Sling procedures for unspecified urinary incontinence

Q:

What code is assigned for sling procedure performed for urinary incontinence not specified as stress incontinence?

A:

There are two main types of urinary incontinence, stress incontinence and urge incontinence. Sling procedures are generally performed for stress incontinence, while urge incontinence is treated with medication, Botox injection or sacral nerve stimulation (Chung et al 2017; MedlinePlus 2017).

When a sling procedure is performed with no documentation on the type of urinary incontinence and clinical clarification is not possible, assign:

- 37044-00 [1109] Retropubic procedure for stress incontinence, male
- or
- 35599-00 [1110] Sling procedure for stress incontinence, female.

Follow the Alphabetic Index:
Sling procedure
  - for
    - - stress incontinence
    - - - female 35599-00 [1110]
    - - - male 37044-00 [1109]

Amendments will be considered for a future edition.

References:


Published 15 December 2018,
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Coding Rule is effective for event records with an event end date on or after 1 January 2019

Ref No: Q3259 | Published On: 15-Dec-2018 | Status: Current

Neonatal sepsis/risk of sepsis

Q:
What code is assigned for suspected neonatal sepsis?

A:

ACS 0012 Suspected conditions provides the following guidelines in regard to suspected diseases and conditions in neonates:

Z03.7 - Observation and evaluation of newborn for suspected condition not found is assigned following the criteria in ACS 1611 Observation and evaluation of newborn and infants for suspected condition not found and ACS 1617 Neonatal sepsis/risk of sepsis.

ACCD acknowledges that the Note at category Z03.7 Observation and evaluation of newborn for suspected condition not found and the risk of sepsis classification instructions within ACS 1617 Neonatal sepsis/risk of sepsis are ambiguous, as neonates with risk of/suspected sepsis may be symptomatic and have other conditions. However, coders should apply the guidelines in ACS 1617 regardless of whether the neonate has signs or symptoms, or coexisting conditions documented.

Therefore:

▪ when there is documentation of “suspected neonatal sepsis” but there is conflicting, unclear or no supporting documentation in the body of the clinical record, seek clinician clarification prior to code assignment
▪ where a diagnosis of ‘neonatal sepsis’ is confirmed, assign a code for sepsis, as per the guidelines ACS 1617 Neonatal sepsis/risk of sepsis
▪ for classification purposes, a diagnosis of ‘risk of sepsis’ or ‘suspected sepsis’ (ie probable, possible, likely, queried sepsis) are synonymous in neonates. Assign Z03.71 Observation of newborn for suspected infectious condition regardless of whether the neonate has signs or symptoms, or coexisting conditions documented.

Amendments may be considered for a future edition.

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for implementation 01 January 2019.
Liver lacerations

Q:
What codes are assigned for liver lacerations documented by grade rather than severity (ie minor, moderate or major)?

A:
ICD-10 (and hence ICD-10-AM) classifies liver lacerations by severity (ie minor, moderate and major). However, clinicians may document liver lacerations using grades (ie grades 1-6).

As a best fit, where a liver laceration is documented using a grading system rather than a severity descriptor, assign:

- S36.13 Minor laceration of liver for Grade 1
- S36.14 Moderate laceration of liver for Grade 2
- S36.15 Major laceration of liver for Grade 3 and above.

Amendments may be considered for a future edition.

Published 15 December 2018,
for implementation 01 January 2019.
Perforator flap

Q:
What code is assigned for a perforator flap?

A:
A perforator flap is a flap consisting of skin and/or subcutaneous fat with its blood supplied by a small isolated vessel. Other types of perforator flaps may also penetrate muscle (muscle perforator) and/or muscle septae (septal perforator), to supply the overlying skin.

The name of a perforator flap is derived from the (perforator) vessel that supplies the blood, and the structures they cross before reaching the skin. For example, anterior intercostal artery perforator (AICAP) flaps, commonly used in breast reconstruction, obtain their blood supply from the intercostal arteries. Some may be named by their anatomical region (eg adipofascial flap, which consists of adipose and fascia layers). Some perforator flaps may also include nerves (eg anterolateral thigh (ALT) flaps) (Blondeel et al. 2003; Kim Kim 2015).

Perforator flaps are not classified in ACHI. Depending on the location of the flap being performed, a perforator flap may be a free flap or an island flap. Therefore, seek clinical advice on the flap undertaken to determine the appropriate code from Chapter 16 Dermatological and plastic procedures when clinical documentation is unclear or unavailable.

When a perforator flap is used in breast reconstruction, assign 45530-02 [1756] Reconstruction of breast using flap.

Follow the ACHI Alphabetic Index:
Flap (repair)
- for
  - reconstruction of breast 45530-02 [1756]

Amendments may be considered for a future edition.

See also Coding Rule: Periosteal flap.

References:

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
- 36800-00 [1090] Bladder catheterisation

Follow the ACHI Alphabetical Index:

Removal - see also Excision - catheter - bladder (endoscopic) (indwelling) - nonoperative (nonendoscopic) NEC

Insertion - catheter - bladder

Amendments have been undertaken for Eleventh Edition.

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Insertion of cardiac contractility modulation (CCM) device

Q:
What code is assigned for the insertion of a cardiac contractility modulation (CCM) device?

A:
Cardiac contractility modulation (CCM) is used for treatment of patients with moderate to severe chronic heart failure who have not responded to medical therapy. The CCM signals are electrical pulses that are delivered by a CCM system, which consists of a small, implantable pulse generator unit (device) and electrodes (leads) similar to a pacemaker. These signals are delivered via the two electrodes during the absolute refractory period (ie the period just after the heart contracts). It comes with a rechargeable battery to minimise the need for replacement.

The CCM device is typically implanted in the right pectoral region and connected to two electrodes that are transvenously placed in the right ventricle of the heart to sense ventricular activity. An optional electrode may also be inserted to sense atrial activity. Unlike the cardiac pacemaker or the defibrillator, the CCM device is designed to modulate the strength of contraction of the heart muscle rather than its rhythm (Impulse Dynamics, 2018).

ACHI does not currently have a specific code for insertion of a cardiac contractility modulation (CCM) device.

Assign 38353-00 [650] Insertion of cardiac pacemaker generator
and
38350-00 [648] Insertion of permanent transvenous electrode into other heart chamber(s) for cardiac pacemaker as a best fit.

Follow the Alphabetic Index:
Insertion
- electrode(s) lead(s)
  - cardiac (for)
  - permanent
  - transvenous (atrium) (right ventricle) 38350-00 [648]
- pacemaker
  - cardiac
  - generator (biventricular) (cardiac resynchronisation therapy) (dual chamber) (single chamber) (triple chamber) 38353-00 [650]

Amendments may be considered for a future edition.

References:

Published 15 December 2018,
for implementation 01 January 2019.
Coding Rule is effective for event records with an event end date on or after 1 January 2019

Ref No: Q3292 | Published On: 15-Dec-2018 | Status: Current

Implantation of endoanchors/endostaples to the stent graft in endovascular aneurysm repair (EVAR)

Q:

What code is assigned for implantation of endoanchors/endostaples to the stent graft in endovascular aneurysm repair (EVAR)?

A:

Endovascular aneurysm repair (EVAR) with stent graft is performed for aortic aneurysms where a stent graft is inserted through a catheter via the femoral artery. The graft is expanded at the site of the aneurysm, reinforcing the weak portion of the aorta and allowing the blood to flow through the stent graft.

Endoanchors/endostaples can be implanted during EVAR to secure a transmural fixation of the endograft to the aorta. The endoanchors can also be implanted as a separate procedure for complications of EVAR such as endovascular leaks or migrated stent grafts (de Vries 2017; UCSF Department of Surgery 2018). Where endoanchors are inserted during the initial EVAR, it is not necessary to assign a separate code as it is inherent in the EVAR procedure.

Where endoanchors are inserted as a standalone procedure (eg for endograft migration or endovascular leaks), assign 33116-00 [762] Endovascular repair of aneurysm as best fit.

Follow the Alphabetic Index:

Repair
- aorta, aortic
- - endovascular (AAA stent) (aneurysm) (dissection) (endoluminal) 33116-00 [762]

Amendments may be considered for a future edition.

References:


Published 15 December 2018,
for implementation 01 January 2019.
Z72.2 Drug use

Q:
When is it appropriate to assign Z72.2 Drug use?

A:
As per Note (b) at the beginning of Chapter 21 Factors influencing health status and contact with health services which states:

Categories Z00–Z99 are provided for occasions when circumstances other than a disease, injury or external cause ... are recorded as 'diagnoses' or 'problems'. This can arise in two main ways:

(b) When some circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury...

The Note at category Z72 Problems related to lifestyle states:

Hazardous use is a pattern of substance use that increases the risk of harmful consequences for the user. In contrast to harmful use, hazardous use refers to patterns of use that are of public health significance despite the absence of any current disorder in the individual user.

Therefore, assign Z72.2 Drug use where there is documentation that a patient is a current user of a drug(s) of addiction and the drug use status is relevant to the current episode of care, however there is insufficient information to assign a code from categories F11-F16, F18 or F19 (ie for acute intoxication, harmful or dependent use).

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

Amendments may be considered for a future edition.

Published 15 December 2018,
for implementation 01 January 2019.

NOT APPLICABLE TO NEW ZEALAND FOR THE DURATION OF 8TH EDITION
Coding Rule is effective for event records with an event end date on or after 1 January 2019

Ref No: Q3296 | Published On: 15-Dec-2018 | Status: Current

Endoscopic septoplasty for Zenker’s diverticulum

Q:
What code is assigned for endoscopic septoplasty for Zenker’s diverticulum?

A:
Zenker’s diverticulum occurs when the pharyngeal lining herniates through the muscles of the pharyngeal wall of the hypopharynx. It is also known as pharyngo-oesophageal diverticulum, hypopharyngeal diverticulum or pharyngeal pouch. Symptoms include dysphagia, regurgitation of undigested food, halitosis, hoarseness, chronic cough and aspiration of the pouch’s content into the lungs.

Endoscopic septoplasty for Zenker’s diverticulum is performed via a flexible endoscope with an overtube, hood or cap. The procedure involves division of the septum (containing the cricopharyngeus muscle) to reconnect the pouch lumen with the normal pharyngo-oesophageal pathway (National Institute for Health and Excellence 2015; Vandergriendt 2018). An endoscopic stapling technique consisting of simultaneously stapling the mucosa edges and cutting the partition may also be performed (Ernster 2018).

For endoscopic septoplasty of Zenker’s diverticulum assign, 41773-00 [421] Endoscopic resection of pharyngeal pouch as best fit.

Follow the Alphabetic Index:
Removal — see also Excision
- pharyngeal
  - - pouch (open)
  - - - endoscopic 41773-00 [421]

Amendments may be considered for a future edition.

References:

Published 15 December 2018,
for implementation 01 January 2019.
Coding Rule is effective for event records with an event end date on or after 1 January 2019

Ref No: Q3299 | Published On: 15-Dec-2018 | Status: Current

**Bone marrow aspirate for bone marrow concentrate graft**

**Q:**
What ACHI codes are assigned when bone marrow aspiration is performed for a bone marrow concentrate graft?

**A:**
Bone marrow aspirate concentrate consists of fluid taken from bone marrow, which is spun down in a centrifuge to separate the cells. The resulting liquid contains a high concentration of stem cells, which are then injected directly into the surgical site to help the healing of bone and joint conditions such as cartilage defects and arthritis (American Orthopaedic Foot & Ankle Society 2018; Chahla et al. 2017).

Where bone marrow aspiration is performed for bone marrow concentrate grafts, assign:

- 13700-00 [801] *Procurement of bone marrow for transplantation* (as best fit), for aspiration of the bone marrow, and
- 14203-01 [1906] *Direct living tissue implantation* for the bone marrow concentrate graft.

Follow the Alphabetic Index:

**Procurement**
- bone
- - marrow, for transplantation 13700-00 [801]

**Implant, implantation**
- living tissue
- - by
- - - direct implantation 14203-01 [1906]

Amendments may be considered for a future edition.

**References:**

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Coding Rule is effective for event records with an event end date on or after 1 January 2019

Ref No: Q3310 | Published On: 15-Dec-2018 | Status: Current

Functional Neurological Disorder

Q:
What codes are assigned for functional neurological disorder?

A:
Functional neurological disorder (FND) is a broad term that includes conditions previously known as ‘conversion’ or ‘dissociative’ disorders. FND features neurological symptoms that cannot be explained by a neurological disease or other medical condition, however the symptoms cause significant distress or problems with functioning (Mayo Clinic 2017).

Assign as a best fit for functional neurological disorder one of the codes listed below by following the Alphabetic Index:

**Disorder** (of) — *see also Disease*
- conversion (*see also Disorder/dissociative*)
- dissociative F44.9
- - affecting
  - - - motor function F44.4
  - - - and sensation F44.7
  - - sensation F44.6
- - specified NEC F44.88
- - transient, occurring in childhood and adolescence F44.82

For example, for limb weakness and paraesthesia due to functional neurological disorder, assign F44.7 *Mixed dissociative [conversion] disorders.*

Note: Do not assign codes for neurological symptoms (eg limb weakness, paraesthesia) of a functional neurological disorder code (see also Note at the beginning of Chapter 18 *Symptoms, signs and abnormal clinical findings, not elsewhere classified*).

Amendments may be considered for a future edition.

**References:**

Published 15 December 2018,
for implementation 01 January 2019.
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 the type of material used for dental restoration (filling), seek clarification from the treating clinician. When this is not possible, assign:

97511-01
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.

NOT APPLICABLE TO NEW ZEALAND FOR THE DURATION OF 8TH EDITION
Drug seeking behaviour

Q:
What code is assigned for drug seeking behaviour?

A:
Within admitted inpatient episodes drug or medication seeking behaviour is defined as a pervasive pattern of requesting medications that have either little or no therapeutic efficacy for the presenting problem and/or in dosages exceeding therapeutic limits. Drug seeking behaviour may have many causes including undertreated pain, anxiety, sleep related issues, somatoform disorders, addiction, or maybe deceptive in nature where the individual is motivated by the desire to misuse medication for non-medical purposes (Bird Gulliver, Wolfsorf Michas 2003, Butterfield 2014).

Where there is documentation of drug seeking behaviour and it is relevant to the episode of care:
- assign a code for the underlying cause (eg drug dependence) if documented with the episode.
- assign Z64.2 Seeking and accepting physical, nutritional and chemical interventions known to be hazardous and harmful, where there is no documentation or clinical confirmation of an underlying cause.

Follow the Alphabetic Index:
Seeking and accepting known hazardous and harmful
- chemical, nutritional or physical interventions Z64.2

Amendments may be considered for a future edition.

References:

Published 15 December 2018,
for implementation 01 January 2019.
**Lipomodelling following breast reconstruction**

**Q:**
What codes are assigned for lipomodelling following breast reconstruction?

**A:**
After breast reconstruction, there may be dents or irregularities in the outline (contour) of the reconstructed breast.

Lipomodelling (also known as ‘lipofilling’) after breast reconstruction is a same-day procedure that involves the injection of fat into the reconstructed breast, to fill dents or irregularities. Lipomodelling may also be performed as a breast enlargement procedure. The procedure involves removing fat from one body part (eg thigh, abdomen) and injecting into the breast. It may be necessary to repeat the procedure to achieve the desired result.

Lipomodelling is not usually performed until the reconstructed breasts have fully healed, which usually takes about 6–12 months (Macmillan Cancer Support 2015).

ACS 1204 *Plastic surgery* states:

When the condition is not specified, or is a term not recognised by ICD-10-AM (eg ageing face), assign Z41.1 *Other plastic surgery for unacceptable cosmetic appearance* or Z42. Follow-up care involving plastic surgery as the principal diagnosis, as appropriate.

Therefore, when a patient is admitted following breast reconstruction for lipomodelling, assign Z42.1 *Follow-up care involving plastic surgery of breast."

Assign 90660-00 [1602] *Administration of agent into skin and subcutaneous tissue* by following the ACHI Alphabetic Index:

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

Amendments may be considered for a future edition.

Published 15 December 2018, for implementation 01 January 2019.
Fungal pneumonia

Q:
What codes are assigned for fungal pneumonia, not elsewhere classified (NEC)?

A:

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

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

Fungal infections are classified in ICD-10-AM to category B35-B49 Mycoses. For fungal pneumonia NEC assign:
J16.8 Pneumonia due to other specified infectious organisms
B48.8 Other specified mycoses

Follow the Alphabetic Index:
Pneumonia
- in (due to)
-- specified
--- organism NEC J16.8

Mycosis, mycotic
- specified NEC B48.8

It is noted that there is inconsistency within the ICD-10-AM in regard to classification of infectious agents. This may be reviewed for a future edition.

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Hormone Resistance in Prostate Cancer

Q:

Is Z07 Resistance to anti-neoplastic drugs assigned for ‘hormone resistance’ in prostate cancer?

A:

Hormone therapy may be administered to patients with prostate cancer (also known as androgen deprivation therapy (ADT)), to slow or prevent the growth of cancer cells. When these patients no longer respond to hormone therapy, the cancer is classified as ‘androgen-independent prostate cancer’ or ‘hormone-refractory prostate cancer (HRPC)’. This is not an adverse effect of the hormone therapy.

The Note at Z07 Resistance to antineoplastic drugs states:
Assign Z07 as an additional code to identify resistance to antineoplastic drugs in the treatment of conditions classified in Chapter 2.

See also the Instructional note at Chapter 2 Neoplasms:
Use additional code (Z07) to identify resistance to antineoplastic drugs.

Therefore, where there is documentation of ‘androgen-independent prostate cancer’ or HRPC or hormone resistance in prostate cancer, assign:

- codes for the neoplasm(s) (see ACS 0236 Neoplasm coding and sequencing) and
- Z07 Resistance to antineoplastic drugs

Follow the ICD-10-AM Alphabetic Index:
Resistance, resistant (to)
- antineoplastic drug(s) Z07

Amendments may be considered for a future edition.

References:


Harvard University 2018, Androgen-independent Prostate Cancer, viewed 15 October 2018 https://www.harvardprostateknowledge.org/androgen-independent-prostate-cancer

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.
Assignment of additional diagnosis codes for prematurity

Q:
Does prematurity need to meet the criteria in ACS 0002 Additional diagnoses?

A:
Prematurity is a significant indicator of neonatal morbidity and mortality. ACS 1618 Low birth weight and gestational age does not specify whether immaturity/prematurity needs to meet the criteria in ACS 0002 Additional diagnoses. However, the Includes note at category P07 reflects the criteria and guidelines in ACS 0002:

*P07 Disorders related to short gestation and low birth weight, not elsewhere classified*

Includes: the listed conditions, without further specification, as the cause of mortality, morbidity or additional care, in newborn

ACS 0002 Additional diagnoses

For 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
- diagnostic procedures
- increased clinical care and/or monitoring

PROBLEMS AND UNDERLYING CONDITIONS

If a problem with a known underlying cause is being treated, then both conditions should be coded.

Therefore, assign a code from subcategories P07.2 Extreme immaturity or P07.3 Other preterm infants for:

- all neonates with a gestational age of less than 37 completed weeks in the birth episode of care
- episodes of care subsequent to the birth episode of care, when immaturity/prematurity meets the criteria in ACS 0002 Additional diagnoses.

ACS 1605 Conditions originating in the perinatal period Example 2 reflects the logic in the second dot point above, where a code for prematurity (P07.22) is assigned as it meets the criteria in ACS 0002 (ie it is the underlying cause of the patient’s jaundice):

A premature infant (born at 27 weeks; birth weight 700g), was transferred from another hospital at 30 days of age, for ongoing care of jaundice of prematurity and low birth weight. During this admission the infant received 24 hours of phototherapy and supplementary feeds.

Codes:

- P59.0 Neonatal jaundice associated with preterm delivery
- P07.22 Extreme immaturity, 24 or more completed weeks but less than 28 completed weeks
- P07.02 Extremely low birth weight 500–749g
- 90677-00 [1611] Other phototherapy, skin

See also Coding Rule: Prematurity and documentation of gestational age.
Endoscopic clipping of bleeding upper gastrointestinal lesions

Q:
What code is assigned for endoscopic clipping of bleeding upper gastrointestinal lesions?

A:
Upper gastrointestinal (UGI) bleeding may be caused by conditions such as peptic (i.e., gastric, duodenal) ulcer, Mallory-Weiss tear, angiodysplasia, arteriovenous malformation or Dieulafoy’s lesions occurring in the stomach, duodenum and oesophagus.

There are several different endoscopic techniques for treatment of UGI bleeding including injection of sclerosants (e.g., epinephrine), thermal therapy (e.g., heat probes, Argon plasma coagulation) and placement of clips (e.g., endoclips), to close the blood vessels. Clipping devices are designed to grasp the submucosa, seal the underlying patent blood vessels, and/or to approximate the sides of lesions during endoscopy to potentially accelerate lesion healing. (Genetic and Rare Diseases Information Centre 2016; Kovacs Jensen 2011).

For endoscopic clipping of bleeding UGI lesions due to any cause, assign 90296-00 [887] *Endoscopic control of peptic ulcer or bleeding* as a best fit.

Follow the Alphabetic Index:
- Clipping (of)
  - peptic ulcer, endoscopic (duodenal) (gastric) 90296-00 [887]

Amendments may be considered for a future edition.

References:


Published 15 December 2018, for implementation 01 January 2019.
Dilation of ileocolic anastomotic stricture

Q: What ACHI code is assigned for dilation of ileocolic anastomotic stricture?

A: Ileocolic anastomotic strictures may occur after ileocaecal resection or hemicolectomy for conditions such as malignancy of the gastrointestinal tract or Crohn’s disease. Endoscopic balloon dilation or surgical resection are performed to treat the ileocolic anastomotic strictures (Ding et al. 2016; Lian et al. 2017).

For dilation of ileocolic anastomotic stricture, assign 32094-00 [917] Endoscopic dilation of colorectal stricture as a best fit.

Follow the Alphabetic Index:
- Dilation
  - stricture
  - - anastomotic (endoscopic)
  - - - colorectal 32094-00 [917]

Amendments may be considered for a future edition.

References:

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Non traumatic rotator cuff tear in Type 2 diabetes mellitus

Q:
What code is assigned for type 2 diabetes mellitus with nontraumatic rotator cuff tear/rotator cuff syndrome?

A:
ICD-10-AM classifies nontraumatic rotator cuff tear and rotator cuff syndrome to M75.1 Rotator cuff syndrome. Therefore, these terms are considered synonymous for classification purposes.

ACS 0401 Diabetes Mellitus and Intermediate Hyperglycaemia/ General classification rules for DM and IH/Rule 2 states:

The terms 'diabetic', 'due to' or 'secondary to' infer a causal relationship between the DM and other conditions. Where such terms are used check the Alphabetic Index for appropriate codes indexed directly under Diabetes, diabetic or appropriate codes indexed under the lead term for the condition with a subterm diabetic.

1. Where rotator cuff tear/syndrome meets the criteria for classification in ACS 0001 Principal diagnosis
2. and ACS 0002 Additional diagnoses and is documented as having a causal relationship (ie diabetic, due
3. to or secondary to) to diabetes mellitus, assign:

E11.61 Type 2 diabetes mellitus with specified diabetic musculoskeletal and connective tissue complication, and
M75.1 Rotator cuff syndrome.

Follow the ICD-10-AM Alphabetic Index:
Diabetes, diabetic (controlled) (mellitus) (without complication)
- rotator cuff syndrome E11.61

Tear, torn (traumatic)
- rotator cuff (complete) (incomplete) (nontraumatic) M75.1

1. Where there is no documented causal relationship between rotator cuff tear/syndrome and diabetes mellitus, assign a code for the DM as per ACS 0401 Diabetes Mellitus and Intermediate Hyperglycaemia /General classification rules for DM and intermediate hyperglycaemia.

Assign M75.1 Rotator cuff syndrome as per the criteria in ACS 0001 and ACS 0002.

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Decompression of sigmoid volvulus

Q:
What code is assigned for endoscopic decompression of sigmoid (colonic) volvulus?

A:
Treatment for colonic (including sigmoid) volvulus may involve endoscopic decompression, detorsion and reduction (EDDR) which is performed via sigmoidoscopy or colonoscopy prior to more complicated surgical interventions such as colonic resection (Tang Wu 2013: Lianos, et al. 2012).

For classification purposes, reduction and decompression are synonymous as interventions for treatment of colonic volvulus.

Where endoscopic decompression of colonic (sigmoid) volvulus is performed, assign 30375-17 [916] Reduction of volvulus of large intestine by following the ACHI Alphabetic Index:

Reduction
- volvulus
  - large 30375-17 [916]

Assign a code for the endoscopy (ie sigmoidoscopy or colonoscopy), as per the guidelines in ACS 0023 Laparoscopic/arthroscopic/endoscopic surgery.

Amendments may be considered for a future edition.

References:

Published 15 December 2018,
for implementation 01 January 2019.
Complications of medical abortion

Q:
What codes are assigned for complications of medical abortion before fetal viability, documented as ‘labour and delivery’, or ‘postpartum’ complications (eg retained placenta or postpartum haemorrhage (PPH)?

A:
The following codes/categories in Chapter 15 Pregnancy, childbirth and the puerperium exclude pregnancy with abortive outcome/abortion (ie they are mutually exclusive):

- O20 Haemorrhage in early pregnancy excludes pregnancy with abortive outcome (O00-O08)
- O22 Venous conditions and haemorrhoids in pregnancy excludes venous complications of abortion or ectopic or molar pregnancy (O00-O07, O08.7)
- O26.2 Pregnancy care of habitual aborter excludes current abortion (O03-O06)
- O88 Obstetric embolism excludes embolism complicating abortion or ectopic or molar pregnancy (O00-O07, O08.2)

Complications of abortion classified to categories O00-O02, are assigned an additional code from category O08 Complications following abortion and ectopic and molar pregnancy.

Complications of a medical abortion that occur during the same episode of care in which the abortion was performed, are classified by the assignment of a relevant fourth character with O04 Medical abortion. Note that retained products of conception (including retained placenta) is classified as an incomplete abortion.

Medical abortion before fetal viability (less than 20 completed weeks (140 days) gestation and/or fetal weight less than 400g) is not classified as a delivery episode of care (ie codes from categories O80-O84 Delivery are not assigned, as per the guidelines in ACS 1511 Termination of pregnancy).

Therefore, for classification purposes, codes for complications of childbirth and the puerperium (ie codes from categories O60-O75 Complications of labour and delivery and O85-O92 Complications predominantly related to the puerperium) are generally not assigned before fetal viability.

However, in some rare scenarios, codes for complications of childbirth or the puerperium may be assigned with codes from category O04, where supported by documentation in the clinical record, if the complication does not exclude abortion (see list above).

See also ACS 1544 Complications following abortion and ectopic and molar pregnancy and ACS 1511 Termination of pregnancy.

Amendments to ICD-10-AM and the ACS have been undertaken for Eleventh Edition.

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 for 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-acting agent such as Clexane or heparin until the patient can safely 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.
Drug induced postural hypotension

Q:
What codes are assigned for drug induced postural hypotension?

A:
Postural (orthostatic) hypotension is a condition that occurs when blood pressure falls significantly when standing up or resuming an upright position quickly. Symptoms include feeling dizzy, lightheaded, faint, falling and blurred vision. Drug induced postural (orthostatic) hypotension occurs when a medication (e.g., antihypertensive, beta blocker, antipsychotic) results in a drop in blood pressure (Cleveland Clinic 2018; Wedro n.d.).

Assign I95.19 Other specified orthostatic hypotension for drug induced postural hypotension.

Follow the Alphabetic Index (Section I):
Hypotension
- orthostatic
  - specified NEC I95.19
- postural
  - specified NEC I95.19

Assign a code from categories Y40-Y59 Drugs, medicaments and biological substances causing adverse effects in therapeutic use to identify the drug or medicament (see ICD-10-AM Alphabetic Index Section III Table of Drugs and Chemicals).

Also assign a code for place of occurrence:
Y92.23 Place of occurrence, health service area, not specified as this facility
OR
Y92.24 Place of occurrence, health service facility, this facility

Follow the Alphabetic Index (Section II):
Place of occurrence of external cause
- health service area (not specified as this facility) NEC Y92.23
- this facility Y92.24

Amendments may be considered for a future edition.

References:
Cleveland Clinic 2018, Orthostatic hypotension, Cleveland Clinic, Ohio, viewed 31 July 2018, https://my.clevelandclinic.org/health/diseases/9385-orthostatic-hypotension


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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:
  1. a code from category O23 Infections of genitourinary tract in pregnancy or
     - O98.0 Tuberculosis in pregnancy, childbirth and the puerperium
     - O98.1 Syphilis in pregnancy, childbirth and the puerperium
     - O98.2 Gonorrhoea in pregnancy, childbirth and the puerperium
     - O98.3 Other infections with a predominant 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:
- compartmental, abnormality
  - broad ligament O34.8
  - cervix O34.4
  - fallopian tube O34.8
  - ovary O34.8
  - pelvic organs or tissues O34.9
  - specified NEC O34.0
- pelvis, with disproportion (bony) (major) NEC O33.0
- perineum O34.7
- uterus NEC O34.5
- congenital O34.0
- vagina O34.6
- vulva O34.7

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Coding Rule is effective for event records with an event end date on or after 1 January 2019

Ref No: Q3386 | Published On: 15-Dec-2018 | Status: Current

Noninvasive ventilation (NIV) provided for less than 1 hour

Q: Is a code assigned when noninvasive ventilation (NIV) is provided for less than 1 hour?

A: ACS 1006 Ventilatory support states:

CLASSIFICATION

1. Code first the ventilatory support

... 

c. For the purpose of calculating the duration of ventilatory support:

- hours of ventilatory support should be interpreted as completed cumulative hours. If a patient is intubated and ventilated for < 1 hour the intubation and ventilation are not coded. This includes patients who die or are discharged or transferred.

Although the above highlighted text relates specifically to continuous ventilatory support, the same logic is applicable to noninvasive ventilatory (NIV) support.

Therefore, if a patient receives NIV for less than one hour, do not assign 92209-00 [Management of noninvasive ventilatory support, ≤ 24 hours].

Ministry of Health comment:

As per the NMDS reporting requirements, total hours on noninvasive (NIV) and mechanical ventilation (MV) are to be rounded up. Therefore, where ventilation is provided less than 1 hour the reported value in the total hours on NIV or MV will be 1.

Amendments may be considered for a future edition.

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Ref No: Q3389 | Published On: 15-Dec-2018 | Status: Current

Terminology for malnutrition

Q:
Is malnourished or malnourishment classified as per malnutrition?

A:
Malnutrition is a noun, defined as “deficiencies, excesses or imbalances in a person’s intake of energy and/or nutrients” (WHO 2016).

Malnourishment, also a noun, is synonymous with malnutrition. Malnourished is the adjectival form, used to refer to someone affected by malnutrition/malnourishment.

The ICD-10-AM General arrangement of the Alphabetic Index of Diseases/Structure states:

In some diagnostic statements, the disease condition is expressed in adjectival form. Sometimes, the index lists both forms but often only the noun form will be found and the clinical coder must make the necessary transformation.

Therefore, where the terms ‘malnourished’, ‘malnourishment’ or ‘malnutrition’ are documented in the clinical record and meet the criteria in ACS 0001 Principal diagnosis and ACS 0002 Additional diagnoses, assign an appropriate code as listed under the lead term Malnutrition in the ICD-10-AM Alphabetic Index.

Amendments may be considered for a future edition.

References:

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Ref No: Q3282 | Published On: 15-Dec-2018 | Status: Current

Periosteal flap

Q:
What code is assigned for a periosteal flap?

A:
A periosteal flap is a vascularised pedicle from the periosteum and the outer layer of bone and plays an important role in bone healing. The rich blood supply of periosteal flaps means they are often used in the reconstruction of complex, large bone defects due to trauma, to assist in bone growth and repair.

Properties of the periosteal flap include its ease of harvesting and its great elasticity, which allows adaptation of the flap over the reconstruction including both bone junctions. However, the main attribute of the periosteal flap is the rich content of stem cells located at the cambium layer, which provide excellent osteogenic and angiogenic properties that biologically support bone healing and revascularization (Christoph et al. 2017; Sierra et al. 2016).

Periosteal flaps are not classified in ACHI. In ACHI, flaps are classified based on the anatomical location of the flap, type of tissue used eg skin, myocutaneous, muscle flap or bone, and the complexity of the flap eg local, distant, island, free, noninnervated or innervated.

When documentation is not available or is unclear, clinical coders must seek clinical advice regarding periosteal flap, to determine the appropriate code to assign from Chapter 16 Dermatological and plastic procedures.

For example, periosteal flap performed during repair of a ruptured extensor carpi ulnaris (ECU) tendon; assign 45206-05 [1651] Local skin flap of hand as a best fit by following the ACHI Alphabetic Index:
Flap (repair)
- wrist (local) (single stage) 45206-05 [1651]

Amendments may be considered for a future edition.

See also Coding Rule: Perforator flap.

References:

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