Hashimoto’s encephalopathy

Q:
What codes are assigned for Hashimoto’s encephalopathy?

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

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

Follow the Alphabetic Index:
Encephalopathy (acute) G93.4

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

Amendments may be considered for a future edition.

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

Published 15 March 2019, for implementation 01 April 2019.
Fat grafting by injection

Q:

What code is assigned for fat grafting by injection?

A:

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

For fat grafting by injection, assign:

90660-00 [1602]

Administration of agent into skin and subcutaneous tissue

Follow the Alphabetic Index:

Administration (around) (into) (local) (of) (therapeutic agent) NEC - specified site - skin (collagen) (fat) (poly-L-lactic acid) (silicone) (subcutaneous tissue) 90660-00 [1602]

Amendments may be considered for a future edition.

References:


Published 15 March 2019,
for implementation 01 April 2019.
E. coli UTI and E.coli bacteraemia

Q:
What codes are assigned for E. coli urinary tract infection (UTI) and bacteraemia?

A:
The urinary tract is the most common site of Escherichia coli (E. coli) infection, and more than 90% of all uncomplicated urinary tract infections (UTI) are caused by E. coli infection. Cases of E. coli bacteraemia are usually associated with UTIs, especially in cases of urinary tract obstruction of any cause (Madappa 2017).

E. coli bacteraemia is a separate clinical concept entity to E. coli UTI, although the two conditions can be present within the same episode of care.

Assign codes for both conditions and sequence as per the guidelines in ACS 0001 Principal diagnosis and ACS 0002 Additional diagnoses.

Assign the following codes for E. coli UTI:
- N39.0 Urinary tract infection, site not specified
- B96.2 Escherichia coli [E. coli] as the cause of diseases classified to other chapters

Where E. coli bacteraemia is also documented, assign:
- A49.8 Other bacterial infections of unspecified site.

Follow the Alphabetical Index:
- Infection, infected
  - Escherichia coli NEC
  - as cause classified elsewhere B96.2
  - urinary (tract) NEC N39.0

Bacteraemia (see also Infection/by type)

Infection, infected
- Escherichia (E.) coli NEC A49.8

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

References:

Published 15 March 2019,
for implementation 01 April 2019.
Insertion of anal seton

Q:
What code is assigned when insertion of anal seton is performed for any documented condition (with or without documentation of anal fistula)?

A:
Setons, made from various material, are commonly used in the treatment of anal fistulas. An anal fistula, also known as fistula-in-ano or perianal sinus tract, is an abnormal hollow tract or cavity lined with granulation tissue and may arise from inflamed or infected glands and ulcers of the rectum and anal canal in conditions such as Crohn’s disease, tuberculosis or diverticulitis. The seton is threaded through the fistula tract to drain, promote fibrosis and cut through the fistula (Poggio 2018; Subhas et al 2012). Setons also act as a marker of the fistula tract for sphincter-sparing procedures such as fistula plug, fibrin glue and ligation of the intersphincteric fistula tract (LIFT). Further operations may be required to replace or adjust the seton.

Where insertion of anal seton is performed for any documented condition (with or without documentation of anal fistula), assign as a best fit:
32166-00 [929] Insertion of anal seton
Or
32159-01 [937] Insertion of seton for anal fistula involving lower half of anal sphincter mechanism
Or
32162-01 [937] Insertion of seton for anal fistula involving upper half of anal sphincter mechanism

Follow the Alphabetic Index:
Insertion
- seton
  - - for
    - - - anal fistula (see also Fistulectomy/anus/with/insertion seton) 32166-00 [929]
    - - - - involving
    - - - - - lower half of anal sphincter 32159-01 [937]
    - - - - - upper half of anal sphincter 32162-01 [937]

Amendments may be considered for a future edition.

References:

Published 15 March 2019,
for implementation 01 April 2019.
Cervical radiculopathy due to spinal stenosis

Q: What codes are assigned for cervical radiculopathy due to spinal stenosis?

A: Cervical radiculopathy is usually due to compression of or an injury to a cervical nerve root by a herniated intervertebral disc or degenerative changes of the spinal canal (RACGP 2019).

For classification purposes, in the absence of another documented cause of radiculopathy, assign a code for nerve root compression.

For example, cervical radiculopathy due to spinal stenosis NOS assign: M48.02† Spinal stenosis, cervical region G55.3* Nerve root and plexus compressions in other dorsopathies (M45–M46†, M48.-†, M53–M54†)

Follow the ICD-10-AM Alphabetic Index:

Compression
- nerve
- - root or plexus (in) NEC
- - - with spinal (vertebra) stenosis M48.0-† G55.3*

Assign and sequence codes as per the guidelines in ACS 0001 Principal diagnosis and ACS 0002 Additional diagnoses.

Where there is documentation of an intervention for decompression of cervical radiculopathy assign 40330-00 [49] Spinal rhizolysis

Follow the ACHI Alphabetic Index:

Decompression
- spinal
- - nerve roots (rhizolysis) 40330-00 [49]

Amendments will be considered for a future edition.

References:

Published 15 March 2019,
for implementation 01 April 2019.
Revision of peritoneovenous shunt

Q:
What code(s) are assigned for a revision of a peritoneovenous shunt?

A:
A peritoneovenous shunt is inserted to enable continuous draining of ascitic fluid from the peritoneal cavity into the venous system, including the Hyde shunt, LaVeen shunt and Dever shunt (Encyclopaedia of Surgery 2019).

ACHI currently does not have a single code for revision of peritoneovenous shunt (where a shunt is removed and a new shunt is inserted), therefore, assign as best fit:

92082-00 [1896] Removal of peritoneal drainage device, and
30408-00 [983] Insertion of peritoneovenous shunt

Follow the ACHI Alphabetic Index:
Removal
- drain
- - peritoneal 92082-00 [1896]

Shunt
- peritoneovenous 30408-00 [983]

For ‘revision’ of a peritoneovenous shunt where there is removal of a peritoneovenous shunt without reinsertion, only assign 92082-00 [1896] Removal of peritoneal drainage device.

Amendments may be considered for a future edition.

References:
Encyclopaedia of Surgery 2019, Peritoneovenous shunt, viewed 12 February 2019 https://www.surgeryencyclopedia.com/Pa-St/Peritoneovenous-Shunt.html

Published 15 March 2019,
for implementation 01 April 2019.
Intraoperative oroantral fistula resulting from tooth removal

Q:
What code is assigned for an intraoperative oroantral fistula resulting from removal of a tooth?

A:
Oroantral fistula (OAF) is a persistent open communication between the oral cavity and the maxillary sinus. It most commonly occurs as a result of extraction of upper molar and premolar teeth due to the anatomical proximity or projection of the tooth roots in the maxillary sinus. Other causes of OAF include tuberosity fracture, dentoalveolar/periapical infections of molars, trauma, implant dislodgement into maxillary sinus, presence of maxillary cysts or tumours, and osteoradionecrosis. The defect after tooth extraction can contaminate the sinus with food and saliva from the oral cavity leading to infection, impaired healing and chronic sinusitis (Khandelwal Hajira 2017).

ACS 1904 Procedural complications states:
Qualifying terms such as 'intraoperative', 'postoperative' or 'postprocedural' may be documented in the clinical record, however these terms may only refer to the timing of an event that occurred during, or after, the procedure. Conditions described in this way should be assigned procedural complication codes only if they meet the following criteria:

• Documentation clearly states that the condition arose as a complication of the procedure

The defect after tooth extraction, resulting from removal of a tooth, without documentation of a causal inference, is not classified as a procedural complication. Assign:

J32.0 Chronic maxillary sinusitis

The indexing and classification of OAF to J32.0 Chronic maxillary sinusitis in ICD-10-AM is consistent with ICD-10, where OAF is classified by its manifestation.

Amendments may be considered for a future edition.

References:

Published 15 March 2019, for implementation 01 April 2019.
Follicular Lymphoma grade 1-2

Q:

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

A:

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

ACS 0233 Morphology states:
If a morphological diagnosis contains two histological terms which have different morphology codes, select the highest number as it is usually more specific.

The morphology codes for follicular lymphoma grade 1 and grade 2 are:
M9695/3 Follicular lymphoma, grade 1
M9691/3 Follicular lymphoma, grade 2

Therefore, as per the guidelines in ACS 0233, where follicular lymphoma grade 1-2 is documented, assign the higher morphology code (and corresponding topography code) for follicular lymphoma grade 1:
C82.0 Follicular lymphoma grade 1
M9695/3 Follicular lymphoma, grade 1

Follow the ICD-10-AM Alphabetic Index:
Lymphoma
- follicular
- - grade 1 (M9695/3) C82.0

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

References:

Published 15 March 2019, for implementation 01 April 2019.
CNS Lymphoma

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

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

For primary central nervous system diffuse large B-cell lymphoma, assign:
C72.9 Malignant neoplasm, central nervous system, unspecified
M9680/3 Lymphoma, large B-cell, diffuse NOS

Follow the ICD-10-AM Alphabetic Index:
Lymphoma (malignant)
- B-cell
  - - diffuse large (anaplastic) (centroblastic) (DLBCL)
  - - - primary
  - - - - central nervous system (M9680/3)
  - - - - - unspecified site C72.9

Amendments may be considered for a future edition.

Published 15 March 2019,
for implementation 01 April 2019.
Restenosis of previous vascular bypass, graft or stent

Q:
What code(s) should be assigned for restenosis of a previous vascular graft/stent?

A:
Restenosis of previous angioplasty, arterial bypass and stent sites may occur as a result of recurrent atherosclerosis or tissue growth, in response to the vascular injury caused by the initial treatment (Fogoros 2017).

ACS 0941 Arterial disease/9. Stenosis states:

...stenosis of other arteries that is not documented as due to another cause is to be assigned the appropriate atherosclerosis code

Therefore, where documentation specifies that restenosis of a peripheral (vascular) bypass graft/stent stenosis is due to recurrent atherosclerosis or the cause is unspecified, assign a code from category I70.2- Atherosclerosis of arteries of extremities.

Also assign Z95.8 Presence of other cardiac and vascular implants and grafts to indicate the stent status.

Where documentation specifies that restenosis of a coronary bypass graft/in-stent stenosis is due to recurrent atherosclerosis or the cause is unspecified, assign I25.11 Atherosclerotic heart disease of native coronary artery.

Also assign Z95.5 Presence of coronary angioplasty implant and graft to indicate the stent status.

Follow the Alphabetic Index:

Stenosis
- due to presence of device, implant or graft NEC
- - arterial graft NEC T82.84

Also assign external case and place of occurrence codes, as appropriate.
The material used for the bypass graft (vein, artery, synthetic, etc.) does not have any bearing on the classification of the stenosis.

Amendments may be considered for a future edition.

References:

Published 15 March 2019,
for implementation 01 April 2019.
Aborted stroke

**Q:**
What code is assigned for aborted stroke?

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

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

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

I63.9 Cerebral infarction, unspecified

Follow the Alphabetic Index:

Stroke (apoplectic) (brain) (paralytic) - ischaemic (see also Infarction/cerebral)

Infarct, infarction (of) - cerebral

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

References:

Published 15 March 2019,
for implementation 01 April 2019.
Open reduction and internal fixation of 4 or more sites of the zygomatic bone

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

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

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

Follow the ACHI Alphabetic Index:
Reduction
- fracture (bone) (with cast) (with splint)
  - - zygoma, zygomatic arch (malar)
  - - - open
  - - - - with fixation
  - - - - - internal
  - - - - - - 3 sites 47771-01 [1368]

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

Amendments may be considered for a future edition.

*Published 15 March 2019,*
*for implementation 01 April 2019.*
Notchplasty without knee reconstruction

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

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

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

Follow the Alphabetic Index:
Ostectomy NEC
- femur
- - distal 48424-07 [1504]

Amendments maybe considered for a future edition.

References:

Published 15 March 2019,
for implementation 01 April 2019.
Gastropexy or cardiopexy performed without fundoplasty

Q:
What codes are assigned for gastropexy or cardiopexy, performed without fundoplasty?

A:
Gastropexy is surgical fixation of the stomach to the abdominal wall and is performed for conditions such as gastro-oesophageal reflux disease, gastric volvulus in high risk patients, paraoesophageal hiatal hernia and in conjunction with percutaneous endoscopic gastrostomy in children for gastric feeding (Atlanta Reflux Group 2018; Merriam-Webster 2018; Yates et al. 2015).

Where gastropexy is documented, assign 30530-00 [886] Fundoplyasty with cardiopexy by following the Alphabetic Index:
Gastropexy 30530-00 [886]

Cardiopexy is fixation of the cardia of the stomach to the diaphragm with the ligamentum teres of the liver and is generally performed with fundoplyasty (fundoplication) for gastro-oesophageal reflux disease and closure of hiatal hernia (Flamant et al, 1991). Cardiopexy may be performed with or without fundoplyasty, however, ACHI does not include a code for cardiopexy alone. Therefore, where cardiopexy is performed, assign 30530-00 [886] Fundoplyasty with cardiopexy regardless of whether fundoplyasty has been performed.

Follow the Alphabetic Index:
Cardiopexy
- with fundoplyasty 30530-00 [886]

Amendments may be considered for a future edition.

References:

Published 15 March 2019,
for implementation 01 April 2019.
Allergic reaction to venom immunotherapy

Q:
What codes are assigned for an allergic reaction to venom immunotherapy?

A:
Venom immunotherapy (VIT) is the specialised form of allergen immunotherapy for patients allergic to Hymenoptera venom. VIT may be associated with local side effects (ie swelling, reddening of skin and itch) and systemic side effects (ie hypotension, fever, nausea and anaphylaxis). Depending on the type of allergy, specific and standardised allergenic extracts of venom (eg bee or wasp) are used (Kołaczek et al. 2017).

Where there is documentation of an allergic reaction to bee venom immunotherapy, assign codes as per the classification guidelines in ACS 1902 Adverse Effects.

Therefore, where the manifestation of the allergic reaction (adverse effect) to VIT is specified in the clinical record, assign:
- A code(s) for the adverse effect/manifestation (eg rash, anaphylaxis – see ICD-10-AM Alphabetic Index Section I)
- Y59.8 Other specified vaccines and biological substances causing adverse effects in therapeutic use.
- Follow the Alphabetic Index Section III Table of Drugs and Chemicals:
  - Immunological agent - specified NEC (Adverse effect in therapeutic use) Y59.8
  - Y92.2 Place of occurrence, health service area, this facility, as appropriate
  - Y92.24 Place of occurrence, health service area, this facility, as appropriate

Where the manifestation of the allergic reaction (adverse effect) to VIT is unspecified, assign T88.7 Unspecified adverse effect of drug or medicament.

Follow the ICD-10-AM Alphabetic Index Section I:
Allergy, allergic (reaction) - drug, medicament and biological (any) (correct medicinal substance properly administered) (external) (internal) T88.7
Assign external cause and place of occurrence codes as listed above.

Amendments may be considered for a future edition.

References:

Published 15 March 2019,
for implementation 01 April 2019.
Follow up for H. pylori after eradication therapy

Q:
What codes are assigned for follow up of H.pylori after eradication therapy, where no associated conditions are present?

A:
The effect of \textit{H pylori} eradication treatment can be assessed by a variety of methods, of which urea breath testing is the easiest and most reliable method. Further endoscopic follow-up is needed in patients with uninvestigated dyspepsia who do not respond to \textit{H pylori} eradication. Patients with complicated peptic ulcer need thorough confirmation of successful \textit{H pylori} eradication. Given the importance of adequate assessment and the fact that the use of acid suppressants interferes with urea breath testing, \textit{H pylori} status is usually checked by repeat endoscopy (Kuipers 2015)

ACS 1122 \textit{Helicobacter Pylori} states:
\textit{Helicobacter pylori (H. pylori)} infection is associated with:
- \textit{H. pylori}-associated chronic gastritis (active chronic gastritis)
- duodenal ulcers
- MALT (mucosa associated lymphoid tissue) lymphoma
- gastric ulcers

B96.81 \textit{Helicobacter pylori [H. pylori] as the cause of diseases classified to other chapters} is assigned when it is found in the presence of the above conditions or there is a documented association with another condition.

B96.81 is not assigned when there is no documented association between the \textit{H. pylori} infection and another condition.

Where the presence of \textit{H. pylori} is documented at follow up, but no associated condition(s) is documented, clinical consultation should be sought to determine if there is a \textit{H. pylori} associated condition present.

If, after clinical consultation, the presence of \textit{H. pylori} was not associated with another condition (or if consultation is not possible), assign:

Z09.2 \textit{Follow-up examination after pharmacotherapy for other conditions}
Z87.18 \textit{Personal history of other digestive system disease}

Follow the Alphabetic Index:
\textbf{Examination} (for) (general) (of) (routine)
- follow-up (following) (routine)
- - pharmacotherapy NEC Z09.2

\textbf{History} (of) (personal)
- disease or disorder (of)
- - digestive system
- - - specified disease or disorder NEC Z87.18

Amendments may be considered for a future edition.

\textbf{References:}

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

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

Internal fixation of an unstable fractures without documentation of reduction

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

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

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

Amendments may be considered for a future edition.

References:

Published 15 March 2019,
for implementation 01 April 2019.
Hookwire localisation of extramammary lesions

Q: What code is assigned for hookwire localisation of lesions other than breast lesions (ie extramammary lesions)?

A: Guide/hook wire localisation (biopsy) of lesions is a technique performed with specific interventional imaging procedures (ie ultrasound, mammography, computerised tomography (CT) etc). For example, CT may be performed to identify the location, size and shape of a lesion. A cannula needle housing a hook wire is inserted using CT guidance and placed close to the lesion. When the outer cannula needle is withdrawn, the horn of the hook wire remains anchored to the lesion, and the patient is transferred to the operating theatre for excisional biopsy of the lesion, which is identified by the location of the hook wire (Li et al 2012).

Where guide/hook wire localisation (biopsy) of a lesion other than the breast (ie extramammary) is performed, do not assign an ACHI code for the guide/hook wire localisation component, as per the guidelines in ACS 0016 General procedure guidelines, as it is inherent in the excisional biopsy procedure performed.

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

Ref No: Q3379 | Published On: 15-Mar-2019 | Status: Current

**Tonic-clonic seizures without documentation of epilepsy**

*Note:* where this is a change in coding practice the coding rule is to be effective for event records with an event end date on or after 1 July 2019 (11th Edition)

**Q:**

What code is assigned for tonic-clonic seizures when there is no documentation of epilepsy?

**A:**

Tonic-clonic seizures are generalised seizures caused by electrical discharges involving both cerebral hemispheres. They are commonly referred to as grand mal seizures. Repeated tonic-clonic seizures are usually caused by epilepsy. Other causes include head injury, brain tumour, stroke, infections such as meningitis, encephalitis, low blood sugar and heavy use of drugs and alcohol (Jarman 2017; Mayo Clinic 2017; Schachter 2017).

Clinical clarification should be sought to determine the cause of the tonic-clonic seizures. If the cause is not known or clinical clarification is not possible, assign G40.6- *Grand mal seizures, unspecified (with or without petit mal)* for tonic-clonic seizures not otherwise specified.

Follow the Alphabetic Index:

**Grand mal**
- seizure (with or without petit mal) G40.6-

Amendments may be considered for a future edition.

**References:**


Published 15 March 2019,
for implementation 01 April 2019.
Alpha-methylacyl-CoA racemase (AMACR) deficiency

Q:
What code is assigned for Alpha-methylacyl-CoA racemase (AMACR) deficiency?

A:
Alpha-methylacyl-CoA (Alpha-methyl-acyl-CoA) racemase (AMACR) deficiency is a rare congenital disorder of metabolism, caused by an AMACR gene mutation. This mutation results in a deficiency of functional enzyme, leading to accumulation of pristanic acid in the blood. Those with AMACR deficiency may have a gradual loss in intellectual functioning, seizures, migraines, or acute episodes of brain dysfunction (encephalopathy) similar to stroke, involving altered consciousness and areas of damage (lesions) in the brain. Other features of AMACR deficiency may include sensorimotor neuropathy, spasticity, ataxia and problems with vision (Genetics Home Reference 2013).

Whist this condition is not classifiable in ICD-10-AM (or ICD-10), it has been included in ICD-11 as a metabolic disorder. Therefore, assign E88.8 Other specified metabolic disorders as a best fit.

Follow the Alphabetic Index:
Error
- metabolism, inborn — see Disorder/metabolism

Disorder (of)
- metabolism NEC
- - specified NEC E88.8

Note that E88.8 has an Instructional note: Code first the manifestation(s), if known.

Amendments may be considered for a future edition.

References:

Published 15 March 2019,
for implementation 01 April 2019.
BMI from calculated EMR fields

Q:
Can clinical coders use BMI values from calculated fields in EMR systems to assign codes from category E66 Obesity and overweight?

A:
Body mass index (BMI) is an index for relating weight to height. BMI provides an estimate of total body fat and related risk of developing weight related diseases.

BMI is less accurate for assessing healthy weight in some groups of people, even though the proportion of weight due to fat or muscle. BMI may not be a reliable measure for:

- certain ethnic groups, such as Pacific Islander, Maori, Aboriginal peoples, South Asian, Chinese and Japanese populations
- body builders or weight lifters
- some high-performance athletes
- pregnant women
- the elderly
- people who use corticosteroids
- people who have a physical disability
- people aged under 18 years
- those with extreme obesity

To determine if a BMI result is a health risk, a healthcare provider would need to perform further assessments such as measurements of skinfold thickness, waist circumference, evaluations of diet, physical activity, family history and other health screenings (CDC 2019).

Obesity or overweight (whether specifically documented or documented as a BMI value) must meet the criteria in ACS 0001 Principal diagnosis or ACS 0002 Additional diagnoses, to assign a code from category E66 Obesity and overweight.

References:

Published 15 March 2019, for implementation 01 April 2019.
Endoscopic vacuum-assisted closure (EVAC) of gastrointestinal defect

Q:
What codes are assigned for insertion, replacement and removal of EVAC for leaking anastomosis following sleeve gastrectomy?

A:
Endoscopic vacuum-assisted closure (EVAC) is a treatment option for repair of gastrointestinal defects (eg perforation/leakage at anastomosis site following oesophagectomy or bariatric surgery). The EVAC applies continuous, controlled negative pressure at the defect site via a (nasal) drainage tube, using a polyurethane sponge connected to an electronic vacuum device. The sponge is replaced every 3-5 days until the defect is healed (Bludau et al 2018; Watson Zuchelli 2018).

- Assign 90305-00 [890] Other procedures on stomach as a best fit for insertion of an EVAC device into the stomach. Follow the ACHI Alphabetic Index:
  
  Procedure
  - stomach NEC 90305-00 [890]
  
  Note: For insertion of an EVAC device into another gastrointestinal site (eg oesophagus or rectum), follow the Alphabetic Index at Procedure/by site.

- Assign 92086-00 [1896] Removal of other device from gastrointestinal tract as a best fit for removal of an EVAC device. Follow the ACHI Alphabetic Index:
  
  Removal
  - device — see also Removal/by type of device
  - - gastrointestinal tract NEC 92086-00 [1896]

- Assign both of the above codes (sequencing 92086-00 [1896] before 90305-00 [890]) for replacement of an EVAC device.

Also assign 30473-00 [1005] Panendoscopy to duodenum when oesophagogastroduodenoscopy is performed, as per the guidelines in ACS 0023 Laparoscopic/arthroscopic/endoscopic surgery.

Amendments may be considered for a future edition.

References:


Published 15 March 2019,
for implementation 01 April 2019.
Neurocognitive disorder

Q:
What code is assigned for neurocognitive disorder?

A:
In the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), dementia was named major neurocognitive disorder (NCD). However, the term dementia may still be used as an acceptable alternative. The two terms are essentially different labels for the same condition; major NCD is equivalent to dementia. The DSM-5 also recognises a less severe level of cognitive impairment termed mild NCD. Mild NCD is equivalent to mild cognitive impairment and to prodromal dementia, again different labels for the same condition (Dementia Australia 2018).

Where there is documentation of ‘major neurocognitive disorder’, assign a code from the options listed under the lead term Dementia.

Where there is documentation of ‘mild neurocognitive disorder’, assign:
F06.7 Mild cognitive disorder

Follow the alphabetic index:
Disorder (of) — see also Disease
- cognitive
- - mild F06.7

Where neurocognitive disorder NOS (not otherwise specified) is recorded, seek clinical clarification as to the type or category of the neurocognitive disorder. Where clinical consultation is not possible, assign F06.7 Mild cognitive disorder as best fit.

Minor amendments will be made in Errata 1 for the Alphabetic Index, and further amendments may be considered for a future edition.

References:

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

Ref No: Q3396 | Published On: 15-Mar-2019 | Status: Current

Behavioural and psychological symptoms of dementia (BPSD)

Q:
Are additional diagnosis codes assigned for behavioural and psychological symptoms of dementia (BPSD)?

A:
Behavioural and psychological symptoms of dementia (BPSD) may develop in persons with any type of dementia.

Examples of BPSD include:
- delusions or hallucinations
- mood disturbance (eg depression, irritability)
- anxiety
- apathy
- agitation
- disinhibition (eg social inappropriateness, impulsivity, risk taking behaviour)
- wandering

BPSD may increase carer burden, distress the person with dementia, and result in institutionalisation and higher costs of care. However, some symptoms may have no impact on the provision of care (Macfarlane O’Connor 2016; myDr 2012; Woodward 2014).

Block R40-R46 Symptoms and signs involving cognition, perception, emotional state and behaviour:
Excludes: those constituting part of a pattern of mental disorder (F00–F99)

The Guidance in the use of ICD-10-AM also states:
Note: Avoid indiscriminate coding of irrelevant information, such as symptoms or signs characteristic of the diagnosis.

Therefore, where BPSD is documented in the clinical record, assign a code for the dementia. Do not assign additional diagnoses from Chapter 18 Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified unless the symptom is significant in its own right and treated independently (see also the Note at the beginning of Chapter 18).

References:

Published 15 March 2019, for implementation 01 April 2019.
ICD-10-AM classification of adverse effect of drugs in therapeutic use

ICD-10 and hence ICD-10-AM, generally classifies drugs by class, not by therapeutic indication. A drug may have multiple indications, or the indication may change over time, but the class remains stable. Therefore, for data consistency, it serves no purpose to change the classification of a drug for every possible therapeutic indication.

As per the guidelines in ACS 1902 Adverse effects, where an adverse effect of a drug in therapeutic use is documented, assign:

- a code for the nature of the adverse effect (ie the manifestation)
- an external cause code for the causative agent as listed in the ICD-10-AM Alphabetic Index Section III Table of drugs and chemicals (Adverse effect in therapeutic use) regardless of the clinical indication
- an appropriate place of occurrence code

For example, assign Y47.1 Benzodiazepines as the adverse effect of clozapine by following the Alphabetic Index Section III Table of drugs and chemicals:

Clozapine (Adverse effect in therapeutic use) Y47.1

Note that the indexing for Antipsychotic drug is a NEC option. The ICD-10-AM Conventions used in the Alphabetic Index of Diseases state that NEC (not elsewhere classified) is:

...added after terms classified to residual or unspecific categories and to terms in themselves ill-defined as a warning that specified forms of the conditions are classified differently. If the clinical record includes more precise information the coding should be modified according.

Category Y49 Psychotropic drugs, not elsewhere classified also Excludes benzodiazepines (Y47.1).

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Cricopharyngeal dilation

Q:
What code is assigned for endoscopic dilation of the cricopharyngeus muscle (upper/superior oesophageal sphincter)?

A:
Treatment options for cricopharyngeal dysfunction (cricopharyngeus muscle dysfunction (CPMD)) include systemic medical therapy, mechanical dilation (dilatation), botulinum toxin injection or cricopharyngeal myotomy. Endoscopic balloon dilation of the cricopharyngeus muscle (upper/superior oesophageal sphincter) is performed to effect relaxation of the muscle (Chandrasekhara et al 2017; Huoh et al 2013; Kocdor et al 2015).

Assign as a best fit 41832-00 [862] Endoscopic balloon dilation of oesophagus for cricopharyngeal (upper oesophageal sphincter) dilation.

Follow the ACHI Alphabetic Index:
Dilation
- oesophagus
  - - endoscopic (by) (for stricture)
  - - - balloon (using interventional imaging techniques) 41832-00 [862]

Amendments may be considered for a future edition.

References:

Published 15 March 2019,
for implementation 01 April 2019.
Incision of ureterocele

Q:
What code is assigned for incision of ureterocele?

A:
A ureterocele is a cystic outpouching of the distal ureter into the urinary bladder. Surgical therapy for ureteroceles may include incision by endoscopic puncture or transurethral unroofing, upper pole heminephrectomy, excision of ureterocele and ureteral reimplantation, and nephroureterectomy (Cooper C, 2017).

For incision of ureterocele, assign 36848-00 [1077] Endoscopic resection of ureterocele, as a best fit.

Follow the ACHI Alphabetic Index:
Resection
- ureterocele
- - endoscopic 36848-00 [1077]

Amendments may be considered for a future edition.

References:

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Multiple administrations of chemotherapy with anaesthesia

Q:
What ACHI codes are assigned when intrathecal chemotherapy is administered with general anaesthesia multiple times during an episode of care?

A:
As per the guidelines in ACS 0044 Chemotherapy:
When a patient receives pharmacotherapy a number of times during an episode of care and the same procedure code applies, assign the procedure code only once.

Therefore, where chemotherapy (ie pharmacotherapy for a neoplasm or neoplasm (treatment) related condition) is assigned with anaesthesia multiple times during an episode of care, assign:
• a code from block [1920] Pharmacotherapy with extension -00 antineoplastic agent once
• multiple anaesthesia codes to indicate the number of visits to theatre (ie as many times as anaesthesia is administered), as per the guidelines in ACS 0031 Anaesthesia/Classification:
2. If the same anaesthetic is administered more than once during different 'visits to theatre', within the total episode of care (eg two general anaesthetics), it should be coded as many times as performed.
6. Sequence the anaesthetic code(s) immediately following the procedure code to which it relates.

Example:
Patient admitted for bone marrow aspiration and trephine (BMAT) and intrathecal (IT) chemotherapy. BMAT and IT chemotherapy performed with general anaesthesia (GA) on first visit to theatre. Two further sessions of IT chemotherapy performed with GA during the episode of care.

Assign:
30084-00 [800] Percutaneous biopsy of bone marrow
96198-00 [1920] Intrathecal administration of pharmacological agent, antineoplastic agent

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Triangular fibrocartilage complex (TFCC) injury repair

Q:

What codes are assigned for triangular fibrocartilage complex (TFCC) injury repair?

A:

The triangular fibrocartilage complex (TFCC) is a bundle of ligaments that connects the radius and ulna with the carpal bones of the wrist. The TFCC is often subject to traumatic injuries and ligament degeneration compromising the movement of the wrist (Lex Medicus, 2018).

ICD-10-AM classification of a triangular fibrocartilage complex (TFCC) injury of wrist is dependent on the cause of the condition. A patient may present with a TFCC condition due to a current trauma, a previously healed trauma or a nontraumatic (degenerative) tear.

Tear of a ligament is classified as a sprain in ICD-10-AM. For a current (traumatic) injury assign S63.58 Sprain and strain of other parts of wrist by following the ICD-10-AM Alphabetic Index:

Sprain, strain
- wrist (cuneiform) (scaphoid) (semilunar)
  - - specified part NEC S63.58

Also assign external cause, place of occurrence and activity codes, as applicable.

For a nontraumatic injury assign M24.23 Disorder of ligament, forearm by following the ICD-10-AM Alphabetic Index and Tabular List/Site of musculoskeletal involvement:

Disorder
- Ligament, forearm M24.23

Assign 49215-00 [1470] Reconstruction of wrist for repair of a triangular fibrocartilage complex tear by following the ACHI Alphabetic Index:

Repair
- - ligament NEC
- - wrist, with reconstruction 49215-00 [1470]

Also assign a code for arthroscopy as per the guidelines in ACS 0023 Laparoscopic/arthroscopic/endoscopic surgery, if applicable

Amendments may be considered for a future edition.

References:

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Rebubbling of DSEK/DSAEK graft

Q: What code is assigned for rebubbling of a Descemet’s stripping (automated) endothelial keratoplasty (DSEK/DSAEK) graft?

A: Descemet’s stripping (automated) endothelial keratoplasty (DSEK/DSAEK) is a partial thickness cornea transplant procedure that involves selective removal of the Descemet membrane and endothelium, followed by transplantation of donor corneal endothelium and corneal stroma. An air bubble is placed in the anterior chamber to support graft adherence (Ophthalmology and Visual Sciences 2016).

Graft dislocation/detachment may be treated with ‘rebubbling’ (ie addition of another air bubble) to achieve adhesion/reattachment of the graft (Chaurasia et al 2011).

Assign 42740-02[185] Administration of therapeutic agent into anterior chamber as a best fit for ‘rebubbling of DSAEK’.

Follow the Alphabetic Index:

Administration (around) (into) (local) (of) (therapeutic agent) - specified site - anterior chamber (by paracentesis) (eye) 42740-02[185]

References:


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