Coding Rule is effective for event records with an event end date on or after 1 July 2018

Ref No: Q3206 | Published On: 15-Jun-2018 | Status: Current

**TNM stage documentation**

**Q:**
Can a code for metastatic (secondary) lymph node neoplasm be assigned based on documentation of TNM staging?

**A:**
The TNM (Tumour, Node, Metastasis) staging system is a classification system used to describe cancer severity based on the size of the primary neoplasm and the extent of its spread in the body. Numbers are assigned after each letter (ie T, N and M) based on standardised criteria (eg T1N0MX or T3N1M0).

Primary tumour (T) – refers to the depth of the tumour invasion.
- TX: Primary tumour cannot be evaluated.
- T0: No evidence of primary tumour.
- T1, T2, T3, T4: Refers to the size and/or extent of the main tumour. A higher number after the T indicates a larger tumour, or invasion into adjacent tissue. T's may be further divided to provide more detail, such as T3a and T3b.

Regional lymph nodes (N) – refers to lymph node involvement.
- NX: Regional lymph nodes cannot be evaluated.
- N0: No regional lymph node involvement (no cancer found in the lymph nodes).
- N1, N2, N3: Involvement of regional lymph nodes (number and/or extent of spread). The higher the number after the N, the more lymph nodes that contain cancer.

Distant metastasis (M) – refers to whether the cancer has spread to other parts of the body
- MX: Metastasis cannot be evaluated.
- M0: No distant metastasis (cancer has not spread to other parts of the body).
- M1: Distant metastasis (cancer has spread to distant parts of the body) (American Joint Committee on Cancer 2017).

ACS 0010 General abstraction guidelines/Test results states:
Laboratory, x-ray, pathological and other diagnostic results should be coded where they clearly add specificity to already documented conditions that meet the criteria for a principal diagnosis (see ACS 0001 Principal diagnosis) or an additional diagnosis (see ACS 0002 Additional diagnoses).

The clarification on the application of the Standards for ethical conduct in clinical coding document states: “...It is not the role of a clinical coder to diagnose. The responsibility for good clinical documentation lies with the clinician. Good clinical documentation is critical to continuity and quality of patient care, patient safety and is the legal record of a patient’s episode of care. Importantly it also supports quality coded data...”.

Therefore, do not assume a neoplasm diagnosis or spread by interpreting the TNM staging system. Use the TNM to add specificity to a neoplastic condition documented elsewhere in the clinical record. Where documentation is unclear, seek clinical clarification to ascertain the severity of the neoplasm. Do not assign neoplasm codes based on the TNM staging alone.

Note: For classification purposes, terms such as “lymph node involvement”/“positive lymph nodes” are regarded as documented evidence of a secondary (metastatic) lymph node neoplasm.

**References:**
Published 15 June 2018,
for implementation 01 July 2018.
Toenail avulsion

Q:

What code is assigned for a total toenail removal where the nail bed was left intact?

A:

There are many reasons for a total or partial nail to be removed, such as recurrent infections or disease within the nail, damage due to injury, ingrown nails or pain, or to repair a nail growth abnormality (DoveMed 2015).

Avulsion of the nail is performed by grasping the sectioned nail with forceps and easing the nail free of the nail bed. Phenol is then applied directly to the nail matrix (The Royal Australian College of General Practitioners 2016).

Currently there is no ACHI code for a total toenail avulsion. Therefore, if the nail bed is left intact, and destruction to the matrix is by application of phenol, acid, electrocautery or laser, assign 47916-00 [1632] Partial resection of ingrown toenail, as a best fit, for a total toenail avulsion (regardless of indication).

Removal of - nail - toe - ingrown - partial (by phenolisation) (electrocautery) (laser) (sodium hydroxide or acid) 47916-00 [1632]

Amendments will be considered for a future edition.

Reference:

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Coding Rule is effective for event records with an event end date on or after 1 July 2018

Ref No: Q3228 | Published On: 15-Jun-2018 | Status: Current

**Spinal Fenestration**

**Q:**

What code is assigned for spinal fenestration (technique)?

**A:**

Spinal fenestration is an approach used to access the spinal nerve roots during spinal surgery (Wankhade et al. 2016). ACS 0016 *General procedure guidelines/Procedure components* states:

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

Therefore, a code for spinal fenestration is not required. Assign ACHI codes for the procedure(s) performed, such as rhizolysis.

Amendments will be considered for a future edition.

**References:**


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Coding Rule is effective for event records with an event end date on or after 1 July 2018

Ref No: Q3232 | Published On: 15-Jun-2018 | Status: Current

Gastric heterotopia of duodenum

Q:

What code is assigned for gastric heterotopia of duodenum?

A:

Duodenal gastric heterotopia is an incidental finding of ectopic gastric foveolar type mucosa in the duodenum at endoscopy. While it is generally assumed to be congenital in origin, there has been evidence of possible association with the presence of gastric fundal gland polyps (Conlon et al. 2013).

Assign Q43.82 Congenital transposition of intestine as a default for duodenal gastric heterotopia. Follow the Alphabetic Index:

Heterotopia, heterotopic — see also Malposition/congenital

Malposition
- congenital
  - intestine (large) (small) Q43.82

If documentation indicates that the condition is not congenital, assign K31.88 Other specified diseases of stomach and duodenum. Follow the Alphabetic Index:

Disease, diseased
- duodenum
  - specified NEC K31.88

Amendments will be considered for a future edition.

References:


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for implementation 01 July 2018.
Creation of testicular thigh pockets for Fournier’s gangrene

Q:
What procedure codes are assigned for creation of bilateral testicular thigh pockets in a patient with Fournier’s gangrene?

A:
Fournier’s gangrene is an acute, sometimes life threatening necrotic infection that affects the scrotum, penis or perineum regions of the body. It is characterised by scrotal pain and redness, with rapid progression to gangrene and tissue shedding (Nall 2018; NORD 2017).

Treatment may involve debridement of extensive areas of necrotic tissue, the administration of antibiotics, and surgical options such as creation of testicular pockets, flaps and skin grafts (Chan 2013; NORD 2017). Where there is significant loss of scrotal tissue, temporary subcutaneous thigh pockets may be created to allow implantation of the exposed testicle to aid and improve any future scrotal reconstruction (Chenam et al. 2015).

Assign 90401-01 [1189] Other procedures on testis, and 90661-00 [1608] Other incision of skin and subcutaneous tissue (assign both codes twice if bilateral) by following the Alphabetic Index:

Procedure
- testis NEC 90401-01 [1189]

And

Incision
- skin (subcutaneous tissue) 90661-00 [1608]

Amendments will be considered for a future edition.

References:

Published 15 June 2018,
for implementation 01 July 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 wound debridement is performed by an allied health professional (outside theatre), assign the general allied health intervention code only (eg 95550-04 [1916] Allied health intervention, podiatry). Do not assign an ACHI code for debridement.
- 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 [1628] 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.

References:
Coding Rule is effective for event records with an event end date on or after 1 July 2018

Ref No: Q3249 | Published On: 15-Jun-2018 | Status: Current

**Neuroendocrine cell hyperplasia of infancy (NEHI)**

**Q:**

What code is assigned for neuroendocrine cell hyperplasia of infancy (NEHI)?

**A:**

Neuroendocrine cell hyperplasia of infancy (NEHI) is an interstitial lung disease that occurs in children, most commonly under two years of age. Symptoms include chronic tachypnoea, crackles, hypoxemia and failure to thrive. Children may be initially diagnosed with asthma, or a chronic respiratory infection, however they do not respond to asthma treatments and corticosteroids (Caimmi et al. 2006; Children's Interstitial Lung Disease Foundation 2017; Popler et al. 2010).

For neuroendocrine cell hyperplasia of infancy (NEHI), assign J84.8 *Other specified interstitial pulmonary diseases* as a best fit. Follow the Alphabetic Index:

**Disease, diseased**
- lung
  - - interstitial
    - - specified NEC J84.8

Amendments will be considered for a future edition.

**References:**

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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.
Current complications of AMI

Q:
When assigning a code for a current complication following AMI (I23.-), can you also assign a code from I21.- or I22.- to identify the specific type of AMI/subsequent MI as the cause of the complication?

A:
The ICD-10-AM Conventions/Multiple condition coding 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, assign I23.0 Haemopericardium as current complication following acute myocardial infarction with either a code from category I21 Acute myocardial infarction or I22 Subsequent myocardial infarction (to identify the specific type of AMI/subsequent MI as the underlying condition).

Follow the Alphabetic Index:

Haemopericardium
- following acute myocardial infarction

Infarct, infarction
- myocardial (acute or with a stated duration of 4 weeks or less) I21.9
- anterior (anteroapical) (anterolateral) (anteroseptal) (transmural) (wall) I21.0
- inferior (diaphragmatic) (inferolateral) (inferoposterior) (transmural) (wall) I21.1
- lateral (transmural) (wall) I21.2
- non-ST elevation I21.4
- nontransmural I21.4
- NSTEMI I21.4
- posterior (true) I21.2
- septal (transmural) I21.2
- specified site (transmural) NEC I21.2
- ST elevation NEC I21.3
- STEMI NEC I21.3
- specified site — see Infarct/myocardium by site
- subendocardial (acute) (nontransmural) I21.4
- subsequent (extension) (recurrent) (reinfarction) I22.9
- anterior (wall) I22.0
- diaphragmatic (wall) I22.1
- inferior (wall) I22.1
- specified NEC I22.8
- transmural NEC I21.3

Amendments will 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 July 2018

Ref No: Q3280 | Published On: 15-Jun-2018 | Status: Current

Denervation of proximal interphalangeal joint

Q:
What code is assigned for denervation of proximal interphalangeal joint?

A:
A denervation procedure involves the surgeon identifying the nerve that transmits pain signals from a joint back to the brain, and dissecting that nerve. Proximal interphalangeal joint denervation is a simple surgical option for patients with painful finger joint arthritis. The denervation does not cure the finger joint arthritis, however the pain is reduced, and pre-surgery joint motion is maintained (Flint 2016; Madsen et al. 2017).

For denervation of a proximal interphalangeal joint, assign 39324-01 [74] Open neurotomy of superficial peripheral nerve.

Follow the Alphabetic Index:

Division (freeing)
- nerve
  - peripheral
  - open (superficial) 39324-01 [74]

Amendments will be considered for a future edition.

References:

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).
• induction of labour. Assign an appropriate 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.
Percutaneous electrical nerve stimulation (PENS)

Q:
What ACHI code is assigned for percutaneous electrical nerve stimulation (PENS)?

A:
Percutaneous electrical nerve stimulation (PENS) is an intervention that is used to alter the nerve and reduce its sensitivity to pain. A specially designed needle delivers low voltage electrical currents into the fatty layer just below the surface of the skin. PENS is similar to transcutaneous electrical nerve stimulation (TENS), however unlike TENS, the needle probes are inserted through the skin and placed as close as possible to the pain-causing nerve (Living with Peripheral Neuropathy 2014; Pain Matrix n.d.).

For percutaneous electrical nerve stimulation (PENS) assign 96155-00 [1880] Stimulation therapy, not elsewhere classified.

Follow the Alphabetic Index:

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

Amendments will be considered for a future edition.

References:

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.