access the interbody space), transforaminal (posterior access but through the side of the foramen) or lateral/extreme lateral (side of body).

Fusion may be performed on the cervical, thoracic, lumbar (most common) or lumbosacral spine.

In an interbody fusion, bone graft is placed between the vertebrae where the intervertebral disc would normally be. Bone graft may be placed in an interbody cage, which is a porous cylinder that allows bone to
grow through and into the next vertebral body; interbody cages are made of titanium alloy, carbon fibre, PEEK (polyetheretherketone) polymer or allograft bone.

In a posterolateral fusion, the bone graft is placed between the transverse processes of the vertebrae.

Advances in surgical techniques, instruments and monitoring mean that many spinal fusion procedures are able to be performed using minimally invasive techniques.

Spinal fusion may be performed with or without internal fixation/instrumentation but most procedures involve instrumentation to provide immediate stabilisation and maintain alignment of the spine whilst the bone graft fuses.

**Spinal fusion codes**

The spinal fusion codes are in block [1389] *Spinal fusion* and [46] *Decompression of cervical spinal cord*. The codes are based on approach, whether a laminectomy was performed, and the number of intervertebral spaces operated on.

For cervical spinal fusion, different codes are assigned depending on whether or not a decompression of the cervical spinal cord is also performed.

The fusion codes include bone graft, fat graft and procurement of graft material (e.g. bone or fat) through the same (operative) incision.

Additional codes should be assigned for the following:

- Excision of vertebra
- Internal fixation
- Procurement of bone graft through separate incision, e.g. from iliac crest
- Procurement of fat for grafting through separate incision
- Rhizolysis (decompression of spinal nerve root).

**Spinal internal fixation/instrumentation** includes the use of implants such as:

- **Screws**
  - Pedicle screws are placed through the pedicle bone and into the vertebral body
  - Provide anchor points for attachment of rods
- **Hooks**
  - Alternative to screws
- **Rods**
  - Used to bridge a length of spine
  - Connect to screws/hooks
  - Nonsegmental fixation is attached at the top and bottom of the fusion area only

- Harrington rods designed for scoliosis surgery are an example of nonsegmental fixation but are largely superseded now
  - Segmental fixation is attached at multiple levels of the fusion area
- More common than nonsegmental
- CD (Cotrel-Dubousset) instrumentation used in scoliosis surgery is an example of segmental fixation
Plates

- May be used instead of rods to connect to screws/hooks
- May be used to span short segments of the spine

Spinal internal fixation/instrumentation may be used without spinal fusion, for example, for stabilisation of traumatic or neoplastic (metastatic) bone fractures.

### Spinal internal fixation/instrumentation codes

The spinal internal fixation/instrumentation codes are in block [1390] Internal fixation of spine. The codes are based on the type of fixation, and the number of intervertebral spaces operated on for the segmental fixation codes.

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#### Back Surgery - L4-5 and L5-S1 Laminectomy, Discectomy and Spinal Fusion

**Diagram:**

- Pre-operative Condition
- Surgery
- Post-operative Condition

**Documentation examples**

The examples below demonstrate the type of documentation seen in spinal surgery and are for information only.

**Example 1:**

**Diagnosis**

Right C5 radiculopathy

**Operation**

**Procedure**

C4/5 ACDF with plate

8mm Synthes cervios cage used with TCP substitute with Vectra plate and 4x16mm self-drilling screws
Operative note
With the patient under GA, lying supine with his neck extended to improve access, the anterior cervical region was prepared with alcoholic iodine. A skin crease right anterior cervical incision was used to gain access to the anterior border of the sternomastoid, then deeper dissection (superior to omohyoid) allowed access to the anterior cervical spine. The image intensifier was used to confirm the C4/C5 level. The anterior 2/3 of the disc space was cleared of soft tissue and degenerate disc material. The anteroinferior edge of the C4 vertebral body was nibbled away and the dense sub-endplate bone was drilled to harvest bone for later use in the interbody cage. The posterior 1/3 of the disc space was then cleared with the high speed drill and punch rongeurs so that the spinal canal and both root canals could be identified and decompressed. Particular attention was paid to decompression of the right C5 root by removal of the posterolateral osteophytes out beyond the pedicle. Haemostasis was assured, then a large 8mm Synthes cage was hammered into the disc space. The wound was then closed in layers. Dressings.

Example 2:

Diagnosis
Lumbar spine L4-5-S1 foraminal stenosis

Operation
Procedure
Lumbar spine L4-5 posterior fusion, L5-S1 PLIF + decompression

Operative note
GA / prone / IV ABx

Posterior midline incision
Erector spinae retracted

Foramin + transverse processes identified
1 x sacrum screw 7.5 x 35mm L R
Il level check L4 6.5x45 6.5x45
5 screws L5 6.5x45 6.5x45
60mm rods S1 7.5x35 7.5x35
Distracted, tightened

L5/S1 disc approached from right
Discectomy/decortication
Interbody fusion with graft/cage
Decompression L4-5-S1
Posterolateral autologous bone graft
Vancomycin powder

II
1 – V 2 – OV 3 – OM Primipore

Example 3:

Diagnosis
Pathological # L3 secondary to bone metastases; compression of spinal nerve roots

Operation
Procedure
Lumbar decompression, rhizolysis, screw and rod fixation

Operative procedure
Under fluoroscopic guidance, pedicle screw placements performed at the L2 and L4 levels. At the L2 level, I placed 2 x 4.5 x 45mm pedicle screws. Similar placements were performed at the L4 level. A decompressive laminectomy was performed from L2 to L4 and decompression of the lateral recess. The spinal nerve roots at this level were rhizolysed. Two parallel lordotic rods (8cm) were then secured onto the polyaxial pedicle screw heads and a 50mm cross link attached at the level of L3 vertebral body.

INTERVERTEBRAL DISC PROSTHESIS
Intervertebral disc prosthesis or artificial disc replacement is an alternative to spinal fusion to treat severe disc degeneration. The procedure is also known as total disc replacement.

The intervertebral disc is surgically removed and the prosthesis inserted in its place. The intervertebral disc prosthesis consists of endplates and a core. The endplates are anchored into the vertebral bodies above and below the disc space and the core sits between the endplates. The core is designed like the original disc, that is, to allow natural motion or movement of the spine and to keep the normal space between vertebrae.

Prosthetic disc nucleus (PDN) replacement or partial disc replacement is an alternative procedure. Only the inner (‘jelly’) nucleus of the disc is replaced; the annulus (outside of the disc) is retained.

C5-6, C6-7 Anterior Cervical Decompression and Total Disc Replacement

HALO
A halo provides immobilisation of the cervical spine, usually after trauma or spinal surgery.

The device consists of a metal ring which is fixed to the skull with metal or titanium pins under local anaesthetic. Adjustable stabilisation bars connect the ring to a vest worn around the patient’s chest. The device is able to provide immobilisation of the head and neck as the skull is ‘locked down’ to the solid thoracic spine, which is a relatively immobile segment of the body.
The halo device is generally required to be worn for three months. Over this time, frequent checks of the correct position and tightness of the device are required.

Cervical Spine Fractures with Application of Halo Fixation

References


Coding from findings on medical imaging (radiological) reports

Q:
How do you decide when a finding on a radiological report should be used to inform coding?

A:
ACS 0010 General abstraction guidelines, test results differentiates between results/findings:

· that clearly add specificity to a documented condition which may be used to inform code assignment

· where the relationship between test results and a documented condition is unclear, test results are not to be used to inform code assignment without clinical confirmation.

Examples:

• Conditions/manifestations (where the classification assumes a causal link), that are listed in test results and not documented or confirmed by the clinician, are not to be used to inform code assignment. For example:
  o Patient with documented diabetes mellitus has a finding of fatty liver on an ultrasound report; do not use the fatty liver to assign E1-.72 *diabetes mellitus with features of insulin resistance.

  o Although the classification links pneumonia and COPD, both conditions must be documented or confirmed by the clinician before applying the guidelines in ACS 1008 Chronic obstructive pulmonary disease (COPD)

  o Although the classification links ureteric calculus and hydronephrosis, both conditions must be documented or confirmed by the clinician to inform code assignment

• Metastases/secondary neoplasms that are identified in medical imaging reports but not documented or confirmed by the clinician are not to be used to inform code assignment.

Where clinical advice is unavailable to clarify the significance of a test result or imaging finding and a documented condition, clinical coders should not use the test result to inform code assignment.

Q:
Can radiological findings be used to identify all injuries in a multiple injury case?

A:
ACS 1907 Multiple injuries has been amended for Ninth Edition to incorporate previously published advice:

When coding the initial admission of a multiple trauma, all injuries documented must be coded to represent the totality of multiple trauma.

ACS 1907 and the previous Coding Rule which informed the Ninth Edition update applies to multiple trauma where there is documentation of multiple injuries ranging from severe and life threatening to less severe e.g. contusions and grazes. The ACS specifies all documented injuries including contusions and grazes (unless associated with a more severe injury of the same site) must be coded to represent the totality of trauma.
In addition, the guidelines must be applied in conjunction with ACS 0010 *General abstraction guidelines*, test results. Therefore, radiological findings may be used to provide specificity to a documented condition (such as the site of a fracture). Do not code conditions identified on test results that are not documented in the clinical record or confirmed by the clinician.

*Published 15 December 2015,*
*for implementation 01 January 2016.*
Use of the subterms in (due to) in ICD-10-AM Alphabetic Index

Q:
Should conditions documented together, but without a stated causal relationship documented, both be coded when they are indexed with the terms in (due to)?

A:
Even though ‘in’ is a preposition, it is not one of the prepositional subterms listed in the convention for prepositional terms in the General arrangement of the alphabetic index of diseases.

The indexing of a condition with the subterm in (due to) in ICD-10-AM Alphabetic Index implies a cause and effect relationship between two conditions.

The following index entries assign a single code that describes a cause and effect relationship between two conditions:

- **Encephalopathy** (acute)
  - in (due to)
    - - birth trauma P11.1
    
P11.1 Other specified brain damage due to birth trauma

- **Myelopathy** (spinal cord)
  - in (due to)
    - - degeneration or displacement, intervertebral disc NEC M51.0

- **M51.0 Lumbar and other intervertebral disc disorders with myelopathy**

Other index entries with the subterm in (due to) assign two codes; that is, a dagger and asterisk pair to describe the cause and effect relationship between two conditions as in the following example:

- **Pyelonephritis** (see also Nephritis/tubulo-interstitial)
  - in (due to)
    - - sepsis NEC A41.-† N16.0*

A41 Other sepsis

- **N16.0* Renal tubulo-interstitial disorders in infectious and parasitic diseases classified elsewhere**

Where the ICD-10-AM Alphabetic Index has linked two conditions using the subterms in (due to), this index entry should be followed except where a specific cause for the condition has been otherwise indicated in the clinical record.

For example, if the patient has pyelonephritis and sepsis during the same episode of care as per the above example, unless documentation identifies that the pyelonephritis is definitively due to another cause, the index pathway should be followed to inform code assignment. The causal relationship between pyelonephritis and sepsis is assumed unless otherwise indicated.

The classification of diabetes mellitus is governed by the specific guidelines in ACS 0401 Diabetes mellitus and intermediate hyperglycaemia – see General classification rules for DM and IH and in particular Rule 3.

ACCD will consider adding explanatory text in the conventions for the use of the subterm in (due to) in ICD-10-AM Alphabetic Index, in a future edition.
Published 15 December 2015, for implementation 01 January 2016.
ACS 0003 Supplementary codes for chronic conditions

Ninth Edition Education FAQs

Q:

Can abbreviations, symbols and synonymous terms be used to assign supplementary codes for chronic conditions (U codes)? For example,

- can ↑BMI be assigned as U78.1 Obesity?
- can hemiparesis be assigned as U80.5 Hemiplegia?

A:

Abbreviations such as ↑BMI are not to be used alone to assign a code for obesity, as there are no supporting index entries to assign obesity on this basis. However, synonymous terms (such as BMI 40 and hemiparesis) which are indexed and classified to obesity and hemiplegia respectively may be used for code assignment.

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

Published 15 September 2015,
for implementation 01 October 2015.
Clinical update: The spine – Part A

ANATOMY

Spinal (vertebral) column – The spinal column is formed by the vertebra and is comprised of various levels:

- cervical (7)
- thoracic (12)
- lumbar (5)
- sacral (5)
- coccygeal (4)

The five sacral vertebrae are fused to form the sacrum, and the four coccygeal vertebrae form the coccyx. The spinal column encloses the spinal cord and meninges.

Spinal canal – The spinal canal is a narrow, fluid-filled space in the spinal column.

Spinal cord – The spinal cord extends from the foramen magnum (within the skull) to the upper part of the lumbar region. There is no spinal cord beyond the first lumbar vertebra.

Spinal nerve roots – There are 31 pairs of spinal nerves. They emerge as paired nerve roots from the anterior and posterior spinal cord. Each nerve is then formed by the union of the paired roots.

Intervertebral discs – The intervertebral disc is a circular piece of cushioning tissue between each of the vertebrae. Their function is mechanical, allowing movement between the axial and appendicular skeleton and the head. They also assist weight bearing and help protect the spinal cord and nerve roots. Each intervertebral disc is known as a level. There is one disc (level) between two vertebrae.
Level – Certain spinal procedures require the specification of the level at which the procedure is being performed. The level of the vertebra is the numbered vertebra, e.g. L4 is the fourth lumbar vertebra.

The term level in relation to spinal surgery refers to the number of levels operated on. Documentation of ‘L4/5’ means the disc is between L4 and L5 (i.e. one vertebral interspace or one disc level). For example T1/T2 = one level, T1/T4 = three levels.

Spinal foramen – Foramen means opening. Its use in relation to the spine applies to any opening allowing passage of the spinal nerves from the vertebral canal.

Pedicles – The pedicle is a stub of bone that connects the lamina to the vertebral body to form the vertebral arch.

Vertebral lamina – The vertebral lamina is part of the vertebra at the back portion of the vertebral arch that forms the roof of the canal through which the spinal cord and nerve roots pass.

Vertebral arch – The vertebral arch is a circle of bone around the canal through which the spinal cord passes. It is composed of a floor at the back of the vertebra, walls (the pedicles), and a ceiling where two laminae join.

Figure 2 – the spinal cord
Figure 3 – the spinal vertebra

DISEASES/CONDITIONS OF THE SPINE

Cord compression – Compression of the cord occurs where disease or injury creates pressure against the spinal cord. Compression may be caused by different types of lesions that result in segmental sensory, motor, reflex and sphincter deficits. Compression is more commonly caused by lesions outside the spinal cord (extramedullary) than by lesions within it (intramedullary). Lesions that compress the spinal cord may also compress the nerve roots (see Radiculopathy).

Disc herniation – Disc herniation, or prolapse, occurs when the outer case of the disc splits resulting in the gel inside bulging out of the disc. This bulging may cause pain by pressing on the spinal cord or nerve root.

Figure 4 – Herniated disc

Dislocation – A dislocation of the spine occurs when the vertebral are misaligned. A subluxation is a partial dislocation. Vertebral dislocations are usually due to trauma and typically involve the facets.

Fracture, compression – In compression fractures, the vertebrae collapses. Compression fractures can be the result of either pathological processes or trauma.

Fracture, pathological – Pathological fractures occur where the bone has been weakened by disease such as with osteoporosis or malignancy. They are common in the thoracic spine (usually below T6) and lumbar...
spine, and may occur with no preceding or only minimal trauma (eg, a minor fall, sudden bending, lifting, coughing).

**Fracture, traumatic** – Traumatic fractures occur as a result of injury and may involve the vertebral body, lamina and pedicles as well as the spinous, articular, and transverse processes.

**Myelopathy** – Diseases or disorders of the spinal cord are referred to as myelopathy. Where this includes disc disorders which impact on the spinal cord, it may result in cord compression.

**Osteoporosis** – Osteoporosis is a progressive metabolic bone disease that decreases bone density, with deterioration of bone structure. Bone weakness leads to fractures with minor or inapparent trauma, particularly in the thoracic and lumbar spine, wrist, and hip.

**Radiculopathy** – Radiculopathy is any disease or disorder impacting on the spinal nerve roots. It is frequently due to compression caused by stenosis or herniation.

**Spinal cord injury** – Injury to the spinal cord occurs when the spinal cord is penetrated or when damage to the vertebrae, ligaments, or discs of the spinal column results in bruising, crushing or tearing of spinal cord tissue. Frequent causes of damage are trauma (car accident, falls, diving etc) or disease (polio, spina bifida, Friedreich’s Ataxia etc).

**Spinal stenosis** – Spinal stenosis is narrowing of the spinal canal and may be congenital or acquired. Stenosis may result in compression of the cord or nerve roots, causing back pain. The most common causes of acquired stenosis are osteoarthritis, degenerative disc disorders, spondylolisthesis, and spondyloolisthesis with compression of the cauda equina.
Spondylosis – Spondylosis is a descriptive term that refers to degeneration (wear and tear) of the vertebrae. Clinically, spondylosis usually occurs with nerve root compression/radiculopathy (see Radiculopathy) or myelopathy (see Myelopathy).

Spondylolisthesis – Spondylolisthesis is the forward slipping of one vertebra over another. When this occurs, the nerves may become compressed in the canal, causing pain.

EFFECTS OF SPINAL CORD INJURY

Nerves run from the spinal column to specific areas of the body. By noting where a person has weakness, paralysis, or other loss of function (and therefore nerve damage), a neurologist can determine where the spinal column is damaged. The Merck Manual details the effects of spinal injury:
<table>
<thead>
<tr>
<th>Level of Injury</th>
<th>Effect*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between C2 and C5</td>
<td>Paralysis of some or all muscles used for breathing and all arm and leg muscles. Typically, fatal unless a ventilator is used.</td>
</tr>
<tr>
<td>Between C5 to C6</td>
<td>Paralysis of legs, trunk, hand and wrist. Weakness of the muscles that move the shoulder and elbow.</td>
</tr>
<tr>
<td>Between C6 to C7</td>
<td>Paralysis of legs, trunk and part of the wrists and hands. Normal movement of the shoulders and elbows.</td>
</tr>
<tr>
<td>Between C7 and C8</td>
<td>Paralysis of legs, trunk and hands.</td>
</tr>
<tr>
<td>C8 to T1</td>
<td>Paralysis of the legs and trunk. Weakness of the muscles that move fingers and hands. Horner syndrome (with a drooping eyelid, a constricted pupil, and reduced sweating on one side of the face). Possibly normal movement of the shoulders and elbows.</td>
</tr>
<tr>
<td>T2 to T4</td>
<td>Paralysis of the legs and trunk. Loss of sensation below the nipples. Normal movement of the shoulders and elbows.</td>
</tr>
<tr>
<td>T5 to T8</td>
<td>Paralysis of the legs and lower trunk. Loss of sensation below the rib cage.</td>
</tr>
<tr>
<td>T9 to T11</td>
<td>Paralysis of the legs. Loss of sensation below the navel.</td>
</tr>
<tr>
<td>T11 to L1</td>
<td>Paralysis of and loss of sensation in the hips and legs.</td>
</tr>
<tr>
<td>L2 to S2</td>
<td>Various patterns of leg weakness and numbness, depending on the precise level of injury.</td>
</tr>
<tr>
<td>S3 to S5</td>
<td>Numbness in the perineum.</td>
</tr>
</tbody>
</table>

*Loss of bladder and bowel control can occur with severe injury anywhere along the spinal column.*

**References:**
National Centre for Classification in Health, 1999, Coding Matters: Decompression laminectomy and discectomy, The University of Sydney, Sydney, NSW.
Shapiro, IM and Risbud, MV (eds) 2013, The Intervertebral Disc: Molecular and structural studies of the Disc in Health and Disease, 1.2.4 Tissues of the intervertebral disk, Springer, New York, USA.
Mullerianosis

Q:
How do you code mullerianosis?

A:
Mullerianosis refers to a structure that is composed of mullerian rests (that is endometrial, endosalpinx (tubal) and/or endocervical tissue), known as a choristoma. A choristoma is a mass of histologically normal tissue that is “not normally found in the organ or structure in which it is located”.

Mullerianosis may be developmental (that is, formed in utero during organ development in the embryo) or acquired. Acquired mullerian diseases (such as endometriosis) are the more common presentation.

Mullerianosis is generally a histological finding, not a clinical diagnosis. When documented on a histopathology report do not assign a code for this finding without confirming its significance with the treating clinician as per the guidelines in ACS 0010 General abstraction guidelines, Findings with an unclear, or no associated condition documented:

Unless a clinician can indicate that a test result is significant and/or indicates the relationship between an unclear test result and a condition, such test results should not be coded.

Where a diagnosis of mullerianosis is confirmed, assign as a best fit a code for endometriosis by selecting the appropriate site code under the lead term Endometriosis.

References:

Published 15 September 2015,
for implementation 01 October 2015.
ACS 0110 SIRS, sepsis, severe sepsis and septic shock

Ninth Edition Education FAQs

Q:

ACS 0110 SIRS, sepsis, severe sepsis & septic shock example 6 describes the patient as having acute multiple organ dysfunction from septic shock. Does this mean that any conditions documented as organ dysfunction equate to an organ failure as the index does not link dysfunction to failure via any index pathway?

Also, the classification instructions for SIRS due to infectious aetiology require clinical coders to follow the instructions for sepsis, but the classification instructions for sepsis requires sepsis to be documented.

A:

Clinical advice provided during revision of ACS 0110 confirmed that for severe sepsis or septic shock, documentation of organ dysfunction can be considered as interchangeable with organ failure where it is unexplained by any other cause. This has been included in the definitions for severe sepsis and septic shock.

This instruction should be applied in relation to sepsis only, and not applied to any other diagnoses.

The ACS classification instructions should be applied in totality. There is a statement in ACS 0110 under Classification, Systemic inflammatory response syndrome [SIRS]:

“Where there is documentation of SIRS due to infectious aetiology, follow the classification guidelines for Sepsis...”.

Therefore, all references to sepsis in the standard also apply to SIRS of infectious origin.

Published 15 September 2015,
for implementation 01 October 2015.
Procedures performed in radiology departments

Q:
Do you need to code procedures performed in privately owned/off site radiology departments?

A:
The purpose of the Admitted Patient Care National Minimum Data Set (APC NMDS) is to collect information about care provided to admitted patients in Australian hospitals.

Procedures performed while a patient is formally admitted should be coded (where they meet the criteria in ACS 0016 General procedure guidelines), irrespective of whether the facility subcontracts another department to perform the procedures, as they are still performed as part of the admitted episode of care.

However, a procedure qualifying for code assignment should not be coded if performed in another facility where the patient has been placed on leave from the admitting facility and admitted to another facility to have the procedure performed.

Additionally, procedures qualifying for code assignment performed in other facilities under a contractual arrangement should be coded as per the guidelines in ACS 0029 Coding of contracted procedures:

*If a hospital treatment is carried out under a contracting arrangement existing between two hospitals, all procedures carried out under the contract are to be recorded and coded in both hospitals. The hospital not carrying out the procedure should flag the appropriate code.*

Reference:

Published 15 September 2015,
for implementation 01 October 2015.
Q: What documentation can be used to assign supplementary codes for chronic conditions (U codes)?

· Do conditions listed under the heading of ‘past history’ or ‘background/problems’ qualify?

· Do conditions need to be medicated to prove they are current?

A: Clinicians may use the heading ‘past history’ to represent conditions or procedures etc. occurring in the past, including the recent past. Therefore, conditions listed under such headings may be part of the current health status of the patient and should not be excluded based on the heading. However, conditions listed in previous admissions and correspondence, but not listed in the current episode of care are not to be used (as per Coding Rule Coding from documentation in previous admissions).

Not all chronic conditions are managed with ongoing medication and so it is not necessary to review medication charts to inform code assignment. ACS example 5 highlights asthma as a child with no further documentation as to its relevance for the adult.

Where a patient episode is documented with a past medical history of hypertension, IHD and OA, all of these conditions should qualify. However, where it is unclear if the condition is continuing in the patient, follow the guidelines in ACS 0003 Supplementary codes for chronic conditions and do not assign a U code.

In the example above, a U code would only be assigned for hypertension as childhood asthma has not occurred since a teenager and ischaemic heart disease is only queried.

Published 15 September 2015, for implementation 01 October 2015.
ACS 0003 Supplementary codes for chronic conditions

Ninth Edition Education FAQs

Q:

Should supplementary codes be assigned for all episodes of care, including same day dialysis?

A:

Supplementary codes should be assigned for all episodes of care where additional diagnoses are routinely assigned. This includes multi-day and same-day episodes of care. As per the Coding Rule *Diabetes and day only admissions* (June 2005), where coding is autogenerated (such as for dialysis episodes) and the full record is not available to inform the coding process, it may not be possible for some hospitals to comply with ACS 0003 *Supplementary codes for chronic conditions* in these episodes.

Published 15 September 2015,
for implementation 01 October 2015.
ACS 0003 Supplementary codes for chronic conditions

Ninth Edition Education FAQs

Q:

In type 2 diabetes mellitus with obesity (E11.72) or type 2 diabetes mellitus with chronic kidney disease (CKD) (stage 3-5) (E11.22), should the U code be assigned where obesity or CKD (stage 3-5) does not meet ACS 0002 Additional diagnoses?

When assigning U codes in a delivery episode, is it necessary to also assign an O code from Chapter 15 Pregnancy, childbirth and the puerperium?

A:

When coding diabetes and either obesity or CKD (stage 3-5) are present and do not meet the criteria for assignment in ACS 0002 Additional diagnoses, the appropriate U codes should be assigned.

Where a U code is applicable in a delivery episode of care, an accompanying code from Chapter 15 Pregnancy, childbirth and the puerperium should not be assigned.

Published 15 September 2015, for implementation 01 October 2015.
ACS 0003 Supplementary codes for chronic conditions

Ninth Edition Education FAQs

Q:
Can more specific conditions be assigned as supplementary codes for chronic conditions (U codes)? For example, can conditions such as portal hypertension, conditions listed in code range I20-I25 or manic depressive bipolar disorder be assigned U codes?

A:
Supplementary codes were designed to capture chronic conditions documented in the medical history often in generalised terms. The aim for hypertension was to collect primary (essential) hypertension not otherwise specified (NOS) not secondary hypertension, but for schizophrenia the aim was to capture any type of schizophrenia documented.

To make this explicit the second errata to Ninth Edition includes an update to the alphabetic index with code ranges applicable to a number of supplementary codes for chronic conditions. Where it was not intended to capture specific forms of the chronic condition, code ranges have not been supplied.

The specific terms listed in the alphabetic index must be followed, and the code range can be referenced to inform code assignment.

For example, where paranoid schizophrenia is documented, follow the index pathway:

Supplementary
- codes for chronic conditions
  - schizophrenia (conditions in F20.-) U79.2
and assign U79.2 Schizophrenia.

For supplementary codes without explicit code ranges, only assign codes from U78-U88 for conditions with no further specification.

For example, where hypertension is documented, follow the index pathway:

Supplementary
- codes for chronic conditions
  - hypertension U82.3
and assign U82.3 Hypertension.

More specific forms of the chronic condition should not be assigned a U code unless indicated by the alphabetic index.

Published 15 September 2015,
for implementation 01 October 2015.
ACS 0003 Supplementary codes for chronic conditions

Ninth Edition Education FAQs

Q:

When should conditions which can be cured, such as obesity or depression, be assigned a supplementary code for chronic conditions?

A:

Supplementary codes for chronic conditions were designed to capture some medical conditions which are or tend to chronicity, or are prevalent health conditions in Australia. It is acknowledged that some of the U code conditions such as obesity and depression are not always chronic and may resolve or be cured. For such conditions, a decision on whether to assign a U code should be made according to the documentation in the current episode of care. Where it is unclear if the condition is current, follow the classification advice in ACS 0003 and do not assign a U code.

(Coding Rule, September 2015)

Published 15 September 2015,
for implementation 01 October 2015.
ACS 0110 SIRS, sepsis, severe sepsis and septic shock

Ninth Edition Education FAQs

Q:

In ACS 0110, why does example 5 assume that bronchopneumonia is due to *Streptococcus pneumoniae* but example 4 does not assume that the sepsis is due to *Coagulase-negative staphylococcus*?

A:

In example 5, sepsis is documented as due to bronchopneumonia and *Streptococcus pneumoniae* was identified as the source of sepsis from the blood culture, therefore A40.3 *Sepsis due to Streptococcus pneumoniae* is assigned.

Example 4 has a clinical diagnosis of sepsis as the blood cultures were negative. Therefore A41.9 *Sepsis unspecified* is assigned for blood culture negative sepsis. Sepsis should not be assumed to be *Coagulase-negative sepsis* based on the wound swab or documentation of sepsis due to IV site infection alone. If the blood cultures were positive for *Coagulase-negative staphylococcus*, or a clinician confirms the specific type of sepsis, it would be appropriate to assign A41.1 *Sepsis due to other specified staphylococcus* but this is not the case in this example.

Published 15 September 2015,
for implementation 01 October 2015.
ACS 0110 SIRS, sepsis, severe sepsis and septic shock

Ninth Edition Education FAQs

Q:

Could you please explain why sepsis rather than pneumonia was selected as the principal diagnosis in example 3?

A:

In all sepsis examples, a principal diagnosis decision is made on a case by case basis.

In example 3, the discharge summary states sepsis due to pneumonia. Therefore, the principal diagnosis has been identified and assigned as sepsis.

Principal diagnosis in some clinical episodes can be difficult to identify, particularly in episodes of sepsis with infection. Therefore, it is necessary to continue to reference the criteria in ACS 0001 Principal diagnosis in order to ensure correct principal diagnosis selection.

Published 15 September 2015,
for implementation 01 October 2015.
Q: In small rural hospitals, can the rehabilitation code still be assigned even when there is no formal rehabilitation program?

A: ACS 2104 Rehabilitation provides classification criteria that Z50.9 Care involving use of rehabilitation procedure, unspecified should only be assigned as an additional diagnosis where there is documented evidence that the patient has been provided with rehabilitation care. Do not assign Z50.9 when a rehabilitation care assessment has been performed but no actual rehabilitation care has been given.

Note that in acute episodes of care, routine allied health interventions alone (such as those that occur post surgery or in preparation for a rehabilitation transfer) should not be interpreted as rehabilitation. The patient must have clinical documentation that they are part of a formal rehabilitation program. Documented evidence of rehabilitation may be in the form of clinician entries or a care plan within the clinical record.

Where these classification criteria are met, Z50.9 Care involving use of rehabilitation procedure, unspecified may be assigned independent of the admitted patient care type.

Published 15 September 2015, for implementation 01 October 2015.
Q:

What condition onset flag (COF) value should be assigned to Z50.9 *Care involving use of rehabilitation procedure, unspecified* as an additional diagnosis in an acute care episode?

A:

Follow the classification advice in ACS 0048 *Condition onset flag*, which specifies that a condition (or diagnosis) arising after admission should be assigned COF 1 *Condition with onset during the episode of admitted patient care*. As per dot point six, this includes disease or administrative codes arising during the episode of admitted patient care. Therefore, where Z50.9 *Care involving use of rehabilitation procedure, unspecified* is assigned as an additional diagnosis in an acute episode of care, assign COF 1.

Published 15 September 2015,
for implementation 01 October 2015.
ACS 2104 Rehabilitation

Ninth Edition Education FAQs

Q:
Could you please clarify whether Z51.5 Palliative care can be used with Z50.9 Care involving use of rehabilitation procedure, unspecified. Occasionally oncology patients are changed to rehabilitation but the intention of treatment is palliative. Do the changes for Ninth Edition restrict assignment of both codes?

A:
As noted in ACS 2104 Rehabilitation and ACS 2116 Palliative care, these codes may be assigned independent of the admitted patient care type. Therefore, if a patient meets the criteria for assignment of both Z51.5 Palliative care and Z50.9 Care involving use of rehabilitation procedure unspecified in the same episode of care, both Z51.5 and Z50.9 may be assigned as additional diagnoses.

Published 15 September 2015,
for implementation 01 October 2015.
ACS 1221 Pressure injury

Ninth Edition Education FAQs

Q:

The ACS notes that pressure injuries that improve or deteriorate during hospitalisation should be assigned a code to reflect the highest stage for that site. Does this include when treatment for a pressure injury continues after a care type change?

A:

Where a pressure injury continues after a care type change, assign an appropriate code from category L89 for the stage of a pressure injury with reference to the documentation within each episode of care. For example, where a patient has a pressure injury stage I in an acute episode of care, which progresses to stage II in a subsequent (eg, palliative) episode of care, assign stage I for the acute episode and stage II for the palliative care episode.

Published 15 September 2015, for implementation 01 October 2015.
Ulcer of lower limb, ankle

Ninth Edition Education FAQs

Q:

With more specific site codes at L97.-, should an ulcer of the ankle be coded to L97.0 *Ulcer of foot* or L97.8 *Ulcer of lower limb, other sites*?

A:

Only assign L97.0 *Ulcer of foot* as per the specific index pathways. For example:

*Ulcer/foot* or

*Ulcer/lower limb/foot*

For documentation of ulcer of ankle, assign L97.8 *Ulcer of lower limb, other sites* by following the index pathways:

*Ulcer/lower limb/specified site NEC* or

*Ulcer/skin/lower limb/specified site*

Published 15 September 2015, for implementation 01 October 2015.
Facial droop with hemiplegia

Ninth Edition Education FAQs

Q:

In the absence of exclusion notes at G81.9 Hemiplegia, unspecified and G83.81 Facial paralysis due to cerebrovascular accident, can these codes both be assigned, or should G83.81 only be assigned for facial droop in the absence of hemiplegia?

A:

Facial paralysis (droop) is inherent in hemiplegia. Therefore, G83.81 Facial paralysis due to cerebrovascular accident should not be assigned in addition to G81.9 Hemiplegia, unspecified. Indexing improvements to support this advice have been included as part of the second errata to Ninth Edition.

Published 15 September 2015,
for implementation 01 October 2015.
Coding of underlying cause of CKD (chronic kidney disease) in a patient who has received a renal transplant

Q: When a patient has had a kidney transplant, is it necessary to code the original underlying cause of CKD, for example, FSGS (focal segmental glomerulosclerosis)?

A: Assign Z94.0 Kidney transplant status and/or N18.- Chronic kidney disease for those patients who have received a kidney transplant only when the criteria in ACS 0002 Additional diagnoses is met as instructed in ACS 1438 Chronic kidney disease:

“For patients who have received a kidney transplant and documentation pertaining to this status satisfies criteria for coding under ACS 0002 Additional diagnoses, assign Z94.0 Kidney transplant status together with N18.3 Chronic kidney disease, stage 3 or higher, as indicated by an eGFR level.”

Do not assign a code for the original condition (e.g. FSGS and IgA nephropathy) that caused the CKD, leading to kidney transplantation, unless the condition recurs in the transplanted kidney.

The instructional note ‘Use additional code to identify underlying disease’ at N18 Chronic kidney disease relates to the current cause of kidney failure which in a transplanted kidney may be graft rejection or recurrence of the original disease.

Example 1 -- A patient with history of ESRF secondary to FSGS received a kidney transplant in 2000. The patient was admitted (3 years later) with decreased renal function (eGFR 24-27) and biopsy of the transplanted kidney confirmed BK Virus nephropathy with no evidence of recurrent FSGS.

Codes:

N28.8 Other specified disorders of kidney and ureter
B97.8 Other viral agents as the cause of diseases classified to other chapters
N18.4 Chronic kidney disease, stage 4
Z94.0 Kidney transplant status

In this scenario, deterioration of kidney function is caused by BK virus nephropathy and there is no evidence of recurrence of FSGS in the transplanted kidney; therefore a code for FSGS is not assigned.

Example 2 -- A patient admitted with pneumonia. Patient had a kidney transplant in 1993 for IgA nephropathy which subsequently failed due to a recurrence of IgA nephropathy in the transplanted kidney, for which the patient received haemodialysis during admission.

Codes:

J18.9 Pneumonia, unspecified
N18.5 Chronic kidney disease, stage 5
N02.8 Recurrent and persistent haematuria, other
Z94.0 Kidney transplant status

In this scenario, the patient received haemodialysis treatment for CKD, attributed to recurrence of IgA nephropathy in the transplanted kidney; therefore a code for IgA nephropathy and transplant status should be assigned.
Missed miscarriage

Q:
How do you code missed miscarriage?

A:
Missed miscarriage is a synonymous term for missed abortion. Therefore, where *missed miscarriage* is documented, assign:

O02.1  *Missed abortion*

by following the index pathway:

*Abortion*
- missed O02.1

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

Published 15 September 2015,
for implementation 01 October 2015.
Classification of promethazine

Q:

Why is poisoning or adverse effect of promethazine, used in the treatment of allergic reactions and vomiting, classified to T43.3 Poisoning by psychotropic drugs not elsewhere classified, phenothiazine antipsychotics and neuroleptics and Y49.3 Phenothiazine antipsychotics and neuroleptics causing adverse effects in therapeutic use in ICD-10-AM?

A:

ICD-10-AM and its parent classification ICD-10, classifies drugs according to the active chemical ingredient (class) rather than by therapeutic indication. Promethazine is a phenothiazine derivative (the largest of the five main classes of antipsychotic (neuroleptic) drugs) in the same drug class as chlorpromazine (Thorazine) and trifluoperazine (Stelazine). However, unlike the other drugs in this class, promethazine is not used as an anti-psychotic. It is used as an anti-histamine, sedative, and antiemetic (anti-nausea).

The class and therapeutic indication for drugs often align but where they don’t it may be incorrectly perceived as an error.

To assign the correct codes for promethazine poisoning or adverse effect in therapeutic use follow the Table of Drugs and Chemicals in the ICD-10-AM Alphabetic Index:

Promethazine (teoclate) .................T43.3  X41  X61  Y11  Y49.3

This is reinforced by the excludes notes for phenothiazine-based neuroleptics at T45.0 Antiallergic and antiemetic drugs and Y43.0 Antiallergic and antiemetic drugs.

Published 15 September 2015,
for implementation 01 October 2015.
ACS 0002 Additional diagnoses and alteration to treatment

Q:
Does a condition meet the criteria in ACS 0002 Additional diagnoses when the medication to treat the condition has been altered to manage an adverse effect or another condition, as in the following scenarios?

- Principal diagnosis of acute on chronic renal failure secondary to frusemide, with a past history of congestive cardiac failure treated with frusemide 80mg BD. Dose of frusemide was decreased to 40mg BD.
- Principal diagnosis of aspirin induced ulcers throughout upper gastrointestinal tract, with a past history of atrial fibrillation for which the patient had been commenced on aspirin. Aspirin was withheld for two days, and the patient was commenced on medication to treat the ulcers.

A:
Based on the limited information in the scenarios described, the conditions listed in the past history/background (congestive cardiac failure and atrial fibrillation) where medication to treat these conditions has been altered should be coded, as per the criteria in ACS 0002 Additional diagnoses; specifically dot point 1, ‘commencement, alteration or adjustment of therapeutic treatment’.

Published 15 June 2015,
for implementation 01 July 2015.
Assigning Z38.- as the principal diagnosis

Q:
What codes, if any, can be assigned as additional diagnoses with Z38.- *Liveborn infants according to place of birth* as the principal diagnosis.

A:
Codes for newborns should be assigned following the guidelines in ACS 1607 *Newborn/neonate* which state:

‘A code from category Z38 *Liveborn infants according to place of birth* should be sequenced as the principal diagnosis only when the newborn is completely well (including those babies who have had a circumcision performed).’

Therefore, Z38.- should be sequenced as the principal diagnosis only in those circumstances where there are no additional morbidity codes that qualify for assignment to classify neonatal morbidity or suspected morbidity. Suspected morbidity would include Z03.71 *Observation of newborn for suspected infectious condition.*

Published 15 June 2015,
for implementation 01 July 2015.
Posterior reversible encephalopathy syndrome

Q:
How do you code posterior reversible encephalopathy syndrome?

A:
Posterior reversible encephalopathy syndrome (PRES) (also known as reversible posterior leukoencephalopathy syndrome) presents with symptoms such as headaches, altered mental state, seizures and visual disturbances. The exact cause is unclear, but most cases of PRES occur with or are due to hypertension (including eclampsia), immunosuppression (including secondary to immunosuppressive treatment), autoimmune disease, antineoplastic agents and renal failure. Radiological (MRI) findings of oedema involving the posterior occipital and parietal lobes of the brain are indicative of PRES and are essential for diagnosis, as PRES is difficult to diagnose clinically. Early diagnosis and treatment is vital to prevent sequelae. Complete reversal of clinical symptoms within weeks is possible if treatment is commenced immediately; which includes withdrawing causative agents and treating severe hypertension and seizures.

The correct code to assign for posterior reversible encephalopathy syndrome is:

I67.8 Other specified cerebrovascular diseases

by following the index pathway:

Disease, diseased
- cerebrovascular
- - specified NEC I67.8

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

References:

Published 15 June 2015,
for implementation 01 July 2015.
Pulsed dose rate cervical and uterine brachytherapy

**Q:**

What is the correct code to assign for cervical and uterine pulsed dose rate brachytherapy?

**A:**

Clinical advice indicates that the radiobiology of pulsed dose rate brachytherapy (PDRB) is similar to low dose rate brachytherapy (LDRB).

For PDRB administration to cervical and uterine cancers, assign the appropriate low dose rate brachytherapy code from block [1790] *Brachytherapy, intracavitary, gynaecological.*

**Q:**

What is the correct code to assign for insertion of applicator(s) for cervical and intrauterine brachytherapy?

**A:**

There is no site specific code for insertion of brachytherapy applicator(s) into cervix or uterus as there is for the eye and prostate.

For consistency with the classification of brachytherapy applicator implantation for other sites assign 90442-00 [1299] *Other procedures on female genital organs* to indicate insertion of the applicators.

Improvements to ACHI will be considered for a future edition.

*Published 15 June 2015, for implementation 01 July 2015.*
Coding from documentation in previous admissions

Q:

There is a Coding Rule relating to diabetes mellitus which states that the condition must be documented in the current admission in order to assign a code for the diabetes. Should that rule be applied to all conditions where there is a coding instruction in a specialty standard to ‘code where documented’?

A:

The Coding Rule *Documentation of diabetes mellitus*, published in June 2012, states that:

‘...previous admissions and correspondence can be used to inform assignment of diabetes mellitus codes. However, previous admissions and correspondence should not be used:

to assign diabetes mellitus if it has not been documented in the current admission...’

This instruction is relevant for all specialty standards instructing that certain conditions must be coded when documented (HIV/AIDS, viral hepatitis and tobacco use), that is, the conditions must be documented within the episode of care in order to be assigned a code.

Published 15 June 2015,
for implementation 01 July 2015.
Replacement of procidentia

Q:
How do you code replacement of procidentia (manual reduction of prolapsed uterus)?

A:
Procidentia is a synonymous term for (organ) prolapse and may refer to uterine prolapse or rectal prolapse.

A vaginal pessary or pack may be inserted as a conservative, noninvasive (temporary) management for procidentia/uterine prolapse, the purpose of which is to support the uterus and prevent further/repeat prolapse. The procidentia (prolapsed uterus) must be reduced prior to insertion of the vaginal pessary or packing.

ACHI does not include a specific code for replacement of procidentia/manual reduction of a prolapsed uterus. Clinical advice confirms that replacement of procidentia/manual reduction of a prolapsed uterus is inherent in the insertion of a vaginal pessary or packing. Therefore, assign one of the following codes:

92104-00 [1900] Vaginal packing

or

92107-00 [1900] Insertion of other vaginal pessary

Amendments to ACHI will be considered for a future edition.

Published 15 June 2015,
for implementation 01 July 2015.
Debridement of skin with suturing

Q:
Is it necessary to assign a code for suturing of skin in addition to a code for (excisional) debridement?

A:
When excisional debridement is performed, it is not necessary to assign an additional code for suturing of a wound at the same site of the debridement. The suturing of the wound is a component of the procedure, as per the guidelines in ACS 0016 General Procedure Guidelines, Procedure components. Improvements to ACHI Alphabetic Index will be considered for a future edition.

Published 15 March 2015,
for implementation 01 April 2015.
Increased S/D (systolic/diastolic ratio) and AEDF (absent end diastolic flow)

Q:
What code should be assigned when increased S/D (systolic/diastolic ratio) or AEDF (absent end diastolic flow) is documented as a reason for induction of labour or caesarean section?

A:
Both systolic/diastolic blood flow velocity ratio (S/D ratio) and end diastolic flow (EDF) are measurements of umbilical artery blood flow in the Doppler ultrasound assessment. Many studies have come to the conclusion that increased S/D and absent end diastolic flow (AEDF) are useful markers in detecting at risk fetuses and in predicting placental insufficiencies.

Assign O36.5 Maternal care for poor fetal growth for documentation of increased S/D or AEDF as it includes maternal care for known or suspected placenta insufficiency. This is the usual indication for intervention such as induction of labour or elective caesarean section.

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

Published 15 March 2015,
for implementation 01 April 2015.
Invasive and in-situ neoplasms of the prostate

Q:

If a trans-rectal ultrasound (TRUS) guided biopsy of the prostate identifies adenocarcinoma (M8140/3) and high grade intraepithelial neoplasia (M8148/2), do you code both or just the adenocarcinoma?

A:

Where a histopathology report details both in situ and invasive cancer within the prostate, the behaviour takes precedence over the histological type and only the morphology and site code for the invasive cancer should be coded.

The sentence in ACS 0233 Morphology:

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

is referring to multiple histological types found within a lesion in one organ, and does not provide guidance with respect to differing morphological behaviours.

In the scenario cited where multiple histological terms/morphologies with different behaviours are reported in a TRUS biopsy of the prostate, only assign codes for the invasive neoplasm (i.e. adenocarcinoma).

This will be clarified in ACS 0233 Morphology in a future edition.

Published 15 March 2015, for implementation 01 April 2015.
Obstetric additional diagnosis sequencing

Q:

Is there a sequencing rule for the O80-O84 Delivery codes when they are assigned as an additional diagnosis? For example, if the principal diagnosis is an antepartum condition such as pre-eclampsia but the patient also has a perineal tear during the delivery, should the O80-O84 code immediately follow the antepartum principal diagnosis, that is, be sequenced as the second code?

A:

The Note at O80-O84 Delivery states:

‘Other abnormalities/complications classifiable elsewhere in Chapter 15 may be assigned in conjunction with codes O80-O84 to fully describe the delivery episode’.

There are no sequencing rules when codes from O84-84 Delivery are assigned as an additional diagnosis, apart from being sequenced before Z37.- Outcome of delivery, as in the instructional note at Z37.-:

‘Code first the delivery (O80- O84)’.

Published 15 March 2015, for implementation 01 April 2015.
Tongue channelling via coblation

Q:
What is the correct procedure code for tongue channelling via coblation?

A:
The term ‘coblation’ means ‘controlled ablation’. Tongue channelling via coblation is also known as coblation tongue reduction, a technique that reduces the overall size of the tongue to eliminate snoring and sleep apnoea symptoms. The procedure is performed by applying radiofrequency energy to the base of the tongue through a probe, which is inserted into the deep tissue of the tongue. Radiofrequency energy causes shrinkage of the deep musculature and soft tissue of the tongue.

Where tongue channelling via coblation is documented, assign 45675-01[1665] Reduction of tongue size, by following the index pathway:

Reduction
- size
- - tongue (macroglossia) 45675-01 [1665]

Improvements to the ACHI Alphabetic Index will be considered for a future edition.

Published 15 March 2015,
for implementation 01 April 2015.
Reversible cerebral vasoconstriction syndrome (RCVS)

Q:
How do you code reversible cerebral vasoconstriction syndrome (RCVS)?

A:
Reversible cerebral vasoconstriction syndrome is synonymously known as:

- acute benign cerebral angiopathy
- Call or Call-Fleming syndrome
- CNS pseudovasculitis
- isolated benign cerebral vasculitis
- reversible cerebral segmental vasoconstriction
- reversible cerebrovascular vasoconstriction syndrome

Reversible cerebral vasoconstriction syndrome is characterised by severe headaches, with or without other acute neurological symptoms, and diffuse segmental constriction of cerebral arteries that resolves spontaneously within 3 months.

There is currently no specific code or index pathway for reversible cerebral vasoconstriction syndrome in ICD-10 (or ICD-10-AM). A submission will be sent to the WHO update reference committee (URC). In the interim, assign I67.8 Other specified cerebrovascular disease by following the index pathway:

Disease

- cerebrovascular

- - specified NEC I67.8

Enhancements to ICD-10-AM will be considered for a future edition.
Clinical update: Cystic fibrosis

Overview
Cystic fibrosis (CF) is a genetic disorder affecting mostly the lungs but also the pancreas, liver, kidneys and intestine. It can also be known as mucoviscidosis ("Cystic fibrosis", 2015) and two thirds of patients are diagnosed by one year of age. CF is a disease with a wide diversity of clinical presentation, severity of symptoms, and rate of disease progression in the organs involved and the clinical manifestations will vary with the patient’s age at presentation (Sharma, 2014).

Causes
Cystic Fibrosis (CF) is a recessive genetic condition resulting from inheriting two copies of faulty gene from both parents (Cystic Fibrosis Australia, n.d.). The faulty gene is called the cystic fibrosis transmembrane conductance regulatory gene (known as the CFTR gene) and is responsible for creating a protein that moves salt and water out of a cell. If the CFTR gene is defective, this results in a build-up of thick, sticky mucus in the body’s tubes and passageways. These blockages damage the lungs, digestive system and other organs, resulting in inflammation (swelling) and repeated infections (NHS Choices, 2014). In the lungs, the mucus clogs the tiny air passages and traps bacteria, resulting in repeated infections which can cause irreversible lung damage and death. In the pancreas, the thick mucus also stops digestive enzymes from reaching the small intestine, which leads to difficulty with digesting fats and absorbing some nutrients. This means that people with CF can have problems with nutrition (Better Health Channel 2012).

Prevalence
- One in every 2,500 Australian babies, male or female, of Northern European ancestry.
- About one in 25 Australians of Northern European ancestry are carriers for the CFTR gene mutation.
- CF is less frequent in Southern European and Middle Eastern populations, and is rare or absent in Asian populations (Genetics in Family Medicine, 2007).

Complications
CF has a wide variety of complications across multiple body systems. These are related to the mucus deposits in various organs, leading to infections and difficulty with absorption of nutrients and vitamins.
Figure 2: What are the signs and symptoms of Cystic fibrosis? (National Heart, Lung, and Blood Institute, 2013)

**Manifestations**

The manifestations of CF affect multiple body systems including:

- respiratory
- gastrointestinal
- genitourinary
- endocrine.
The image above identifies the potential manifestations of CF. Additional manifestations which may occur include:

- pulmonary hypertension
- fatty liver
- liver failure
- cholecystitis
- rickets (Sharma, 2014).

**Management**

CF has no cure, however, treatments have greatly improved in recent years. The goals of CF treatment include:

- preventing and controlling lung infections
- loosening and removing thick, sticky mucus from the lungs
- preventing or treating blockages in the intestines
- providing enough nutrition, preventing dehydration (a lack of fluid in the body) (National Heart, Lung, and Blood Institute, 2013).

Treatment options include:

- antibiotics – to treat chest and lung infections
- intensive physiotherapy – to clear mucus from the lungs
- enzyme replacement capsules with food to aid digestion
• salt vitamin supplements
• bronchodilators – a type of medication that helps expand the airways inside the lungs, making it easier to breathe
• inhaled mucus-clearing treatments – such as Pulmozyme, hypertonic saline (a strong salt solution) and mannitol dry powder
• exercise – to help clear the airways and build core strength (Cystic Fibrosis Australia, n.d.; NHS Choices, 2014).

In some cases a lung transplant may eventually be required if the lungs become extensively damaged.

References:
Diabetes with gouty arthropathy

Q:
Should diabetes be associated with gouty arthropathy?

A:
People with diabetes are prone to a number of musculoskeletal complications. Many of these problems are not unique to diabetes but occur more frequently in this condition. Both neurogenic arthropathy and arthropathy NEC with diabetes are classified to E1-.61 *Diabetes mellitus with specified diabetic musculoskeletal and connective tissue complication.

Although gout and diabetes have common risk factors (i.e. they often occur together), ICD-10-AM does not classify diabetes with gouty arthropathy. Therefore, diabetes with gouty arthropathy should not be assigned to E1-.61 * Diabetes mellitus with specified diabetic musculoskeletal and connective tissue complication.

Published 15 December 2014,
for implementation 01 January 2015.
Clinical update: Skin

The NCCH previously published an article titled "How it works - SKIN" in 2003. This article has been updated here to assist clinical coders to understand how skin works. The skin is a functional system of tissues and cells that provides protection from the external environment. The skin is comprised of two main layers - the epidermis and dermis - with subcutaneous tissue beneath.

Figure 1 - Structure of the skin

Epidermis

The epidermis is the thin outer layer that is composed of stratified squamous epithelium. There are four different types of cells found in the epidermis:

- keratinocytes
- melanocytes
- Langerhans cells
- Merkel cells

The epidermis is organised into four sublayers or strata:

- stratum basale (basal layer)
- stratum spinosum (spinous layer)
stratum granulosum (granular layer)

stratum corneum (keratinised or horny layer)

Newly formed cells in the stratum basale move up towards the surface of the skin pushing old cells upwards. The old cells rise to the surface accumulating keratin as they move. The old cells die, flatten out and overlap to form a tough membrane on the outer surface of the epidermis. Eventually these cells are shed off as calluses or collections of dead skin and are replaced by underlying cells that also become filled with keratin. This process is known as keratinisation and takes between two and four weeks to complete.

Dermis

The dermis, located beneath the epidermis, is considerably thicker because it is composed of connective tissue containing elastic fibres (elastin) and protein fibres (collagen). The elastin and collagen fibres give the skin pliability but are resistant to stretching. The dermis contains hair follicles, nails, sweat glands, sebaceous glands, blood vessels and nerves.

The two sublayers of the dermis are:

Papillary layer - a thin layer of loose connective tissue that lies beneath the epidermis. It contains capillaries that nourish the epidermis.

Reticular layer - a dense layer of connective tissue that consists of elastin and collagen fibres.

Elastin and collagen fibres give the skin pliability. Ageing, hormones and ultraviolet rays cause degeneration of elastin and collagen fibres, resulting in wrinkles and sagging of the skin.

Subcutaneous tissue

The subcutaneous tissue, also called the superficial fascia or hypodermis, is found beneath the dermis. Subcutaneous tissue consists of adipose (fat) and connective tissue and accommodates large blood vessels and nerves. Fibres in the dermis extend downwards into the subcutaneous tissue connecting the skin to it. In turn, the subcutaneous tissue connects to underlying muscles, bones and tissue.

Skin functions

The primary functions of the skin are:

- protection
- regulation of body temperature
- excretion
- detection of stimuli
- synthesis of vitamin D
- blood reservoir

Protection

The skin, as a physical barrier to the external environment, protects the body from injury, infection, loss or gain of bodily moisture and UV radiation. The skin's layers of cells provide a protective barrier to underlying body tissues and organs against abrasion and other injuries. Lipid secretions produced by the sebaceous glands assists in preventing loss and gain of bodily moisture. Sebaceous glands in the dermis secrete sebum to lubricate the hair and repel water from the skin. Protection against UV radiation is provided by melanocytes. These pigment-forming cells located at the base of the epidermis produce melanin. Melanin absorbs UV light to protect the epidermis and dermis from the harmful effects of UV light. Exposure to ultraviolet rays stimulates the melanocytes to produce extra melanin resulting in tanned skin.
Regulation of body temperature

The skin plays a significant role in maintaining body temperature. Sweat glands and blood vessels act as temperature regulators of the skin. Changes in body temperature are detected by receptors in the skin that send nerve impulses to the brain, which respond by sending output nerve impulses back to the sweat glands and the blood vessels. Perspiration is constantly produced by sweat glands. The amount of perspiration sweat glands release is determined by changes in body temperature. An increase in body temperature causes sweat glands to produce perspiration more rapidly. A decrease in body temperature causes sweat glands to produce perspiration less rapidly. Blood vessels in the skin dilate or constrict to assist in maintaining body temperature. When body temperature rises, blood vessels dilate increasing blood flow through the skin, allowing heat to radiate into the external environment. A lowered body temperature causes blood vessels to constrict decreasing blood flow through the skin, minimising radiation of heat into the external environment.

Excretion

Sweat glands play a small part in the removal of wastes, such as nitrogen, sodium and salt, from the bloodstream. These wastes are present in perspiration secreted by the sweat glands.

Detection of stimuli

Nerve endings in the epidermis and dermis are called receptors. Receptors perform an important sensory function as they detect stimuli in the external environment. They are specifically designed to respond to temperature, pressure, pain or touch. Some areas of the body have more receptors than others, for example, the fingertips have a vast number of touch receptors, which makes them extra sensitive. Pain receptors are evenly distributed all over the skin and are crucial in preventing injury. The detection of other sensations such as wetness, softness and sharpness is caused by stimulation of different types of receptors at the same time.

Synthesis of vitamin D

Vitamin D is an essential precursor to calcitriol, a hormone required for calcium absorption and bone development. While vitamin D may be obtained through diet, ninety percent of vitamin D is produced in the skin. Only a small amount of UV exposure is required for vitamin D production.

Blood reservoir

Skin serves as a blood reservoir as it contains many blood vessels. The blood vessels supply nutrients to the cells in the basal layer and also remove waste products.

Skin facts

- The skin of an average adult weighs about 4 kilograms
- Adult skin surface area is approximately 2 square metres
- Skin cells replace themselves every 28 days
- Old skin cells make up the majority of household dust
- About 70% of skin is water

Accessory structures

Accessory structures of the skin include:

- hair
- sebaceous glands
- exocrine glands
sweat glands
nails

Healing properties

Skin has exceptional self-healing properties, especially when only the epidermis is damaged. When injury damages the dermis healing can be achieved if the injured area is in a region of the body with a rich blood supply. Deeper wounds that penetrate to underlying tissue heal by scar formation. Scar tissue is deficient in infection resisting and metabolic functions of healthy skin.

Granulation tissue - newly growing capillaries and connective tissue form granular projections on the surface of ulcers or healing wounds.

Scar tissue - dense fibrous contracted connective tissue that has formed over a healed wound. Scar tissue is also referred to as cicatricial tissue.

Keloid scar - raised red or pink fibrous scar tissue that is the result of excessive tissue repair at the edges of a wound or incision. Keloid scars are more common in people with dark pigmented skin compared to fair skin.

SunSmart UV Alert

The SunSmart UV Alert is a tool you can use to protect yourself from ultraviolet (UV) radiation. It lets you know the time during that day you need to be SunSmart. The Alert is issued by the Bureau of Meteorology when the UV index is forecast to reach 3 or above. At that level, it can result in damage to your skin and lead to skin cancer.

Classification

The codes for skin conditions and procedures are primarily located in ICD-10-AM Chapter 12 Diseases of the skin and subcutaneous tissue (L00-L99) and ACHI Chapter 16 Dermatological and plastic procedures (blocks 1600-1718).

Helpful hints within the classification

Just a reminder of the following hints and tips which are located in the tabular:

L00-L08: Infections of the skin and subcutaneous tissue

*Use additional code (B95-B97) to identify infectious agent.*

L20-L30: Dermatitis and eczema
Note: In this block the terms dermatitis and eczema are used synonymously and interchangeably.

L55: Sunburn

\[1911\]

Includes:

- burns from exposure to man-made ultraviolet radiation

Use additional code (T20-T25, T29-T30) to identify site of sunburn.

Use additional code (T31) to identify the percentage of body surface area.

Use additional external cause code (Chapter 20) to identify cause.

1644: Split skin graft to burn of other sites

Split skin autograft to burn of other sites

Includes:

- debridement of burn of same site
- dressing of burn of same site
- excision of burn of same site
- excision of skin for graft
- repair of secondary defect by suture

References


ACS 1544 Complications following abortion and ectopic molar pregnancy

Q:

Is example 2 in ACS 1544 Complications following abortion and ectopic molar pregnancy correct and if so does this mean that multiple codes can be assigned to add specificity to O03-O07 codes i.e. those which specify ‘other and unspecified complications’?

A:

ACS 1544 Complications following abortion and ectopic and molar pregnancy was revised in an erratum to first edition as follows:

First Edition:

O08 should be assigned as an additional code with O00-O02 (Ectopic pregnancy, Hydatidiform mole, Other abnormal products of conception) to identify associated complications. “O08 may be assigned with categories O03-O07 (Spontaneous abortion, Medical abortion, Other abortion, Unspecified abortion, Failed attempted abortion) where the addition of this code provides fuller details of the complications.

First Edition errata:

An O08 code should also be assigned as an additional code to identify a complication associated with categories O00-O02 (Ectopic pregnancy, Hydatidiform mole, Other abnormal products of conception).

The modification to the standard indicated that codes from O08 should not be assigned in addition to codes in the range O03-O07. Categories O03-O06 (Spontaneous abortion, Medical abortion, Other abortion, Unspecified abortion) are intended to classify complications from an abortion occurring during the same episode of care and codes from O08 Complications following abortion and ectopic and molar pregnancy are intended to classify complications arising from an abortion occasioning a subsequent episode of care.

Example 2 should have been amended as part of the erratum to First Edition i.e. O08.6 Damage to pelvic organs and tissues following abortion and ectopic and molar pregnancy should have been removed. The following amendments to this example will be included in the first errata to Ninth Edition:

EXAMPLE 2:

Incomplete abortion with perforation of uterus.

Codes:  O06.3  Unspecified abortion, incomplete, with other and unspecified complications
        O08.6  Damage to pelvic organs and tissues following abortion and ectopic and molar pregnancy
        O71.02  Traumatic rupture of uterus before onset of labour
        O09.-  Duration of pregnancy

An additional code O71.02 Traumatic rupture of uterus before onset of labour is assigned to provide further details of the complication, by following the index pathway:

Perforation, perforated (nontraumatic)

- uterus

- - obstetric trauma (during labour)

- - - before onset of labour O71.02
ACS 1544 is not explicit about whether chapter codes such as acute kidney failure (N17.-), urinary tract infection (N39.0) can be assigned in addition to codes in the range O03-O07. However, following the principles of multiple coding (see ACS 0002 Additional diagnoses) assignment of codes from other chapters may be assigned if they provide further specificity.

The classification for pregnancy with abortive outcome (O00-O08) and ACS 1544 have been flagged for review in a future edition of ICD-10-AM.

Published 15 December 2014, for implementation 01 January 2015.
Adipose-derived stem cell therapy

Q:

How do you classify adipose-derived stem cell therapy?

A:

Stem cells may be used as an adjunct therapy during certain procedures to encourage cell regeneration. For example, stem cells may be injected into a joint following chondroplasty for a chondral defect, with the expectation that they are able to convert to cartilage-like cells and encourage cartilage regeneration.

Adipose-derived stem cells may be used as they are abundant in quantity and are harvested by liposuction. Following liposuction, the tissue is processed outside of the body (to separate the stem cells from the fat and other cells etc) and then injected back into the patient’s defective joint.

Adipose-derived stem cell therapy more closely resembles autologous chondrocyte implantation than traditional stem cell transplantation, which is performed via bone marrow transplantation. Therefore, where adipose-derived stem cell therapy is performed, assign:

14203-01 [1906] Direct living tissue implantation

by following the index pathway:

Implant, implantation

- living tissue
- - by
- - - direct implantation

Amendments to ACHI Alphabetic Index will be considered for a future edition.

Published 15 December 2014,
for implementation 01 January 2015.
Malpresentation, disproportion and abnormality of maternal pelvic organs

Q:
When should codes from O32-O34 versus O64-O66 be assigned?

A:
The codes from O64-O66 are assigned when a condition classifiable to O32-O34 is first diagnosed during labour, OR requires care and/or intervention during labour because it is considered that the condition has affected the labour and/or delivery. This is consistent with the guidelines in ACS 1506 Fetal presentation, disproportion and abnormality of maternal pelvic organs, the includes notes at O32-O34 and the relevant index entries.

To summarise the guidelines in ACS 1506:

Where care or intervention is required due to malpresentation, disproportion or abnormality of the maternal pelvic organs before the onset of labour, assign a code from block O32-O34 (that is, known before onset of labour, care or intervention required before onset of labour, eg breech presentation diagnosed before the onset of labour and proceeds to elective caesarean section without labour).

Where the malpresentation, disproportion or abnormality of maternal pelvic organs requires care and/or intervention during labour, assign a code from blocks O64-O66 (that is, known before onset of labour, care or intervention required during labour; this includes failed trial of labour).

Where the malpresentation, disproportion or abnormality of maternal pelvic organs is first diagnosed during labour, assign a code from blocks O64-O66 (that is, not known before onset of labour).

(See also ACS 1506 Fetal presentation, disproportion and abnormality of maternal pelvic organs.)

Amendments to ACS 1506 will be considered for a future edition of the Australian Coding Standards.

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

Published 15 September 2014, for implementation 01 October 2014.
Clinical update: Dental Services

Coding of dental procedures is a very specialised area that requires an understanding of dental terminology and anatomy. In 1998, NCCH published a two-part article entitled “Clinical Coder’s Guide to Dental Services”. These articles have been updated here to assist coders to understand common procedures and terms used in dental services.

In ACHI, Eighth Edition dental intervention codes are based on The Australian Schedule of Dental Services and Glossary (9th Edition) published by the Australian Dental Association Incorporated.

Tooth Anatomy

Knowledge of the anatomy of teeth is important in the understanding of both the disease processes and interventions required for the treatment of dental diseases (see Figure 1).

Figure 1 - Tooth anatomy

Definitions

**Enamel**
The tough, shiny, white outer surface of the tooth.

**Dentin**
The hard but porous tissue located under both the enamel and cementum of the tooth. Dentin is harder than bone.

**Cementum**
The layer of tough, yellowish, bone-like tissue that covers the root of a tooth. It helps hold the tooth in the socket. The cementum contains the periodontal membrane.

**Crown**
The visible part of a tooth.

**Tooth root**
The portion of the tooth that lies beneath the gum line and is embedded in bone. The tooth root serves as an anchor to hold the tooth in position.

**Pulp**
The soft inner structure of a tooth consisting of nerve and blood vessels.

**Gingiva**
The gum.

**Deciduous teeth**
The primary or baby teeth; the first set of teeth that are later replaced by permanent teeth.
Exfoliation  The process by which the deciduous teeth fall out to make way for the eruption of permanent teeth.

Eruption  The process by which the teeth break through the gums.

Types and Position of Teeth

Anterior  The teeth in front of the mouth eg centrals, laterals and cuspids.

Posterior  The teeth at the back of the mouth including molars and bicusps.

Incisors  The four front teeth in the lower and upper jaw are called incisors. The central pair in the lower and upper jaw are called central incisors and the teeth on either side of the central incisors are called lateral incisors. These teeth are broad and flat with a narrow edge that is used for cutting or snipping off pieces of food.

Canines  The four canine teeth are situated next to the lateral incisors on the lower and upper jaw. They are also referred to as eyeteeth or cuspids. Canines are the longest and most stable teeth in the mouth. They are used to rip and tear food and have a single long root.

Premolars  Next to each of the canine teeth are two premolars, also referred to as bicusps. These teeth are a cross between canines and molars. Like the canine teeth, premolars have sharp points for ripping; however they also have a broad surface, like molars, for chewing and grinding.

Molars  The last three teeth on both sides of the mouth, in the upper and lower jaw. They are numbered first, second or third molar according to their location. The third molars are also referred to as wisdom teeth. Wisdom teeth are the last teeth in the mouth and are the last teeth to erupt. Molars are the largest teeth in the mouth. They have a broad surface that is used for crushing, grinding and chewing food.

Figure 2 - Types of Teeth
Dental Notation (Dental Numbering) Systems

Tooth notation, or numbering, systems are used by dentists to associate information to a specific tooth. These notation systems are used in medical records and operation reports to help to identify which specific tooth is being treated. Two common tooth numbering systems used in Australia are the Federation Dentaire Internationale (FDI) Two Digit Notation method and the Palmer notation method.

FDI Two Digit Notation Method

This notation method is a combination of two numbers. The first number indicates the tooth’s location (upper left or right, lower left or right) and the second number indicates the specific tooth (see Table 1).

Table 1 - Quadrant Codes

<table>
<thead>
<tr>
<th>Adult Teeth</th>
<th>Adult Teeth</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - upper right</td>
<td>5 - upper right</td>
</tr>
<tr>
<td>2 - upper left</td>
<td>6 - upper left</td>
</tr>
<tr>
<td>3 - lower left</td>
<td>7 - lower left</td>
</tr>
<tr>
<td>4 - lower right</td>
<td>8 - lower right</td>
</tr>
</tbody>
</table>

Each quadrant contains eight teeth. The teeth are assigned a number from 1 to 8 starting at the central incisor (1) and working toward the 3rd molar (8) (see Table 2).
Table 2 - Tooth Codes
1 - central incisor
2 - lateral incisor
3 - canines
4 - 1st premolar
5 - 2nd premolar
6 - 1st molar
7 - 2nd molar
8 - 3rd molar

The combination of these two numbers make up the FDI two digit notation number (see Figure 4).

<table>
<thead>
<tr>
<th>Permanent Teeth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper Right</td>
</tr>
<tr>
<td>18 17 16 15 14 13 12 11</td>
</tr>
<tr>
<td>48 47 46 45 44 43 42 41</td>
</tr>
<tr>
<td>Lower Right</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary teeth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper Right</td>
</tr>
<tr>
<td>55 54 53 52 51</td>
</tr>
<tr>
<td>85 84 83 82 81</td>
</tr>
<tr>
<td>Lower Right</td>
</tr>
</tbody>
</table>

Figure 4 - FDI Tooth Notation Method for Permanent and Deciduous Teeth

Palmer Notation Method

Permanent Teeth
In this method the teeth are also divided into quadrants and are numbered from 1 to 8 in the same manner as the FDI notation method. However, the method of identifying the specific quadrant is different. Each quadrant is identified by an \( L \) shaped symbol. The number of the tooth then sits inside the \( L \) shaped symbol, with the upper and lower quadrants identified by whether the shape is right side up or upside down as follows (see Figure 5 and Example 1):

\[
\begin{array}{c|c}
\text{Upper right} & \text{upper left} \\
\hline
\text{Lower right} & \text{lower left}
\end{array}
\]

Figure 5 - Palmer Notation Method for Permanent Teeth

Example 1

Using the Palmer notation, this symbol identifies an upper-right first premolar tooth.

Deciduous Teeth
The Palmer notation method has a different method for numbering deciduous teeth. The teeth are identified by the letters A to E. The teeth are assigned a letter starting at the central incisor (A) and working toward the 3rd molar (E). The system for the identification of the tooth’s position is exactly the same as for permanent teeth (see Figure 6 and Example 2).

<table>
<thead>
<tr>
<th>Upper right</th>
<th>upper left</th>
</tr>
</thead>
<tbody>
<tr>
<td>E</td>
<td>D</td>
</tr>
<tr>
<td>L</td>
<td>A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lower right</th>
<th>lower left</th>
</tr>
</thead>
<tbody>
<tr>
<td>E</td>
<td>D</td>
</tr>
<tr>
<td>L</td>
<td>A</td>
</tr>
</tbody>
</table>

*Figure 6 - Palmer Notation Method for Deciduous Teeth*

**Example 2**

Using the Palmer notation method, this symbol identifies a deciduous lower-right central incisor tooth.

**Tooth Surfaces**

There are five possible tooth surfaces that can be restored: buccal, distal, lingual, mesial, and occlusal/incisal (see Figure 7).

**Dental Restorations**

Dental restorations or fillings are used to restore function and integrity to the structure of teeth. The most common causes for the loss of tooth structure are dental caries or tooth trauma.

Dental restorations are classified into two types, direct and indirect (see Table 3).

Direct restorations are performed by placing the restorative material directly onto the tooth. These types of restorations are usually performed in one visit and examples include dental amalgam, glass ionomers, resin ionomers and resin composite fillings.
Indirect restorations involve materials that have been fabricated outside the mouth. Examples include inlays, onlays, veneers, crowns and bridges.

*Table 3 - Restorative Material*

<table>
<thead>
<tr>
<th>Material Type</th>
<th>Direct</th>
<th>Indirect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adhesive or tooth-coloured</td>
<td>Compomer composite resin (eg CR, Z100, AECR) glass ionomer (Ketac, Photac, GIC, Dyract) polymer glass porcelain/ceramic acrylic</td>
<td>chrome cobalt gold non precious metal</td>
</tr>
<tr>
<td>Metallic</td>
<td>Amalgam (mercury based alloy) Galloy (gallium based alloy) gold foil</td>
<td>chrome cobalt gold non precious metal</td>
</tr>
</tbody>
</table>

*Removal of Teeth*

**Non-surgical extraction**

Also referred to as simple extraction is generally performed under local anaesthetic and is performed on teeth that can be seen in the mouth. The tooth is held with forceps which are then moved back and forth to loosen the tooth until it is removed. Sometimes a luxator is used to help loosen the tooth before it is extracted.

**Surgical extraction**

An incision is made into the mucosa and a mucoperiostial flap is raised in order to extract the tooth. In some cases, the tooth will need to be broken into sections to be removed. Surgical extractions may involve teeth that are not visible in the mouth either because the tooth has broken off or has not yet erupted through the gum. Surgical extractions are also performed if a tooth is impacted.

**Tooth impaction**

Occurs when a tooth fails to erupt through the gum (or only partially erupts) at the expected time. Wisdom teeth, the last teeth to erupt, are the most common teeth to become impacted.

There are four types of tooth impaction - erupted (already in the mouth), full bony impaction (see Figure 8), partial-bony (see Figure 9) and soft tissue impaction (see Figure 10). An impacted tooth may be painless, however, pain and swelling occurs when the tooth tries to erupt through the overlying gum. Pain may be felt in nearby teeth or the ear on that side. A partially erupted tooth may collect food and debris leading to gum swelling and pericoronitis.

*Figure 8 - Full Bony Impaction*
Removal of impacted teeth

The procedure for the removal of wisdom teeth varies according to the type of impaction. Wisdom teeth may grow in different directions due to lack of space in the jaw. As a result, the complexity of the surgery depends on the type of impaction. If the tooth has erupted fully it may be removed by a simple extraction. However, a full bony impaction will require a complex surgical extraction.

Impacted wisdom teeth are generally removed by surgical extraction. An incision is made into the gum and the gum tissue is moved out of the way. This exposes the tooth and the bone overlying it. In order to access the tooth, any bone in the way needs to be carefully removed. Once the tooth is exposed, it may need to be broken into pieces or sectioned in order to be removed. Sectioning the tooth enables the tooth to be removed through the smallest possible incision, with the loss of the least amount of bone. Sectioning the tooth also protects important nerves and blood vessels that surround the tooth. Once the tooth has been removed the gum tissue is replaced and the wound is sutured.

Classification

Australian Coding Standards

Dental procedures should be coded following ACS 0016 General Procedure Guidelines, and ACS 0809 Intraoral Osseointegrated Implants. Dental procedures are excluded from ACS 0020 Bilateral/multiple procedures.
ACS 0016 General Procedure Guidelines
This standard instructs that procedures which are individual components of another procedure should not be coded.

Fissure sealing may be performed alone or it may be performed as part of tooth preparation for a restoration procedure. Where a restoration includes a fissure sealant on the same tooth, then only assign a code for the restoration.

ACS 0809 Intraoral Osseointegrated Implants
The intraoral osseointegrated implants procedure is a complicated two stage procedure. This standard provides guidelines to assist with coding in this area.

ACS 0020 Bilateral/Multiple Procedures
Codes in Chapter 6 Dental Services do not meet the criteria in ACS 0020 Bilateral/Multiple Procedures for ACHI Eighth Edition. Generally, dental procedures should be coded as many times as they are performed. However the following guidelines should be applied to the coding of dental procedures:

- When a code includes reference to a number of teeth it should only be assigned once. For example 97311-03 [457] Removal of 3 teeth or part(s) thereof specifies the removal of 3 teeth therefore this procedure code should only be assigned once.
- Dental codes that specify per tooth, per root or per cusp (etc) should be coded as many times as they are performed. For example as 97171-00 [455] Odontoplasty, per tooth should be coded as many times as it is performed.
- Codes that don’t indicate that they classify a specific number of teeth should be coded as many times as performed. For example, if documentation specifies that 97414-00 [462] Pulpotomy was performed on four teeth, it should be assigned four times.

ACHI
In ACHI Eighth Edition, there are a range of codes to reflect the number of teeth extracted: 1 tooth, 2 teeth, 4 teeth, 5-9 teeth, 10-14 teeth and ≥ 15 teeth. These codes are located in blocks [457] Nonsurgical removal of tooth and [458] Surgical removal of tooth to simplify the code selection when the mucosa has been incised and the mucoperiosteal flap raised.

Surgical extraction versus nonsurgical extraction: The distinction between surgical extraction of teeth and nonsurgical extraction of teeth is not always clear.

Documentation of "incision of mucosa" is an indication of a surgical tooth extraction. Therefore the following inclusion terms aid code selection:

- "Incision of mucosa and raising of mucoperiosteal flap to remove tooth, followed by suturing of the wound" in block [458] Surgical removal of tooth.

Full Dental Clearance is the process whereby all remaining teeth in the mouth are removed. A definition has been added to 97322-01 [458] Full dental clearance to clarify the meaning of the term. Codes also exist for a "full upper clearance" and a "full lower clearance". A "full upper clearance" is when there are no teeth remaining in the upper jaw after the procedure and a "full lower clearance" is when there are no teeth left in the lower jaw after the procedure.
### ACHI Dental Procedures and Definitions

The following tables list the types of dental interventions that may be performed.

#### Preventative Dental Services

<table>
<thead>
<tr>
<th>Blocks [453] to [455]</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Removal of plaque or stain</td>
<td>Removal of dental plaque and/or stains from the surfaces of all teeth.</td>
</tr>
<tr>
<td>Fissure sealing and/or tooth surface sealing</td>
<td>Sealing of non-carious pits, fissures or cracks in a tooth with an adhesive material to prevent development of dental caries at the site.</td>
</tr>
<tr>
<td>Odontoplasty</td>
<td>Modification of the contour of the crown of a tooth or the anatomy of the fissure of a tooth.</td>
</tr>
</tbody>
</table>

#### Periodontic Interventions

<table>
<thead>
<tr>
<th>Block [456]</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Root planing with subgingival curettage</td>
<td>The surface of the tooth root is planed to remove rough or contaminated cementum, dentine or deposits of calculus with curettage of the soft tissues of the periodontal pocket and removal of granulation tissue.</td>
</tr>
<tr>
<td>Gingivectomy</td>
<td>A surgical procedure to remove the soft tissue wall of the periodontal pocket or swollen gum tissue.</td>
</tr>
<tr>
<td>Periodontal flap surgery</td>
<td>Incision and raising of a flap of gingival tissue to enable removal of inflammatory or granulation tissue.</td>
</tr>
<tr>
<td>Crown lengthening</td>
<td>A flap procedure to establish an apical gingival margin for greater exposure of the tooth structure.</td>
</tr>
<tr>
<td>Osseous graft</td>
<td>A surgical procedure in which a piece of bone or a synthetic substitute is used to replace or repair alveolar bone.</td>
</tr>
<tr>
<td>Osseous surgery</td>
<td>Re-shaping and modifying defects and deformities in the bone supporting and surrounding teeth.</td>
</tr>
<tr>
<td>Gingival graft</td>
<td>Transference or transplanting gingival or other soft tissue from a donor area in the patient's mouth to an area around a tooth or implant to remedy a gingival deficiency.</td>
</tr>
</tbody>
</table>

#### Oral Surgery

<table>
<thead>
<tr>
<th>Blocks [457] to [458]</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nonsurgical removal of teeth</td>
<td>Removal of teeth not requiring a surgical incision (ie without incision of mucosa). See block [457].</td>
</tr>
<tr>
<td>Sectional removal of teeth</td>
<td>Removal of teeth in sections. Bone removal may be necessary however a surgical incision is not required. See block [457].</td>
</tr>
<tr>
<td>Surgical removal of teeth</td>
<td>Removal of teeth where a surgical incision is required. See block [458].</td>
</tr>
<tr>
<td>Full upper dental clearance</td>
<td>Removal of all remaining teeth in the upper jaw.</td>
</tr>
<tr>
<td>Full lower dental clearance</td>
<td>Removal of all remaining teeth in the lower jaw.</td>
</tr>
<tr>
<td>Full dental clearance</td>
<td>Removal of all remaining teeth in the jaw.</td>
</tr>
<tr>
<td>Surgical removal of teeth requiring bone removal and tooth division</td>
<td>Removal of teeth where both removal of bone and sectioning of the tooth is required following a surgical incision. See block [458].</td>
</tr>
</tbody>
</table>

#### Endodontics

<table>
<thead>
<tr>
<th>Blocks [462] to [464]</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulpotomy</td>
<td>Removal of part of the vital tooth pulp from the pulp chamber. The remaining pulp is then covered with a protective dressing or cement. See block [462].</td>
</tr>
<tr>
<td>Obturation</td>
<td>The phase of a root canal treatment that creates a fluid tight seal along the length of the root canal system.</td>
</tr>
<tr>
<td>Extirpation of pulp</td>
<td>Removal of pulp, or necrotic debris of pulp from a tooth’s root canal system.</td>
</tr>
</tbody>
</table>
Restorative Types

Blocks [465] to [469]

Procedure/Terms  Definition
Restoration  Construction and insertion into a tooth of a restoration which may be metallic, resin-based or porcelain.
Pin retention  Small pins are inserted into the tooth to provide extra support for the restoration material.
Stainless steel crown  A preformed crown is trimmed, contoured and used as coronal tooth restoration.
Post  Insertion of a post into a prepared root canal to provide an anchor for an artificial crown or other restoration.

Prosthodontics

Blocks [470] to [477]

Procedure/Terms  Definition
Cast for crown  A post and core fabricated accurately to the dimension of a prepared root canal to provide a foundation for an artificial crown.
Temporary Crown  Construction of a temporary restoration usually made from a resin, to protect the underlying tooth prior to construction of permanent crown.
Full Crown  An artificial crown or full veneer is used to restore a tooth's size, shape and strength.
Pontic Bridge  That part of a bridge which replaces clinical crowns of missing teeth.
Complete denture  A removable dental prosthesis constructed to replace all missing teeth and tissues.
Partial denture  A denture provided for a dental arch in which one or more natural teeth remain.
Partial denture components  Metal clasp carefully designed to fit round a tooth. Its main purpose is to hold the denture in place.
- Retainer  A unit of a partial denture that rests upon a tooth surface to provide support for the denture.
- Occlusal rest  A bar that joins sections of a partial denture.
- Connecting bar  An extension of a denture covering the occlusal surface of remaining teeth.
Overlay  This procedure involves the addition of one or more teeth to a denture.
Immediate replacement of tooth  A resilient tissue bearing surface is added to a denture
Resilient lining  Replacement of the tissue fitting surface of a denture to improve its accuracy and fit.
Denture maintenance - Relining  Replacement of the resin base of a denture to improve its accuracy and fit. It is different from rebasing in that it also permits rearrangement of teeth.
Denture maintenance - Remodelling  This involves the removal and replacement of a denture base.
Denture maintenance - Rebasing  An appliance constructed from either acrylic resin or metal designed to hold or maintain mobile teeth in their predetermined position.
Splints  A prosthesis constructed to close a congenital or acquired opening in the palate. Usually attached to a partial or complete denture.
Obturator  This process involves the staining and carving of the outer surfaces of the denture.
Denture characterisation  A negative imprint from which a reproduction or cast can be made.

Dental impression  A negative imprint from which a reproduction or cast can be made.
**Orthodontics**
Blocks [479] to [483]

<table>
<thead>
<tr>
<th>Procedure/Terms</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Removable orthodontic appliance - Passive removable appliance</td>
<td>An appliance designed to maintain the position of the teeth.</td>
</tr>
<tr>
<td>Removable orthodontic appliance - Active removable appliance</td>
<td>As opposed to the passive appliance, an active appliance exerts force on teeth or arches to achieve tooth or dental arch movement.</td>
</tr>
<tr>
<td>Fixed orthodontic appliance - banding</td>
<td>The application of bands and/or brackets to correct tooth position or arch form.</td>
</tr>
<tr>
<td>Extraoral appliance</td>
<td>Extraoral head gear connected to an intra-oral appliance which makes use of the support of the back of the head and neck to transmit extraoral force which is then distributed to the teeth.</td>
</tr>
</tbody>
</table>

**General Dental Services**
Blocks [484] to [489]

<table>
<thead>
<tr>
<th>Procedure/Terms</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occlusal splint</td>
<td>An appliance made of acrylic resin which is designed to relieve abnormal pressures exerted on the temporomandibular joint (TMJ) and other supporting structures.</td>
</tr>
</tbody>
</table>

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Low grade versus noninvasive papillary urothelial carcinoma

Q:
Are low grade and noninvasive papillary urothelial carcinoma the same?

A:
Clinical advice confirms that:

- the morphological descriptions ‘low grade’ and ‘noninvasive’ are not synonymous as a tumour can be both ‘low grade’ and ‘invasive’, i.e. ‘low grade’ is not equivalent to ‘noninvasive’
- low grade papillary urothelial carcinoma NOS should default to carcinoma in situ unless it is specified as ‘invasive’ wherein it is considered to be malignant.

There is currently no index pathway which specifies low grade when papillary urothelial carcinoma is so described, therefore assign:

D09.0 Carcinoma in situ of bladder  
M8130/2 Papillary Transitional Cell Carcinoma, non-invasive

following the index pathway:
Carcinoma
...
- papillary
  - - urothelial (M8130/3) — see also Neoplasm/bladder/malignant
  - - - noninvasive (M8130/2) D09.0
  ...
- urothelial
  - - papillary, noninvasive (M8130/2) D09.0

There is also no index pathway which specifies low grade invasive when papillary urothelial carcinoma is so described, therefore assign:

C67.- Malignant neoplasm of bladder  
M8130/3 Papillary Transitional Cell Carcinoma

following the index pathway:
Carcinoma
...
- papillary
  - - urothelial (M8130/3) — see also Neoplasm/bladder/malignant

Clinical advice also indicates that the description ‘low malignant potential’ is not synonymous with ‘low grade’ and therefore must be specifically documented before assigning the following code:

Carcinoma
...
- papillary
- - urothelial
- - - of low malignant potential (M8130/1) D41.4

Indexing improvements to support this code assignment will be considered for a future edition.

See also ACS 0010 General abstraction guidelines.
Pancytopenia

Q: Where there is documentation of pancytopenia and one or two of the blood abnormalities in the clinical record, is a code assigned for each of the specific blood abnormalities as well as the pancytopenia code? Do each of the blood abnormalities have to meet the criteria in ACS 0002 Additional Diagnoses?

A: ACS 0304 Pancytopenia/Definition states:

Pancytopenia is a general term for the simultaneous decrease in haemoglobin level (anaemia), white cell count (leukocytopenia/neutropenia/leukopenia) and platelet count (thrombocytopenia).

Attempt to obtain clarification from the clinician of the specific blood abnormalities (anaemia, neutropenia and thrombocytopenia) and assign codes for these conditions rather than assigning the default for pancytopenia.

Assign codes for each of the specific blood abnormalities only if they meet the criteria of additional diagnosis in ACS 0002 Additional Diagnoses.

Do not assign an additional code for ‘pancytopenia’ (D61.9 Aplastic anaemia, unspecified).

Amendments to ACS 0304 Pancytopenia will be considered for a future edition.

Published 15 December 2013, for implementation 01 January 2014.
Respiratory failure, type I acute and chronic

Eighth Edition Education Workshop FAQs - Part 2

Q:
If a patient has acute and chronic type I respiratory failure should both be coded?

A:
Where the type I respiratory failure is documented as both acute and chronic during an episode of care, assign a code for each (see ACS 0001 Principal diagnosis, Acute and chronic conditions).

Published 12 December 2013,
for implementation 01 January 2014.
Respiratory failure, mixed type I and type II

Eighth Edition Education Workshop FAQs - Part 2

Q:
What code should be assigned where the clinician documents mixed type I and type II respiratory failure? Can both codes be assigned?

A:
Respiratory failure results in abnormal blood gases and is always the consequence of another condition. Clinical advice confirms that type I and type II respiratory failure cannot occur at the same time, as in type I respiratory failure the carbon dioxide levels are normal or low, in contrast to type II respiratory failure where carbon dioxide levels are high.

However, type I and type II respiratory failure could occur at separate times during the course of an admission. Therefore codes for type I and type II respiratory failure can be assigned according to the documentation in the episode of care, noting that they cannot occur at the same time.

Published 12 December 2013, for implementation 01 January 2014.
ACS 0048 Condition onset flag

Q:

Eighth Edition Education Workshop FAQs - Part 2

Could Condition Onset Flag (COF) value of 1 be assigned to a patient who is admitted with diabetes and develops uncontrolled diabetes during the episode of admitted patient care?

A:

Clinical advice indicates that diabetes can become uncontrolled during the course of an admission, therefore COF 1 should be assigned for E1.65 *** diabetes mellitus with poor control where it is clearly documented that controlled diabetes develops into poorly controlled or unstable diabetes during the episode of care. (see ACS 0048 Condition onset flag, Guide For Use, Point 5.)

Published 12 December 2013,
for implementation 01 January 2014.
ACS 0020 Bilateral/multiple procedures – skin lesions

Q:

Eighth Edition Education Workshop FAQs - Part 1

If one lesion is excised but the histopathology report indicates that there was more than one morphological type in the excised tissue, how many times should the ACHI code be assigned?

A:

The ACHI code should be assigned as many times as the procedure is performed. Where one lesion is excised, the procedure code should be assigned once only, regardless of the number of morphological types reported.

Published 17 October 2013, for implementation 01 November 2013.
ACS 0048 Condition onset flag

Q:

Eighth Edition Education Workshop FAQs - Part 1

Where a patient with chronic obstructive pulmonary disease develops pneumonia during the episode of care, what COF would be assigned to the pneumonia code?

A:

A COF of 1 should be assigned to the pneumonia code as this condition arose during the episode of admitted patient care.

Published 17 October 2013,
for implementation 01 November 2013.
ACS 2114 Prophylactic surgery

Q:

Eighth Edition Education Workshop FAQs - Part 1

Patients who have neoplastic bone disease sometimes have a nail inserted into the diseased bone to assist in the prevention of fractures. As the clinicians refer to this as prophylactic surgery should a code from Z40.- Prophylactic surgery be assigned?

A:

ACS 2114 Prophylactic surgery principally provides instruction for assigning ICD-10-AM codes where prophylactic surgery is performed on healthy organs in patients who have known risks for the development of malignant disease. The standard does not currently provide specific guidelines for the assignment of an additional diagnosis of Z40.-, for other types of prophylactic surgery. However, consideration will be given to expanding this standard in the future to address other scenarios where surgery is considered prophylactic.

Therefore, for this scenario assign the neoplastic bone disease as the principal diagnosis and a code from Z40.- is not currently required.

Published 17 October 2013,
for implementation 01 November 2013.(116,940),(534,965)
ACS 0048 Condition onset flag

Q:

Eighth Edition Education Workshop FAQs - Part 1

What COF should be assigned where a patient is admitted with chronic obstructive pulmonary disease and develops an acute respiratory infection during the episode of care?

A:

When two conditions are described within a combination code, such as J44.0 *Chronic obstructive pulmonary disease with acute lower respiratory infection*, assign COF 1 if one of those conditions meets the criteria for assignment of COF 1 and the condition is not represented by another code with a COF value of 1 (refer ACS 0048 *Condition onset flag, Guide for use, point 5*)

Published 17 October 2013,
for implementation 01 November 2013.
ACS 0048 Condition onset flag

Q:

Eighth Edition Education Workshop FAQs - Part 1

Why can’t a COF 1 be assigned to J44.1 *Chronic obstructive pulmonary disease with acute exacerbation, unspecified* where the acute exacerbation arises during the episode of care?

A:

A chronic disease that is present on admission and is exacerbated during the episode of care should be assigned a COF of 2 (refer ACS 0048 *Condition onset flag, Permissible values*).

Published 17 October 2013,
for implementation 01 November 2013.
Jaundice:

Q:

Eighth Edition Education Workshop FAQs - Part 1

Where a neonate is readmitted for phototherapy, does the procedure code for phototherapy need to be assigned in addition to the ICD-10-AM code for jaundice?

A:

The code for phototherapy of the newborn, 90677-00 [1611] Other phototherapy, skin, should only be assigned where the phototherapy is sustained for >12 hours as per the specific instructions contained within ACS 1615 Specific diseases and interventions related to the sick neonate.

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

Published 17 October 2013,
for implementation 01 November 2013.
Resistance to antimicrobial and antineoplastic drugs

Q:

Eighth Edition Education Workshop FAQs - Part 1

Can a code for resistance to antibiotics be assigned where the resistance is not documented by the clinician, however the information is in the pathology report and the antibiotic treatment is changed?

A:

The clinician must document the drug resistance in the record in order to assign a code from Z06.- Resistance to antimicrobial drugs (see ACS 0112 Infection with drug resistant microorganisms).

Published 17 October 2013, for implementation 01 November 2013.
Resistance to antimicrobial and antineoplastic drugs

Q:

Eighth Edition Education Workshop FAQs - Part 1

Where MRSA is documented by the clinician, can the information from the pathology report be used where it provides the information about whether the MRSA is multi resistant or methicillin resistant?

A:

The guidelines in ACS 0010 *General abstraction guidelines*, direct that diagnostic results should be used to add specificity to already documented conditions that meet the criteria for code assignment. As it is important to establish whether MRSA is referring to methicillin resistance as opposed to the less specific and less common usage ‘multi resistance’ the diagnostic results should be referenced (see ACS 0112 *Infection with drug resistant microorganisms*).

Published 17 October 2013,
for implementation 01 November 2013.
Eighth Edition Education Workshop FAQs - Part 1

Where there is no degree specified for the haemorrhoids but the clinician has documented ‘retract spontaneously’, can the haemorrhoids be assumed to be second degree, as in the inclusion term in the Tabular List at K64.1 Second degree haemorrhoids?

A:

Following the coding process, the code for second degree haemorrhoids can be assigned in this case by following the index entry first:

Haemorrhoids
- 2nd degree (grade/stage II) (with prolapse but retracts spontaneously)

Then by reference to the inclusion term at K64.1 Second degree haemorrhoids in the Tabular List, where it specifies ‘Haemorrhoids that prolapse on straining but retract spontaneously.’ (refer to Tabular List of Diseases, Guidance in the use of ICD-10-AM).

Published 17 October 2013, for implementation 01 November 2013.
Haemorrhoids

Q:

Eighth Edition Education Workshop FAQs - Part 1

What haemorrhoid code should be assigned when a patient is admitted for banding of haemorrhoids?

A:

ACS 0942 Banding of haemorrhoids was deleted for Eighth Edition as the banding related to internal haemorrhoids, which is no longer relevant now that haemorrhoids are classified by degree. Therefore code assignment is determined by the clinical documentation.

Published 17 October 2013,
for implementation 01 November 2013.
Haemorrhoids

Q:

Eighth Edition Education Workshop FAQs - Part 1

What code(s) should be assigned when multiple grades of haemorrhoids are documented or terminology such as grade II-III haemorrhoids is used?

A:

While there is currently nothing in the classification to preclude the assignment of multiple codes to reflect different stages of haemorrhoids, clinical advice indicates that it is only necessary to assign one code for the most severe haemorrhoid grade.

Improvements to the classification will be considered in the future to reflect this advice.

Published 17 October 2013,
for implementation 01 November 2013.
Haemorrhoids

Q:

Eighth Edition Education Workshop FAQs - Part 1

If haemorrhoids are documented as either ‘internal’ or ‘external’ do they still have to be assigned a code for unspecified?

A:

The classification of haemorrhoids is by degree. If the degree is not specified, the correct code to assign is K64.9 Haemorrhoids, unspecified following the index entry:

**Haemorrhoids** (bleeding) (external) (internal) (without mention of degree) K64.9

The terms ‘internal’ and ‘external’ are nonessential modifiers that do not affect the code assignment.

*Published 17 October 2013,
for implementation 01 November 2013.*
Single event multilevel surgery (SEMLS)

Q:

Eighth Edition Education Workshop FAQs - Part 1

Can the codes from block [1580] Single event multilevel surgery [SEMLS] be assigned where a child with cerebral palsy has the multiple procedures performed as in the Tabular List, however the clinician has not documented SEMLS?

A:

Single event multilevel surgery, or SEMLS, needs to be documented in order to assign the codes from block [1580] Single event multilevel surgery [SEMLS]. If there is uncertainty as to whether it is SEMLS being performed then the clinical coder should clarify with the clinician.

Published 17 October 2013,
for implementation 01 November 2013.
Minimally invasive procedures proceeding to open procedures

Q:

Eighth Edition Education Workshop FAQs - Part 1

If a patient has a diagnostic laparoscopy performed and then proceeds to have an open procedure, should a code be assigned for the diagnostic laparoscopy?

A:

A code for the diagnostic laparoscopy should be assigned in addition to the open procedure code(s). It is only appropriate to assign 90343-01 Looparoscopic procedure proceeding to open procedure where the procedure was intended to be performed using a minimally invasive technique but then is converted to an open procedure due to a complication or other unplanned circumstance. These codes should not be used for diagnostic endoscopy/laparoscopy/arthroscopy.

Published 17 October 2013,
for implementation 01 November 2013.
Principal diagnosis assignment for syndromes

Q:
Where a patient is admitted for treatment of a particular component of a syndrome, should a code for the syndrome or the particular component, be assigned as the principal diagnosis?

A:
Where a patient presents for management of a component of a previously diagnosed syndrome, a code for the component should be assigned as the principal diagnosis. Where ICD-10-AM:

• provides a specific code for the underlying syndrome, assign this code as an additional diagnosis (refer ACS 0001 Principal diagnosis, Problems and underlying conditions).

• does not provide a specific code for the underlying syndrome, refer to ACS 0005 Syndromes for instruction regarding assignment of additional diagnosis codes.

Published 15 June 2013, for implementation 01 July 2013.
Viral hepatitis

Viral hepatitis

Patients with chronic viral hepatitis are often asymptomatic or may have abnormal liver function tests (LFTs). An indication of chronic viral hepatitis is a raised level of alanine transaminase (ALT) and/or aspartate aminotransferase (AST), in the absence of other causes of liver inflammation such as alcohol, non-alcoholic fatty liver disease. Generally, patients with chronic viral hepatitis are followed up 6-12 monthly with blood tests. Six monthly ultrasounds are recommended for surveillance of hepatocellular carcinoma (primary liver cancer) in all patients with cirrhosis, and in some patients with chronic HBV infection in the absence of cirrhosis.

Generally, after recovery from an infection with an organism, a person will develop antibodies to the pathogenic organism. Antibodies to certain infectious diseases can also be produced by vaccination. In these vaccinated people, future blood tests demonstrating the antibodies will indicate past infection or immunisation. Detection of antibodies does not indicate active infection; this is confirmed by detecting the virus in the blood. A person with detectable virus in their blood may or may not manifest symptoms but is potentially infectious and the virus can be transmitted to others.

It is important to understand the distinction between a person who has an active infection (at risk of transmission of infection to others and disease progression) and a person whose antibody results indicate past infection or immunisation to an infectious disease (not an infection risk, and usually not at risk of disease progression). The role of antibody tests in distinguishing between disease status and past infection varies depending on the infection. In some situations, testing for viral nucleic acid (DNA or RNA) is required to determine if actual infection is present.

Hepatitis A

Transmission within families is common. In developing countries, the usual source of infection is faecal contamination of drinking water. The hepatitis A virus (HAV) is detected by two antibody tests:

1. IgM antibody: positive result indicates recent infection. 2. IgG antibody (anti-HA): positive result indicates past infection (previous exposure to HAV) or immunity through vaccination.

Hepatitis B

Most people who are infected with HBV as adolescents or adults do not develop symptoms and clear infection spontaneously - they make a full recovery and are left with immunity for life. However, following acute infection, a small minority (approximately 5%) of patients will progress to a chronic infection.

In contrast, most of the global burden of chronic hepatitis B results from mother to infant transmissions or infection in early childhood, in high prevalence countries. Newborn babies of mothers who have hepatitis B (HBsAg positive) are at risk of infection and should receive HBV vaccination and immunoglobulin (within 12 hours of birth and complete a full HBV vaccination schedule). People who are infected with HBV as infants or in early childhood are often asymptomatic, but usually progress to chronic HBV infection.

There are two categories of tests used to diagnose and manage HBV infection:

1. serological assays: enzyme immunoassay (EIA) detects specific antibody(ies) to HBV and antigen(s) and includes HBsAg, anti-HBs, HBeAg, anti-HBe, anti-HBcAg.  2. molecular assays: detect and/or quantify the amount of viral nucleic acid (HBV DNA [deoxyribonucleic acid]). Tests are divided into two types:

   qualitative assays: detects presence or absence of HBV DNA

   quantitative assays: measures the amount of HBV DNA ('viral load') in serum (this is the preferred testing method and includes polymerase chain reaction (PCR) and transcription-mediated amplification (TMA) assays).
Antiviral therapy is used to treat patients with HBV infection, with the current aim of treatments to suppress virus replication and prevent progression of liver disease (EASL 2012). Spontaneous clearance of HBV infection may occur without treatment. This is common in adults following acute infection, but can also occur in people with chronic HBV infection. Resolution of HBV infection is rare with current treatment. Resolved HBV infection is defined as 'previous HBV infection without further virologic, biochemical or histological evidence of active virus or disease' (Lok McMahon 2009, p. 4).

Hepatitis C

The majority of patients (60-70%) with acute HCV infection will progress to a chronic infection. Spontaneous viral clearance after acute HCV infection occurs without treatment in 30-40% of people, usually within the first 6 months after infection. There are two categories of tests used to diagnose and manage HCV infection:

1. serological assays: enzyme immunoassay (EIA) detects specific antibody to HCV (anti-HCV).
2. molecular assays: detect and/or quantify the amount of viral nucleic acid (HCV RNA [ribonucleic acid]). Tests are divided into three types:
   - qualitative assays: detects presence or absence of HCV RNA
   - quantitative assays: measures the amount of HCV RNA ('viral load') in serum. This is usually by polymerase chain reaction (PCR).
   - genotype assay: there are 6 main genotypes of HCV. Choice and duration of antiviral treatment, as well as likelihood of response is strongly related to the infecting genotype.

Antiviral therapy is used to treat patients with HCV infection, with the aim of virological cure. Therapy is for a defined time period, usually 24 or 48 weeks. HCV infection is considered to be successfully treated when SVR (sustained virological response) is attained. SVR is defined as the absence of HCV RNA in serum 24 weeks after discontinuing therapy (Ghany et al. 2009, p. 1341).

Hepatitis D

Testing for HDV involves serology for hepatitis D antibodies (anti-HDV). However, this does not allow determination of active infection or prior exposure. Hepatitis D virus RNA testing has only limited availability in research settings.

Hepatitis E

It is endemic in South-East Asia, countries of the Soviet region, India, mid-east Africa and Central America. Large outbreaks are usually spread by contaminated water. Direct person to person spread can occur but is less common. The normal course of infection is an acute and a relatively benign illness. Whereas, HEV in pregnancy can cause fulminant hepatic failure, particularly in the third trimester, with mortality rates of 15-25%.

It was previously thought that HEV is never a chronic infection. However, it has been recently recognised that hepatitis E may result in chronic infection, particularly in immunosuppressed individuals such as organ transplant recipients (Kamar et al. 2012, p. 6).

Acknowledgements:

The NCCC would like to thank Dr Mark Douglas, Associate Professor Simone Strasser and Associate Professor Stuart Roberts for their invaluable contribution to updating viral hepatitis in the classification system.

References:


Long term use of insulin

Q:
When should Z92.22 Personal history of long term (current) use of other medicaments, insulin be assigned? Is it appropriate to assign Z92.22 when insulin treatment is initiated during the admission with the intent of treatment to be ongoing at the time of discharge?

A:
Follow the instruction in the Tabular List at E11, E13 and E14 which states, "Use additional code (Z92.22) to identify current pre-admission or ongoing insulin treatment" to assign Z92.22 Personal history of long term (current) use of other medicaments, insulin.

Therefore, Z92.22 should be assigned with codes from category E11, E13* and E14 (and not E10) where insulin treatment is ongoing, that is long-term not short term.

Z92.22 should not be assigned where insulin treatment is:

- initiated during the current episode - even if the intention is that the insulin treatment will be ongoing at the time of discharge
- used to control diabetes mellitus during an episode of care (eg. postoperatively)
- used to treat Type 1 diabetes mellitus as this is standard treatment for Type 1 diabetes mellitus.

Revision of the wording of the use additional code instruction at categories E11, E13* and E14 will be considered for a future edition of ICD-10-AM.

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

Published 15 December 2012,
for implementation 01 January 2013.
The diabetic foot

The diabetic foot is a complication of diabetes often requiring extended hospitalisation for successful treatment (weeks or months). It is characterised by an infected ulcer over a weight-bearing area of the foot, where a number of other factors contribute to the breakdown of the skin and underlying connective tissues and even involvement of the neighbouring bone. The presence of diabetic peripheral sensory neuropathy can result in a painless lesion and possibly develop from total unawareness of injury to the foot due to insensitivity to heat or other form of injury. Compromised circulation decreasing the capacity for response to antibiotics due to poor oxygenation and access of the antibiotics to the ulcerated area. Excessive 'loading' of parts of the foot already subject to breakdown because of poor quality tissue damaged by the diabetic process is an important contributing factor and might be due to changes in gait following amputations to the same or other foot with similar combinations of diabetic complications.

Typically the diabetic foot features an ulcer which does not respond to 'aggressive' traditional treatments with antibiotics, etc and such condition is the leading cause of lower limb amputation in medical practice and patients undergoing such need for amputation have an increased risk of death within five years.

Classification of diabetic foot

Please refer to ACS 0401 Diabetes mellitus and intermediate hyperglycaemia - 1 July 2012 revision.

The text below reinforces the guidelines in ACS 0401 Diabetes mellitus and intermediate hyperglycaemia, 6. Diabetic foot and clarifies the sequencing of codes for diabetic foot.

Assign E1-.73 *Diabetes mellitus with foot ulcer due to multiple causes when:

- 'diabetic foot' is documented in the clinical record, or
- the criteria specified in ACS 0401 Diabetes mellitus and intermediate hyperglycaemia, 6. Diabetic foot are met.

Additional codes for the specific complications of DM or IH should be assigned in accordance with Rule 4a and Rule 4b.

Sequencing of codes for diabetic foot should be determined by:

- ACS 0001 Principal diagnosis, with particular attention to:
  - the 'after study' principle
  - Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis
  - Two or more diagnoses that equally meet the definition for principal diagnosis
  - ACS 0002 Additional diagnoses.
Intramucosal adenocarcinoma/carcinoma of the colon

Q: What is the correct morphology behaviour code to assign for intramucosal carcinoma or adenocarcinoma of the colon?

A: The first layer of the bowel wall referred to as the mucosa consists of the surface epithelium, lamina propria and muscularis mucosa. Intramucosal adenocarcinoma/carcinoma refers to carcinoma confined to these layers of the bowel wall and is usually in situ.

For documentation of intramucosal adenocarcinoma/carcinoma of the colon without further qualification, the coder should, in the first instance, verify the correct morphology behaviour code with the clinician. Where clinical clarification is not possible, assign one of the following morphology codes as appropriate:

M8140/2 Adenocarcinoma in situ NOS

M8010/2 Carcinoma in situ NOS

The NCCC will consider indexing improvements for intramucosal carcinoma/adenocarcinoma of the colon in a future edition of ICD-10-AM.

Bibliography:

Published 15 December 2012, for implementation 01 January 2013.
Follicular non-Hodgkin lymphoma

Q: What is the correct code to assign for follicular non-Hodgkin lymphoma?

A: Follicular lymphoma is a specific type of non-Hodgkin lymphoma classified to category C82 Follicular lymphoma in ICD-10-AM. Assign an appropriate neoplasm and morphology code for follicular non-Hodgkin lymphoma by following the index pathway:

Lymphoma
- follicular

NCCC will consider improvements to the Alphabetic Index for this condition for a future edition of ICD-10-AM.

Bibliography:

Published 15 December 2012, for implementation 01 January 2013.
Postictal state

Q:
What is the correct code to assign for a patient who is admitted for postictal state following an epileptic seizure? Specifically what is the correct code assignment for postictal state characterised by confusion?

A:
The postictal state is described as being the abnormal condition that occurs between the end of an epileptic seizure and the return to the baseline condition, or the interictal state. A patient admitted in a postictal state may have a number of symptoms and signs, including focal deficits (such as aphasia and hemiplegia) or diffuse cerebral dysfunction (such as delirium and psychosis). The postictal state may be further complicated by injuries or secondary medical conditions.

When assigning codes for postictal state, codes for both the specific manifestation(s) and epilepsy should be assigned, in accordance with the guidelines in ACS 0001 Principal diagnosis.

Where postictal state is documented without further specification, assign G40.90 Epilepsy, unspecified, without mention of intractable epilepsy.

For confusion in the postictal state, assign F05.8 Other delirium following the index pathway:

Confusion, confused
- epileptic F05.8

Also assign a code for the epilepsy.

NCCC will consider improvements to the index for 'postictal state' for a future edition of ICD-10-AM.

Published 15 December 2012, for implementation 01 January 2013.
Open reduction and internal fixation of frontal sinus fracture

Q:
What is the correct procedure code to assign for open reduction with internal fixation of a frontal sinus fracture?

A:
Published literature and clinical advice received from the Australian and New Zealand Association of Oral and Maxillofacial Surgeons, indicates that the frontal sinuses are a pair of cavities in the frontal bone of the skull. Due to their location, any fractures involving the frontal bone that require surgery are compound by nature as they involve the underlying frontal sinus and in more severe cases the dura and brain.

Therefore, the correct ACHI code to assign for open reduction with internal fixation of fracture of the frontal sinus is 39609-02 [25] Reduction of compound skull fracture following the index pathway:

Reduction
- fracture (bone) (with cast) (with splint)
- - skull (closed) (comminuted)
- - - open (comminuted) (compound) 39609-02 [25]
- - - - with
- - - - - internal fixation 39609-02 [25]

NCCC will revise the classification of open reduction with internal fixation of fracture of the frontal sinus for a future edition of ACHI. This will include a review of the includes note 'frontal sinus' at block [1365] Reduction of fracture of nasal bone and the index entries Elevation, bone fragments, sinus, frontal and Elevation, fracture, sinus, frontal which currently assign 41737-00 [389] Other intranasal procedures on frontal sinus.

Bibliography:

Published 15 December 2012, for implementation 01 January 2013.
Low birth weight and prematurity

Q:
Should low birth weight always be coded in conjunction with prematurity in the birth episode and subsequent episodes of care?

A:

ACS 1618 Low birth weight and gestational age is not explicit about whether codes should be assigned for both birth weight and gestational age in all episodes of care, however the note at P07 Disorders related to short gestation and low birth weight, not elsewhere classified in the Tabular List states:

"Note: When both birth weight and gestational age are available, priority of assignment should be given to gestational age."

This note instructs that codes for both birth weight and gestational age should be assigned when the documentation is available and that priority of code assignment should be given to P07.2- Extreme immaturity and P07.3- Other preterm infants over P07.0- Extremely low birth weight and P07.1- Other low birth weight.

Clinical advice confirms that the guidance provided in the Tabular List is appropriate for the birth episode, however low birth weight is usually not significant in subsequent neonatal admissions and therefore should not be routinely assigned. A code for low birth weight should only be assigned in a subsequent episode of care if it meets ACS 0002 Additional diagnoses.

NCCC will review ACS 1618 Low birth weight and gestational age and clarify the note at P07 Disorders related to short gestation and low birth weight, not elsewhere classified in the Tabular List for a future edition of ICD-10-AM and ACS.

Published 15 December 2012, for implementation 01 January 2013.
Diabetes mellitus and eradicated cataract

Q:
Is E1-.39 *Diabetes mellitus with other specified ophthalmic complications the correct code to use for diabetes mellitus with history of cataract eradicated by previous surgery? If so, does the assignment of E1-.39 in this scenario count towards the criteria for assignment of E1-.71 *Diabetes mellitus with multiple microvascular and other specified nonvascular complications?

A:
Current clinical advice confirms that surgery to remove a cataract in a patient with DM does eradicate the ophthalmic complication, therefore E1-.39 *Diabetes mellitus with other specified ophthalmic complications should not be assigned. And consequently, eradicated cataract does not contribute to the allocation of E1-.71 *Diabetes mellitus with multiple microvascular and other specified nonvascular complications.

Please note: The final DM education material which was placed on the NCCC website (posted June 2012) includes this advice, however the material distributed at the Diabetes Workshops did not (as these were conducted before we were made aware of the updated clinical advice).

Please refer to ACS 0401 Diabetes mellitus and intermediate hyperglycaemia, 7. Eradicated conditions and DM (1 July 2012) for revised instructions and examples which reflect current clinical advice.
Unknown primary with neoplasm site default in Alphabetic Index

Q:
When certain morphologies have a site default code in the Alphabetic Index but the coding scenario is a known secondary with clinical documentation of 'unknown primary', should the primary site be coded to C80.- *Malignant neoplasm without specification of site* or should the clinical coder be guided by the default site in the index? Examples include:

**Adenocarcinoma**
- parietal cell (M8214/3) -- see Neoplasm, stomach, malignant

**Carcinoma**
- renal (cell) (M8312/3) C64

**Melanoma** (malignant) (M8720/3) C43.9

A:
Clinical coders should not presume the primary site of these types of neoplasms based on the default site codes listed in the Alphabetic Index. These index defaults indicate that certain morphological types of cancer are usually of a particular site eg. stomach, kidney or skin; however this should not override clinician documentation that the primary site is unknown.

Clinical advice also confirms that, in those rare circumstances, where such neoplasms are documented as having an unknown primary they should be coded as such ie. an unknown primary.

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for implementation 01 January 2013.
Transvaginal oocyte retrieval (TVOR)

Q:

What is the appropriate code to use for transvaginal oocyte retrieval (TVOR) where no oocytes were retrieved?

A:

Transvaginal oocyte retrieval (TVOR) is a procedure performed under a light anaesthetic as part of the in-vitro fertilisation (IVF) program. An ultrasound probe is inserted into the vagina to visualise the ovaries, then using ultrasound guidance, a needle penetrates the vaginal wall into the ovarian follicles and aspirates the follicular fluid. An egg is not always obtained from each follicle.

The correct code to assign for TVOR irrespective of whether an oocyte has been retrieved is:

13212-00 [1297] Transvaginal ovarian retrieval

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for implementation 01 January 2013.
Endoscopic clipping of a bleeding duodenal arteriovenous malformation

Q:
What is the correct code to assign for endoscopic clipping of a bleeding duodenal arteriovenous malformation (AVM)?

A:
Clinical advice confirms that the procedure for endoscopic clipping of a bleeding duodenal arteriovenous malformation (AVM) is similar to endoscopic clipping of bleeding duodenal ulcer in technique, complexity and resource use.

Therefore, the correct code to assign for endoscopic clipping of a bleeding duodenal AVM is 90296-00 [887] Endoscopic control of peptic ulcer or bleeding.

NCCC will consider improvements to ACHI to reflect this advice for a future edition.

Published 15 December 2012,
for implementation 01 January 2013.
Gestational diabetes mellitus (GDM)

ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - Education Workshop FAQs

Please refer to ACS 0401 Diabetes mellitus and intermediate hyperglycaemia - 1 July 2012 revision.

Q:

This advice has been deleted from ACS 0401 - 1 July 2012:

"Gestational diabetes may recur in a subsequent pregnancy and when this occurs, assign a code for gestational diabetes, with Z87.5 Personal history of complications of pregnancy, childbirth and the puerperium." *(Source, ACS 0401, Seventh Edition, 1 July 2010, Gestational diabetes mellitus)*

Is the advice still valid?

A:

This advice was removed from ACS 0401 to standardise the assignment of Z87.5 *Personal history of complications of pregnancy, childbirth and the puerperium* in line with ACS 2112 *Personal history*. Z87.5 *Personal history of complications of pregnancy, childbirth and the puerperium* should only be assigned according to the guidelines in ACS 2112 *Personal history*. See also ACS 0401, 2. *Specific classification principles for DM and IH, DM and IH in pregnancy, childbirth and the puerperium*.

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

Published 15 June 2012, for implementation 01 July 2012.
Diabetes mellitus with features of insulin resistance

ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - Education Workshop FAQs

Please refer to ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision.

**Q:**

If a patient previously had conditions (such as obesity or characteristic dyslipidaemia) which qualified them for assignment of E1-.72 *Diabetes mellitus with features of insulin resistance* but in a more recent episode of care no longer has those qualifying conditions (because they are no longer obese or their dyslipidaemia is controlled by medication) do they still qualify for the assignment of E1-.72 *Diabetes mellitus with features of insulin resistance*?

**A:**

Clinical advice confirmed that if conditions which previously contributed to the assignment of E1-.72 *Diabetes mellitus with features of insulin resistance* (such as obesity or characteristic dyslipidaemia) are no longer current, then these conditions should no longer be considered as contributing to the criteria for assignment of E1-.72 *Diabetes mellitus with features of insulin resistance*.

**Q:**

Can test results alone be used to identify characteristic dyslipidaemia in order to assign E1-.72 *Diabetes mellitus with features of insulin resistance*?

**A:**

No, test results alone cannot be used to identify elevated fasting triglycerides or depressed HDL-cholesterol, as per the guidelines in ACS 0010 *General abstraction guidelines, Test results*. The following guidelines which are also represented in ACS 0401, *3. DM and IH with features of insulin resistance* and ACS 0401, *Figure 1* should be followed in order to identify "characteristic dyslipidaemia":

1. if there is clinician documentation of "dyslipidaemia/hypercholesterolaemia/high cholesterol/ hyperlipidaemia", then seek confirmation that levels of either "elevated fasting triglycerides" (=1.7 mmol/L) or "depressed HDL-cholesterol" (male =1.03, female =1.29) meet the required values for characteristic dyslipidaemia in order to assign E1-.72 *Diabetes mellitus with features of insulin resistance*.

2. if there is NO clinician documentation of dyslipidaemia/hypercholesterolaemia/high cholesterol/ hyperlipidaemia, then clinician documentation of both "elevated fasting triglycerides" (=1.7 mmol/L) and "depressed HDL-cholesterol" (male =1.03, female =1.29) is required - test results can only be used to confirm the levels meet the required values for characteristic dyslipidaemia in order to assign E1-.72 *Diabetes mellitus with features of insulin resistance*.

**Q:**

Are there specific diagnostic criteria for characteristic dyslipidaemia for the Indigenous Australian population?

**A:**

Clinical advice confirmed that there are no population specific criteria for characteristic dyslipidaemia for use in Australia.

Published 15 June 2012, for implementation 01 July 2012.
Diabetes mellitus and day only admissions

ACS 0401 Diabetes mellitus and intermediate hyperglycaemia - Education Workshop FAQs

Please refer to ACS 0401 Diabetes mellitus and intermediate hyperglycaemia - 1 July 2012 revision.

Q:

Does diabetes mellitus have to be coded for day only admissions, in particular day only dialysis admissions?

A:

There is no exception to the rule that diabetes mellitus should be coded when documented. Therefore, diabetes mellitus should be coded when documented in same day admissions.

Dialysis admissions

The issue of whether to code diabetes, or any other additional diagnosis, when dialysis episode coding is autogenerated is unique. The following advice was published in Coding Matters, September 2008:

"Q: In day only dialysis admissions, should codes be assigned for any additional diagnoses, e.g. CKD, diabetes etc?

A: As most day only dialysis admissions are autogenerated, it is difficult to assign additional diagnosis codes when the full record is not available at the time of the coding process. Therefore, for day only admissions for dialysis, only assign Z49.1 Extracorporeal dialysis for extracorporeal dialysis or Z49.2 Other dialysis for peritoneal dialysis together with the appropriate procedure code. Additional diagnosis codes should only be assigned if the conditions meet ACS 0002 Additional diagnoses." (Coding Matters, Volume 15, Number 2, September 2008)

Further to the Coding Matters advice above, ACS 0001 Principal diagnosis, Problems and underlying conditions states:

"If a patient presents with a problem, and the underlying condition is known at the time of admission, and only the problem is being treated, then the problem should be assigned as the principal diagnosis code. The underlying condition should be sequenced as an additional diagnosis code."

Therefore, it is more accurate to state:

"... Additional diagnosis codes should be assigned if the conditions meet the criteria for code assignment as per the guidelines in ACS 0001 Principal diagnosis, Problems and underlying conditions or ACS 0002 Additional diagnoses".

However, as most day only dialysis admissions are coded using autogenerate software, it is difficult to assign additional diagnosis codes for specific patients. In addition the full record is not always available at the time of the patient’s admission to inform the coding process. The NCCC recognises these system issues and accepts, for now, that it will not be possible for many hospitals to comply with ACS 0001 Principal diagnosis, Problems and underlying conditions and ACS 0002 Additional diagnoses for these episodes.

This advice supersedes the previous advice published in Coding Matters, September 2008 (Volume 15, Number 2), Day only admissions and additional diagnoses, which will be retired on 30 June 2012.

Published 15 June 2012, for implementation 01 July 2012.
Documentation of diabetes mellitus

ACS 0401 Diabetes mellitus and intermediate hyperglycaemia - Education Workshop FAQs

Please refer to ACS 0401 Diabetes mellitus and intermediate hyperglycaemia - 1 July 2012 revision.

Q:
Can you refer to previous admissions to inform code assignment for diabetes mellitus? How far back in the clinical record can you go for information? Do you use past admissions to gather information about complications of DM to assign codes from E1-.7- *Diabetes mellitus with multiple complications? 

A:

The following statement is included in the Introduction to the Australian Coding Standards (ACS):

"It is assumed that coding decisions are not made solely based on information provided on the clinical record front sheet and/or discharge summary (or a copy of same) but that analysis of the entire clinical record is performed before code assignment."

Therefore, previous admissions and correspondence can be used to inform assignment of diabetes mellitus codes. However, previous admissions and correspondence should not be used:

- to assign diabetes mellitus if it has not been documented in the current admission.
- to inform the assignment of diabetes mellitus codes which have contributing conditions which may no longer be relevant or where criteria has changed over previous editions of the classification, e.g. hypertension being used to assign a code for features of insulin resistance.

Q:

Are nurses considered clinicians when it comes to documentation for clinical coding? What documentation is sufficient to warrant coding of DM? Specifically, should a code for DM be assigned by virtue of a nurse checking a 'tick box' on a form such as a pre-admission check list?

A:

The Introduction to the Australian Coding Standards, How to use this document contains the following guideline:

"The term 'clinician' is used throughout the document and refers to the treating medical officer but may refer to other clinicians such as midwives, nurses and allied health professionals. In order to assign a code associated with a particular clinician's documentation, the documented information must be appropriate to the clinician's discipline."

The NCCC supports this guideline and maintains that documentation by any clinician can be used to determine conditions that should be coded. However, clinical coders should also be guided by the following from the Introduction to the Australian Coding Standards:

"If a clinical record is inadequate for complete, accurate coding, the clinical coder should seek more information from the clinician. When a diagnosis is recorded for which there is no supporting documentation in the body of the clinical record, it may be necessary to consult with the clinician before assigning a code."

While ACS 0401, Rule 1 specifies that DM should always be coded, general coding and abstraction guidelines should still be followed.
Specific examples from 2012 Diabetes Mellitus Workshop

Material: Scenario J

ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - Education Workshop FAQs

Please refer to ACS 0401 Diabetes mellitus and intermediate hyperglycaemia - 1 July 2012 revision.

**Q:**

In *Scenario J*, could I70.23 *Atherosclerosis of arteries of extremities with ulceration* be assigned according to Rule 4b?

"*Scenario J* - This 67 year old male presented for below knee amputation as treatment of foot ulcer. Also has Type 2 DM with PVD and neuropathy."

**A:**

The final code assignment for *Scenario J* is:

- E11.73 *Type 2 diabetes mellitus with foot ulcer due to multiple causes*
- E11.51 *Type 2 diabetes mellitus with peripheral angiopathy, without gangrene*
- E11.40 *Type 2 diabetes mellitus with unspecified neuropathy*

*Rule 4b* specifies that conditions classified outside of category E09-E14 should only be assigned when the condition meets ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*. In *Scenario J*, there is no evidence that PVD met ACS 0001 or ACS 0002, therefore I70.23 *Atherosclerosis of arteries of extremities with ulceration* was not assigned.

*Published 15 June 2012, for implementation 01 July 2012.*
Eradicated conditions and diabetes mellitus

ACS 0401 Diabetes mellitus and intermediate hyperglycaemia - Education Workshop FAQs

Please refer to ACS 0401 Diabetes mellitus and intermediate hyperglycaemia - 1 July 2012 revision.

Q:

If a patient with diabetes mellitus has had a vascular reconstruction procedure for PVD should a Z code be added to indicate the previous surgery even though the PVD is not eradicated?

A:

ACS 0401, 7. Eradicated conditions and DM advises that a vascular reconstruction procedure may eradicate a manifestation of peripheral arterial disease, such as an ulcer, but does not eradicate the peripheral arterial disease. DM with peripheral arterial disease should be coded with Z95.8 Presence of other cardiac and vascular implants and grafts or Z95.9 Presence of cardiac and vascular implants and grafts, unspecified to indicate the status of the previous surgery.

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Specific examples from 2012 Diabetes Mellitus Workshop

Material: Example 14

ACS 0401 Diabetes mellitus and intermediate hyperglycaemia - Education Workshop FAQs

Please refer to ACS 0401 Diabetes mellitus and intermediate hyperglycaemia - 1 July 2012 revision.

Q:

In Example 14, why isn't I70.23 Atherosclerosis of arteries of extremities with ulceration assigned given that the peripheral vascular disease meets Rule 4b?

"EXAMPLE 14 Patient with a history of Type 2 diabetes mellitus, peripheral vascular disease and peripheral neuropathy was admitted for treatment of a left foot ulcer. The foot ulcer was treated with daily dressings. Diabetic educator spoke to the patient in relation to their ongoing insulin medication. The vascular surgeonreviewed the patient’s peripheral vascular disease and decided that the patient was unfit for surgery."

A:

The final code assignment for Example 14 is:

E11.73 Type 2 diabetes mellitus with foot ulcer due to multiple causes
E11.51 Type 2 diabetes mellitus with peripheral angiopathy, without gangrene
E11.42 Type 2 diabetes mellitus with diabetic polyneuropathy
Z92.22 Personal history of long term (current) use of other medicaments, insulin

While the PVD meets Rule 4b, I70.23 Atherosclerosis of arteries of extremities with ulceration is not assigned following Rule 6, which instructs that multiple codes should not be assigned when the DM code identifies the elements documented in the diagnosis: the PVD is identified in E11.51 and the ulcer is identified in E11.73.

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Diabetic foot

ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - Education Workshop FAQs

Please refer to ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision.

**Q:**

With reference to the criteria for coding diabetic foot (ACS 0401, *Diabetic foot*) does amputee status meet the criteria at Category 2d when the amputation was due to an injury/trauma not related to diabetes mellitus complications?

**A:**

Clinical advice confirmed that amputee status of the lower limb, regardless of what caused the amputation, contributes to the criteria for diabetic foot as specified in ACS 0401, *Diabetic foot, Category 2d*. This is because prior amputation presents increased risk of contralateral foot lesion (e.g., ulcer) and other complications (e.g., excessive loading) associated with diabetic foot.

**Q:**

With reference to the criteria for coding diabetic foot (ACS 0401, *Diabetic foot*) does an ulcer and/or infection of lower limb (not foot) - for example ulcer of calf - meet the criteria at Category 1?

**A:**

Clinical advice confirmed that the Category 1 of the diabetic foot criteria (ACS 0401, *Diabetic foot*) is limited to ulcer and/or infection of the foot region (including heel and toes).

**Q:**

L97.0 *Ulcer of foot* should not be assigned for foot ulcer in addition to E11.73 *Type 2 diabetes mellitus with foot ulcer due to multiple causes* following ACS 0401, *Rule 6*. However, can L97.8 *Ulcer of lower limb, other sites* or L97.9 *Ulcer of lower limb, unspecified* be assigned for ulcer of lower limb (not foot) in addition to E11.73?

**A:**

L97.8 *Ulcer of lower limb, other sites* or L97.9 *Ulcer of lower limb, unspecified* may be assigned, in addition to E11.73, for an ulcer of the lower limb (not foot region: foot, heel, toes) if the ulcer meets ACS 0002 *Additional diagnoses* in its own right.

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

Published 15 June 2012,

for implementation 01 July 2012.
Diabetes mellitus with multiple microvascular complications

Q:
Using ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision, what are the correct codes to assign for the following scenario: Scenario: Patient admitted for acute kidney failure and also has NIDDM (meeting ACS 0002 *Additional diagnosis*) and retinopathy (not meeting ACS 0002 *Additional diagnosis*).

A:
Please refer to the rules in ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision. In the scenario cited, the correct code assignment applying ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision is:

- N17.9 Acute kidney failure, unspecified
- E11.29 Type 2 diabetes mellitus with other specified kidney complication
- E11.31 Type 2 diabetes mellitus with background retinopathy
- E11.71 Type 2 diabetes mellitus with multiple microvascular and other nonvascular complications

The acute kidney failure (N17.9) is assigned as the principal diagnosis as it meets ACS 0001 *Principal diagnosis*. The complications of diabetes - acute kidney failure (E11.29) and retinopathy (E11.31) - classified to category E09-E14 are coded to reflect the severity of the diabetes (refer to ACS 0401, *Rule 4a*). The presence of both acute kidney failure and retinopathy qualifies the coding of E11.71 which is sequenced as an additional code (refer to ACS 0401, *4.1 DM with multiple microvascular and other nonvascular complications*). Retinopathy (H35.0) is not coded as it does not meet ACS 0002 *Additional diagnoses* (refer to ACS 0401, *Rule 4b*).

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Diabetes mellitus and carpal tunnel syndrome

Q:

Is there further clinical advice regarding the following Coding Matters advice (2006, Volume 13, No 3)?

"The NCCH was asked to clarify whether carpal tunnel syndrome in a patient with diabetes should be assigned E1-.41 Diabetes Mellitus with diabetic mononeuropathy as carpal tunnel syndrome can be regarded as a mononeuropathy. Clinical advice received by the NCCH on this issue indicates that it is still under deliberation and no consensus has been achieved. Therefore, until further clinical advice is received, carpal tunnel syndrome in a patient with diabetes should not be coded to diabetic mononeuropathy."

A:

The NCCC sought current clinical advice which confirmed that there is no association between diabetes mellitus and carpal tunnel syndrome. Therefore, assignment of E1-.41 Diabetes mellitus with diabetic mononeuropathy is not appropriate for diabetes mellitus and carpal tunnel syndrome.

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for implementation 01 July 2012.
Diabetes mellitus and macular degeneration

Q:
Should E1-34 *Diabetes mellitus with other retinopathy be assigned in addition to H35.3 Degeneration of macula and posterior pole in a patient with macular degeneration and diabetes mellitus?

A:
The NCCC sought current clinical advice which confirmed that there is no association between diabetes mellitus and macular degeneration. Therefore, assignment of E1-34 *Diabetes mellitus with other retinopathy following the index entry Diabetes, with, maculopathy is not appropriate for macular degeneration with diabetes mellitus.

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for implementation 01 July 2012.
Diabetes mellitus and additional specific codes

Q:
A code is assigned for diabetes mellitus with peripheral vascular disease (PVD) - the PVD does not meet the criteria for ACS 0002 Additional diagnoses. If there is more information about the PVD (eg PVD with rest pain), can a specific PVD code be assigned as an additional code (eg I70.22 Atherosclerosis of arteries of extremities with rest pain)?

A:
Please refer to ACS 0401 Diabetes mellitus and intermediate hyperglycaemia - 1 July 2012 revision. Following ACS 0401 Diabetes mellitus and intermediate hyperglycaemia, Rule 4b complications of diabetes classified outside of category E09-E14 are assigned only when that condition meets the criteria in ACS 0001 Principal diagnosis or ACS 0002 Additional diagnoses. Therefore, if the PVD itself does not meet criteria for coding, an additional code to add specificity for PVD should not be assigned.

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for implementation 01 July 2012.
Stroke with hemiplegia

Q:

ACS 0604 Stroke, 1. Current, Sequelae (late effects) states:

"While the patient is receiving continuing treatment, regardless of the period of time elapsed since the stroke, assign a code from categories I60-I64 (cerebrovascular diseases) with any applicable deficit codes (e.g., hemiplegia)."

Given the above, should a code be assigned for hemiplegia where a patient is admitted for treatment of a stroke but the hemiplegia has resolved prior to admission?

A:

For the scenario cited, the hemiplegia should not be coded as the deficit (hemiplegia) is not an 'applicable' deficit when it has resolved and does not meet the criteria for assignment as per ACS 0002 Additional diagnoses.

Published 15 June 2012, for implementation 01 July 2012.
Z09 Follow-up examination after treatment for conditions other than malignant neoplasms

Q:
Is it appropriate to assign Z09.0 *Follow-up examination after surgery for conditions other than malignant neoplasms* where there has been a previous biopsy? In addition, where there are multiple treatment modalities for a condition and the patient is admitted for follow-up, which code from category Z09 *Follow-up examination after treatment for conditions other than malignant neoplasms* should be assigned?

A:
When assigning Z09.0 *Follow-up examination after surgery for conditions other than malignant neoplasms*, a previous biopsy does not meet the criteria for assignment of this code, as a biopsy is diagnostic and not considered surgical treatment. The correct code to assign from this category for a follow-up examination after multiple treatment modalities (when there is no recurrence of disease) is Z09.7 *Follow-up examination after combined treatment for other conditions*.

Published 15 June 2012, for implementation 01 July 2012.
Morphology codes

Q:
Does the sentence in ACS 0233 Morphology - "If a morphological diagnosis contains two histological terms which have different M codes, select the highest number as it is usually more specific" apply to a morphological diagnosis from one biopsy or two biopsies taken at different times for a recurrent tumour?

A:
The statement cited in the question above applies to one histological sample which describes a neoplasm using more than one histological term for which there are separate morphology codes. It does not apply to multiple histological diagnoses from different timeframes or different episodes of care, even if in reference to the same tumour.

Published 15 December 2011, for implementation 01 January 2012.
Recurrence of transitional cell carcinoma (TCC) of the bladder

Q:
When a previously resected TCC of the anterior wall of the bladder represents with a recurrence in the dome of the bladder, what is the correct neoplasm code to assign? Following ACS 0237 Recurrence of malignancy would you assign C67.3 Malignant neoplasm of anterior wall of bladder or C67.1 Malignant neoplasm dome of bladder as the principal diagnosis?

A:
ACS 0237 Recurrence of malignancy states:
"If the primary malignancy previously eradicated has recurred, assign a code for the original primary site using the appropriate code from C00-C75. Code also any secondary sites mentioned."

Clinical advice also confirms that, for the scenario cited, this is usually considered a recurrence of the primary bladder tumour and not as two primary invasive bladder tumours or a secondary tumour. Therefore, the correct code to assign in this scenario is C67.3 Malignant neoplasm of the anterior wall of the bladder. However, if there is any uncertainty concerning code assignment then confirmation should be sought from the clinician, as per the guidelines in ACS 0010 General abstraction guidelines.

Published 15 December 2011,
for implementation 01 January 2012.
Depression due to a medical condition

Q:
Is it appropriate to assign F06.33 Organic depressive disorder for documentation of depression due to a medical condition?

A:
The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IVTR®) states:

"In DSM-III-R, the Mental Disorders Due to a General Medical Condition and the Substance-Induced Disorders were called 'organic' disorders and were listed together in a single section...DSM-IV eliminates the term organic and distinguishes those mental disorders that are due to a general medical condition from those that are substance induced and those that have no specific etiology...

The essential feature of Mood Disorder Due to a General Medical Condition is a prominent and persistent disturbance in mood that is judged to be due to the direct physiological effects of a general medical condition. The mood disturbance may involve depressed mood; markedly diminished interest or pleasure; or elevated, expansive, or irritable mood."

Therefore, it is appropriate to assign F06.33 Organic depressive disorder for documentation of depression due to a medical condition, by following the index pathway:

**Disorder**
- mood
  - - due to (secondary to)
    - - - general medical condition F06.3-

The underlying condition may also be assigned as per ACS 0001 *Principal diagnosis, Problems and underlying conditions.*

Published 15 October 2010, for implementation 01 November 2010.
Fetoscopic tracheal balloon occlusion

Q:
What is the correct intervention code to assign for fetoscopic tracheal balloon occlusion?

A:
Fetoscopic tracheal occlusion (FETO) is a minimally invasive antepartum procedure performed to treat severe congenital diaphragmatic hernia (CDH), which is associated with a high rate of neonatal death due to pulmonary hypoplasia. "Temporary tracheal occlusion is a technique which prevents the normal efflux of foetal lung fluid, which enhances positive pressure in the growing lungs and promotes lung growth (Harrison et al. 2003). Originally, occlusion occurred by placement of an occlusion clip around the trachea via open hysterotomy. However, due to the high rate of preterm delivery and irreversible damage to the laryngeal nerve and trachea, and difficulty for reversal, fetoscopic tracheal occlusion using a detachable balloon has been developed (Harrison et al.1998). The detachable balloon can be placed via one fetobronchoscopic port and deflation at birth aids an easier reversal. This minimally invasive technique may improve postnatal survival in patients with severe CDH and may be used in conjunction with postnatal management strategies." (ASERNIP-S, 2005) The correct code to assign for FETO is 90464-00 [1332]

Correction-- see also Repair

- fetal defect (intrauterine) 90464-00 [1332]

or

Procedure

- fetal, in utero

  - - therapeutic 90464-00 [1332]

The NCCC has flagged Antepartum repair procedures for review in a future edition of ACHI.

Reference:

Australian Safety and Efficacy Register of New Interventions Procedures-Surgical, 2005, Horizon Scanning Technology Prioritising Summary - Fetoscopic tracheal occlusion using a detachable balloon, Canberra, Australia.

Published 15 October 2010,
for implementation 01 November 2010.
McRoberts manoeuvre

Q:

If there is documentation that a McRoberts manoeuvre has been performed during delivery, which code should be assigned O80 Single spontaneous delivery or O83 Other assisted single delivery?

A:

McRoberts manoeuvre is performed for shoulder dystocia (sometimes documented as 'impacted' or 'difficult' shoulders). Delivery of the shoulders is facilitated by flexing the mother's hips to increase the pelvic diameter. Clinical advice confirms that when this manoeuvre is performed during delivery assign O83 Other assisted single delivery. Shoulder dystocia must be documented before assigning O66.0 Labour and delivery affected by shoulder dystocia, as this technique is sometimes employed prophylactically in anticipation of a potential shoulder dystocia.

Published 15 October 2010,
for implementation 01 November 2010.
The place of occurrence code for an intentional overdose of prescribed drugs should be assigned according to where the overdose took place. If the overdose took place at home, the correct place of occurrence code is Y92.09 Other and unspecified place in home. This is different to assigning a place of occurrence code where there has been an adverse effect of a prescribed drug. The place of occurrence in these circumstances is:

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

OR

Y92.24 Place of occurrence, health service area, this facility, where the adverse effect occurs as opposed to where the manifestation of the adverse effect occurs.

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

Published 15 June 2010,
for implementation 01 July 2010.
Administration of Haemaccel®

Q:

Should a code be assigned for infusion of Haemaccel®?

A:

Haemaccel® is a plasma substitute, administered to treat or prevent hypovolaemic shock caused by plasma/blood volume deficiency due to conditions such as haemorrhage or burns. Haemaccel® is a gelatin solution derived from cows, but is not a blood product. Although the code for infusion/transfusion of Haemaccel® is located in block [1893] Administration of blood and blood products, the guidelines in ACS 0302 Blood transfusions should not be followed for this procedure, as it is not a blood product. Therefore, it is unnecessary to assign a code for administration of Haemaccel® (or similar plasma volume expander) when documented in the clinical record, except for neonates where the guidelines in ACS 1615 Specific diseases and interventions related to the sick neonate should be followed.

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

Published 15 June 2010,
for implementation 01 July 2010.
Methicillin Resistant or Multi-Resistant *Staphylococcus aureus* (MRSA) or Vancomycin Resistant Enterococcus (VRE) carriers

Q: When is it appropriate to assign a code for a carrier or suspected carrier of MRSA or VRE?

A: Where documentation indicates that a patient is a carrier or suspected carrier of MRSA or VRE, assign Z22.3 *Carrier of other specified bacterial diseases*, if it meets the criteria for code assignment as per ACS 0002 *Additional diagnoses*, and assign a code from Z06.5- – Z06.7- for the drug resistant microorganism.

For a carrier of MRSA follow the index pathway:

**Carrier (suspected)**

- staphylococci Z22.3

and

**Resistance, resistant (to)**

- methicillin (cloxacillin) (dicloxacillin) (flucloxacillin)(oxacillin) Z06.52

OR

**Resistance, resistant (to)**

- multiple

  - - antibiotics Z06.67

For a carrier of VRE follow the Alphabetic Index:

**Carrier (suspected)**

- streptococci Z22.3

and

**Resistance, resistant (to)**

- vancomycin Z06.61

See also Coding Rule: *Carrier of drug resistant microorganisms*.

Q: Should Z29.2 *Other prophylactic pharmacotherapy* be assigned if pharmacotherapy is commenced for a carrier or suspected carrier of MRSA or VRE?

A: There are no guidelines requiring the assignment of Z29.2 *Other prophylactic pharmacotherapy* where pharmacotherapy is commenced for carriers or suspected carriers of MRSA or VRE, so this code should not be assigned in a multi day admission.

Published 15 December 2009, for implementation 01 January 2010.
ACS 0002 Additional diagnoses and specialty standards

Q:

Do specialty standards override the guidelines in ACS 0002 Additional diagnoses?

A:

To determine if a condition or status should be coded as an additional diagnosis follow the flow chart below:

Example 1 -- A patient recovering from a stroke is diagnosed with dysphagia, reviewed by the clinician and commenced on enteral feeding, which continues for six days and is then ceased. The patient is then placed on a modified diet until they are discharged from hospital. Following the flowchart dysphagia meets the criteria for code assignment as per the guidelines in ACS 0002 and ACS 0604 Stroke, states:

'Dysphagia - should be assigned only when requiring nasogastric tube/enteral feeding, or when the dysphagia is present at discharge or still requiring treatment more than 7 days after the stroke occurred.'

Therefore, dysphagia also meets the criteria for code assignment as per the guidelines in ACS 0604 Stroke and should be coded.

Example 2 -- A patient recovering from a stroke is diagnosed with dysphagia, reviewed by the Speech Pathologist and placed on a modified diet. The dysphagia resolves rapidly and the patient is discharged on Day 6 on a full diet. Following the flowchart dysphagia meets the criteria for code assignment as per the guidelines in ACS 0002, but ACS 0604 Stroke states:
'Dysphagia - should be assigned only when requiring nasogastric tube/enteral feeding, or when the dysphagia is present at discharge or still requiring treatment more than 7 days after the stroke occurred.'

Therefore, dysphagia does not meet the criteria for code assignment as per ACS 0604 Stroke and should not be coded.

**Example 3** -- Patient is admitted to hospital for resection of ingrown toe nail and is noted to be a current smoker. Smoking does not meet the criteria for code assignment as per the guidelines in ACS 0002, but ACS 0503 Drug, alcohol and tobacco use disorders states:

'Z72.0 Tobacco use, current Assign this code if the documentation indicates that:

1. The patient has smoked tobacco (any amount) within the last month.'

Therefore, 'Current use of tobacco' meets the guidelines for code assignment as per ACS 0503 Drug, alcohol and tobacco use disorders and should be coded.

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for implementation 01 January 2010.
Coding of findings on pathology results

The following queries highlight an issue as to whether findings on pathology results (often received after patient separation) should be coded.

Q:

A patient is admitted with menorrhagia for vaginal hysterectomy, pathology results show leiomyoma of the uterus, with no documented connection on the report or in the record between the menorrhagia and the leiomyoma. Would you code the leiomyoma?

A:

Clinical advice confirms that leiomyomas/fibroids may or may not be an incidental finding:

‘Fibroids can be incidental within the uterus and may not be the reason for the uterus being removed. Such fibroids are often small and in the subserous or intramural position in the uterus. If, however, the uterus is massively enlarged, it can certainly cause menorrhagia and would be the reason for the hysterectomy. Small fibroids in the submucous position can cause severe menorrhagia and could be a reason for hysterectomy. For the above reasons, unless the fibroids are indicated to be the reason for the hysterectomy by the operating surgeon, the surgeon should be asked to advise whether the fibroids were the reason for the surgery, and if the answer was YES, code accordingly.’ Pepperell, Roger, OG Clinician/OG CCCG (personal communication).

Therefore, coders should follow the guidelines in ACS 0010 General abstraction guidelines, Findings with an unclear, or no associated condition documented which states:

‘Unless a clinician can indicate that a test result is significant and/or indicates the relationship between an unclear test result and a condition, such test results should not be coded.’

Where there is uncertainty, such as when histopathology indicates a subserous leiomyoma, which are known to cause menorrhagia, coders should verify with the clinician whether the leiomyoma is significant to determine whether it should be coded.

Q:

A patient is admitted with haematuria secondary to benign prostatic hypertrophy (BPH). A TRUS biopsy was performed and pathology reveals adenocarcinoma, but the documented principal diagnosis is BPH. Would you code the adenocarcinoma?

A:

This scenario is an example of poor documentation and so the guidelines below from ACS 0010 General abstraction guidelines should be followed in this instance:

‘It is important to seek clinical advice where necessary for: verification of diagnoses recorded on the front sheet which are not supported in the clinical record, and clarification of discrepancies between investigation results and clinical documentation.’

The following is advice received by the NCCH from the Nephrology CCCG:

‘The only reason to perform a TRUS and biopsy is to diagnose a cancer. No one biopsies a prostate because they suspect BPH. A finding of cancer is significant but may still result in no change to a treatment plan.’ Travis, Douglas, Urologist/Nephrology CCCG (personal communication).

Therefore, when presented with poor documentation as indicated in the scenario above, coders should seek advice from the treating clinician to determine the correct principal diagnosis.

Q:
A patient is admitted with chronic ongoing pelvic pain for abdominal hysterectomy. Pathology results show CIN III, would you code CIN III as an additional diagnosis?

A:

Clinical advice confirms that CIN III in the scenario cited is an unexpected finding: 'CIN III usually does not produce any symptoms at all, and certainly not pelvic pain. It results in an abnormal smear test, which then requires assessment by colposcopy and biopsy. It is usually treated by laser or cone biopsy, rarely by hysterectomy. In this instance it was likely to be an unexpected finding on histologic examination of the excised uterus, where the uterus was removed for pain not the CIN III.' Pepperell, Roger, OG Clinician/OG CCCG (personal communication). Therefore, in the scenario cited CIN III should not be coded as per the guidelines in ACS 0010 General abstraction guidelines.

Q:

A patient is admitted with breast hypertrophy for reduction mammoplasty. After discharge pathology of the breast reveals ductal carcinoma in situ (DCIS). Would you code the DCIS?

A:

In the scenario cited the finding of DCIS on pathology is an unexpected finding and should not be coded, as per the guidelines in ACS 0010 General abstraction guidelines. The above scenarios have also highlighted an issue where coders may consider it necessary to assign a cancer code to generate a cancer notification for the cancer registry. Coders should be aware that the pathology department will do this automatically, irrespective of whether the condition is coded in the inpatient episode of care.

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Use of abbreviations, symbols and test result values to inform code assignment for abnormal pathology results

Q:
When can coders use abbreviations, symbols and test result values documented in the clinical record to assign conditions, eg ↓Hb or Hb 98 documented and transfusion given - can anaemia be assigned? ↓K or K2.9 documented and potassium supplements commenced - can hypokalaemia be assigned?

A:
Clinicians may document test result values as well as abbreviations and symbols in the clinical record as shorthand to indicate conditions such as anaemia, hypokalaemia, hypercalcaemia etc.

Where such shorthand is used to document/describe a condition, each instance must be assessed on its merits and where possible confirmed with a clinician to ensure that the documentation sufficiently describes a condition that is both supported by an appropriate index entry and meets the criteria in ACS 0001 Principal diagnosis or ACS 0002 Additional diagnoses.

Test result values, symbols and abbreviations are not to be used in isolation to inform code assignment and coders should therefore:

- clarify the significance of the documented shorthand (test result, values, abbreviations and symbols) with the clinician to inform code assignment

Where this is not possible assign a code for the condition represented in shorthand (as described above) only if:

- test results (pathology report) verify that a result is abnormal AND
- there is an appropriate ICD-10-AM index pathway AND
- it meets the criteria in ACS 0001 Principal diagnosis or ACS 0002 Additional diagnoses.

For example, where ↓Hb or a haemoglobin level (eg.Hb 98) is documented as the indication for a transfusion and the test results (pathology report) and/or the clinician verifies the patient's haemoglobin is below the normal range, follow the index pathway:

Low

- haemoglobin

to assign D64.9 Anaemia, unspecified.

Where ↓K or a potassium level (eg.K 2.9) is documented as the indication for commencement of medication and the test results (pathology report) and/or the clinician verifies the patient's potassium is below the normal range, follow the index pathways:

Deficiency

- potassium (K)

Depletion

- potassium

Hypokalaemia

Hypopotassaemia
to assign E87.6 Hypokalaemia.

However, if ICD-10-AM does not provide an index look up or there is uncertainty or ambiguity in relation to such abbreviated forms of documentation, always confirm with the clinician prior to code assignment.

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for implementation 01 October 2009.
Incontinence

Q:

Please clarify ACS 1808 *Incontinence* below in relation to the following:

**1808 INCONTINENCE**

"Incontinence is clinically significant when the incontinence:

• is not clinically considered to be physiologically normal,
• is not clinically considered to be developmentally normal, or
• is persistent in a patient with significant disability or mental retardation.

Urinary and faecal incontinence codes (R32 *Unspecified urinary incontinence*, R15 *Faecal incontinence*) should be assigned only when the incontinence is persistent prior to admission, is present at discharge or persists for at least seven days."

Should coders use the information in the first paragraph of the ACS to determine if the incontinence is 'clinically significant' before following the classification advice in the second paragraph or is this paragraph for information only?

A:

R32 Unspecified urinary incontinence and R15 Faecal incontinence should be assigned if they meet the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*. Additionally, advice in ACS 1808 *Incontinence* should be followed. Therefore, the first paragraph is for information only.

Q:

When following the classification advice in the second paragraph, would a code for incontinence be assigned for any patient, with any length of stay (including same day) admitted for any condition who was incontinent once only, providing it was on their day of discharge. That is, would you assign an additional code for incontinence for a same day admission of an elderly patient where voluminous incontinence is noted but is not the principal reason for admission?

A:

Coders should apply the advice in the second paragraph where the intent is to code 'persistent' faecal and/or urinary incontinence. So, for a same day episode of care, the advice to assign a code for incontinence present at discharge should only be followed where the documentation confirms that incontinence is a persistent problem.

Q:

Does this ACS cover all types of urinary incontinence or only those classifiable to R32 *Unspecified urinary incontinence*?

A:

The advice in ACS 1808 is for urinary incontinence classifiable to R32 *Unspecified urinary incontinence*, only. It does not apply to other types of urinary incontinence e.g. overflow, stress incontinence etc.

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Anticoagulation therapy pre and post surgery

Q:
What is the correct code assignment for patients admitted prior and post surgery for anticoagulation therapy when the surgery is performed at another hospital?

A:
The correct code assignment for a patient admitted for anticoagulant stabilisation prior to surgery to be performed at another hospital is:

Z51.4 Preparatory care for subsequent treatment, not elsewhere classified
Z92.1 Personal history of long term (current) use of anticoagulants

The correct code assignment for a patient admitted for anticoagulant stabilisation post surgery performed at another hospital is:

Z48.8 Other specified surgical follow-up care
Z92.1 Personal history of long term (current) use of anticoagulants

See also ACS 2103 Admission for post acute care.

NB: If there is a contractual arrangement existing between the two hospitals in the scenario cited then the guidelines within ACS 0029 Coding of contracted procedures should also be followed.

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

Published 15 December 2008,
for implementation 01 January 2009.
Pharmacotherapy (5 of 7)

Q:
If admission is for removal of Port-A-Cath, should the neoplasm codes be assigned as additional diagnosis?

A:
To assign a code for the neoplasm, this condition needs to meet the criteria in ACS 0002 Additional diagnoses (refer also to question 4 above).

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Pharmacotherapy (7 of 7)

Q:
What ICD-10-AM/ACHI codes are assigned for an admission for port flush only?

A:
Assign Z45.2 Adjustment and management of vascular access device and 13939-02 [1922] Maintenance (alone) of vascular access device.

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Pharmacotherapy (6 of 7)

Q:
Which ICD-10-AM/ACHI codes are assigned for a CADD disconnection only?

A:
Assign Z45.1 *Adjustment and management of drug delivery or implanted device* and 13942-02 [1922] *Maintenance (alone) of drug delivery device*.

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Pharmacotherapy (4 of 7)

Q:
If a patient is admitted for insertion of a Port-A-Cath, should Z45.2 Adjustment and management of vascular access device be assigned as the principal diagnosis or the reason for the insertion i.e. cancer codes?

A:
As per ACS 0002 Additional diagnoses:

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

If the admission is only for the insertion of a Port-A-Cath then Z45.2 is assigned as the principal diagnosis. Additional diagnosis codes for the neoplasm are only assigned if the condition meets ACS 0002 Additional diagnoses, i.e. if treatment of the neoplasm commences during the episode of care.

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Principal/Additional diagnoses (2 of 3)

Q:
If a patient is admitted with chest pain and there is documentation of risk factors such as hypertension, family history of IHD etc and tests such as scans are performed for the risk factors, should the risk factors be coded?

A:
As per ACS 0002 Additional diagnoses - Risk factors, these factors should only be coded if they meet the additional diagnosis criteria or another standard indicates they should be coded, i.e. if the tests are performed for the hypertension, family history of IHD etc, these conditions would then meet the additional diagnosis criteria for code assignment.

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Principal/Additional diagnoses (1 of 3)

Q: Patient admitted for breast lumpectomy histopathology pending and patient was discharged. Findings showed cancer. What is coded as the principal diagnosis, the breast lump or the cancer?

A: As per ACS 0010 General abstraction guidelines - Test results, the histopathology result is providing further specificity to an already documented condition. In this scenario the patient was admitted for the removal of a breast lump and the histopathology confirmed that the lump was cancerous; therefore, the cancer would be coded as the principal diagnosis.

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Lateral canthal sling

Q:
What is the correct procedure code to assign for a lateral canthal sling?

A:
A lateral canthal sling is a relatively new procedure performed for repair of ectropion/entropion. Block [239] Procedures for ectropion or entropion contains several procedures which are specifically used to repair ectropions and/or entropions. However, ACS 0741 Ectropion/Entropion also advises that "Other procedures classified elsewhere in the ACHI Tabular List may be performed to repair an ectropion or entropion, such as grafts, canthoplasty and tarsal strip procedure". The correct code to assign for lateral canthal sling is 45614-01 [1684] Tarsal strip procedure with additional codes 42590-00 [235] Lateral canthoplasty and/or 45626-00 [239] Correction of ectropion or entropion by suture technique, as appropriate.

Bibliography

Published 15 March 2008,
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Velamentous Insertion of Cord

Q: What is the correct code to assign for velamentous insertion of cord?

A: Normally, veins run from the middle of the placenta via the umbilical cord to the fetus. The umbilical cord inserts on the placental mass in about 99% of cases, with the insertion site varying from the centre of the fetal surface to the border of the placenta. Velamentous insertion is used to describe the condition in which the umbilical cord inserts on the chorioamniotic membranes rather than on the placental mass. The incidence of this condition is about 1.1% in singleton gestations and 8.7% in twin gestations. The incidence of velamentous insertion is even higher in early pregnancy: in spontaneous abortions it has been estimated to be 33% between the ninth and twelfth weeks and 26% between the thirteenth and sixteenth weeks. The most significant problem arising from a velamentous insertion of the umbilical cord is vasa praevia, a dangerous condition in which the velamentous umbilical vessels traverse the fetal membranes in the lower uterine segment below the presenting part. In 6% of singleton gestations with a velamentous insertion, vasa praevia is a coexisting condition. These unprotected vessels may rupture at any time during pregnancy, causing fetal haemorrhage and death. The picture below shows a velamentous cord insertion.

For velamentous insertion of cord, where care or intervention is required before the onset of labour, assign O43.1 Malformation of placenta following the pathway:

Insertion
- cord (umbilical) lateral or velamentous O43.1
or
Pregnancy
- complicated by
  - abnormal, abnormality
  - - placenta, placental (vessel) O43.1

Where the abnormality is first diagnosed during labour, or requires care and/or intervention during labour, assign O69.8 Labour and delivery complicated by other cord complications following the pathway:

Complication(s)
- umbilical cord
  - - velamentous insertion O69.8

Bibliography
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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Dementia due to secondary parkinsonism

Q:
If a patient has dementia due to secondary parkinsonism, is it correct to assign F02.3 as an additional code to capture the dementia in the context of Parkinson’s disease?

A:
F02.3* Dementia in Parkinson’s disease is an asterisk code and should only be assigned in combination with G20 Parkinson’s disease as it appears in the Alphabetic Index. For example:

Parkinsonism

- with

- - dementia G20+ F02.3*

G20 Parkinson’s disease classifies idiopathic or primary parkinsonism/Parkinson’s disease or parkinsonism/Parkinson’s disease not otherwise stated. Secondary parkinsonism is similar to Parkinson’s disease, but is caused by certain medications, other nervous system disorders or other illnesses. It is classified in ICD-10-AM to G21 Secondary parkinsonism where the dagger asterisk convention does not apply.

Therefore, when a patient has dementia linked to secondary parkinsonism, assign a code from G21 with F03 Unspecified dementia and sequence following the criteria in ACS 0001 Principal diagnosis, Aetiology and manifestation convention.

Bibliography


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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Assignment of Chapter 17 Congenital malformations, deformations and chromosomal abnormalities codes (Q00-Q99) as additional diagnoses

The NCCH was asked to clarify if Q codes should be assigned as additional diagnoses to indicate the genetic nature of a disease in conditions such as otosclerosis, familial adenomatous polyposis (FAP) and hereditary non-polyposis colon cancer (HNPCC). The issue of genetic links to specific conditions is complex and controversial. Debate on this issue is ongoing at the World Health Organization within the revision work on ICD-11. A congenital condition is one that is present at or before birth. Congenital conditions may be inherited. For example, osteogenesis imperfecta is a genetic disorder that is present at birth. Some congenital conditions are acquired due to the impact of environmental factors on the developing fetus. These conditions are not inherited. For example, congenital syphilis is caused by Treponema pallidum, passing through the placenta. It should be noted that some congenital conditions, although present at birth, may not be detected for some years. A genetic condition occurs due to defective genes and tends to run in families. Genetic disorders may be present at birth (and hence are also congenital) or they may occur at any time throughout life. An individual may carry a defective gene and never exhibit the characteristics of that disease.

Classification

Codes from Chapter 17 Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99) should only be assigned for a condition by following the correct pathways in ICD-10-AM Alphabetic Index. An exception is the assignment of a code from Q87.- Other specified congenital malformation syndromes affecting multiple systems as detailed in ACS 0005 Syndromes. For otosclerosis, assign a code from H80 Otosclerosis. Research indicates that genetic susceptibility is only one of a number of risk factors that may cause the condition. Other risk factors include gender, pregnancy, race, non-fluoridated water or viral infections. The exact cause is often unknown. Although otosclerosis may be caused by genetic susceptibility, it is not generally present at birth (and is therefore not a congenital condition). Similarly, although FAP and HNPCC are caused by defective genes, affected individuals are not born with colon disease and some may never develop colon disease.

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

Published 15 September 2006,
for implementation 01 October 2006.
Morphology codes for the abbreviated term 'Ca'

The NCCH was asked to clarify whether the abbreviation 'Ca' should be interpreted as 'cancer' or 'carcinoma'. The NCCH was also asked which morphology code to assign when the abbreviation 'Ca' is used in the absence of any other defining documentation in a medical record. Clinicians, cancer registries and various medical dictionaries have all indicated that 'Ca' can be used interchangeably to mean 'cancer' or 'carcinoma'. On further review of the use of this abbreviation, WHO ICD-10 indicates that the term 'cancer' when modified by an adjective or adjectival phrase indicating a morphological type, should be coded in the same manner as 'carcinoma' with that adjective or phrase. Thus, 'squamous cell cancer' should be coded in the same manner as 'squamous cell carcinoma', which appears in the list under 'Carcinoma' (ICD-10-AM Alphabetic Index of Diseases). If the term 'cancer' is preceded by a term other than a morphological descriptor, assign the morphology code M8000/3 Neoplasm, malignant. Therefore, if prostate Ca is documented without any available histology report or clinical clarification, assign M8000/3 Neoplasm, malignant.

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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Albumex transfusion

Albumex is a natural plasma component prepared from pooled human plasma and is used as a plasma volume expander in the treatment of shock due to blood loss. The classification of drugs in ICD-10-AM is according to their class and not their therapeutic indication. Plasma volume (blood) expander is classified as a type of blood product in ICD-10-AM. Therefore, transfusion of Albumex should be classified according to the guidelines in ACS 0302 *Blood transfusions*.

**Classification**

For documentation of transfusion of Albumex, assign 92062-00 [1893] *Administration of other serum*.

**Bibliography**


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

Published 15 June 2005, for implementation 01 July 2005.
Spinal cord compression secondary to neoplasm

The NCCH was asked to comment on the classification of spinal cord compression secondary to a neoplasm. The inquirer suggested G99.2* Myelopathy in diseases classified elsewhere should be used as an additional diagnosis to indicate that spinal cord compression has occurred as the result of a coexisting neoplastic condition, for example, rectal carcinoma. The NCCH agrees with this logic. Spinal cord compression is a type of myelopathy, that is, functional disturbance or pathological change in the spinal cord. However, since G99.2* is a general, unspecified code, an additional code should also be assigned to specify the type of myelopathy.

Classification

Where spinal cord compression is documented as occurring as the direct consequence of a neoplastic condition, the following codes should be assigned to complete the clinical picture:

G99.2* Myelopathy in diseases classified elsewhere

G95.2 Cord compression, unspecified

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for implementation 01 October 2004.