Contents

Clot retention secondary to transurethral resection of the prostate (TURP) 3
Current complications of AMI 4
Acute urinary retention due to clot obstruction in urinary catheters 5
Pre-op Workup 6
Mollaret meningitis 8
Assignment of specific sepsis codes with or without positive blood culture on pathology 9
Nicotine dependence tests 10
Short gut syndrome (short bowel syndrome) 11
Drug-induced conditions 12
Endoscopic cystogastrostomy 14
Rectus sheath haematoma secondary to overwarfarinisation 15
Recurrent post procedural wound infection due to mesh 16
Acquired brain injury (ABI) NOS 17
Mast Cell Activation Syndrome 18
Neonatal hypoglycaemia in infant of diabetic mother 19
Osseointegration of limb implants on amputees 20
Facial palsy due to lacunar syndrome, injury, tumours or other disorders 21
Y95 *Nosocomial condition* 23
CPR related injuries 24
Selection of morphology codes from pathology reports 25
Dialysis dysequilibrium syndrome 26
Lords plication of hydrocele 27
Non accidental injury 28
Same-day admissions for chemotherapy/pharmacotherapy for neoplasm(s) and neoplasm related conditions 29
Retinal artery occlusion 30
Basilar artery coiling 31
Cerebellar ataxia, neuropathy, vestibular areflexia syndrome (CANVAS) 32
Injection of sclerosing agent with aspiration of hydrocele 33
External cause code for complication of percutaneous angioplasty with stenting of coronary arteries 34
Insertion of leadless/transvenous pacemaker 35
Lymph node neck dissection 36
Incision and drainage of abscess with curettage 37
Conditions described as secondary to or due to 38
External cause code for allergic reaction to over the counter hair dye 39
Zika virus; use of WHO code for emergency use 40
Elevated PSA 41
Coblation of the laryngotrachea 42

Drug-induced anaemia 43
Same-day chemotherapy for neoplasm; participant in clinical drug trial 44
Gastroenteritis or diarrhoea due to Norovirus 45
E13 *Other specified diabetes mellitus* 46
Thrombectomy and embolectomy of multiple arteries 47
Middle East Respiratory Syndrome (MERS) 48
Paediatric Autoimmune Neuropsychiatric Disorders (PANDAS) 49
Catheterisation and cannulation in neonates 50
Excision of neuroblastoma 51
Necrotic leg ulcer with diabetes mellitus and peripheral vascular disease (PVD) 52
Contrast induced acute kidney failure (injury) 54
Confusion or delirium with dementia 55
Intraoperative floppy iris syndrome (IFIS) 57
Donor Lymphocyte Infusion 58
Skin Necrosis 59
Removal of urethral sling following male stress incontinence procedure 60
CIN III as principal diagnosis and indication for LLETZ procedure 61
Principal diagnosis for prophylactic PEG insertion prior to oropharyngeal radiation therapy 62
Z03 *Medical observation and evaluation for suspected diseases and conditions* 63
Ultrasound guided compression of pseudoaneurysm 64
Alternating hemiplegia of childhood 65
Banding of GAVE at gastroscopy 66
Same-day admission for both radiotherapy and chemotherapy 67
Healthcare associated *Staphylococcus aureus* bacteraemia (HA SAB) (2 of 2) 68
Clinical diagnosis versus histology 69
Morphology of recurrent mediastinal tumour 70
Principal diagnosis for insertion of fiducial markers (use of Z51.4 *Preparatory care for subsequent treatment, not elsewhere classified*) 71
Hypertensive kidney disease with kidney failure (I12.0) 72
Pelvic collection 73
Open reduction and internal fixation (ORIF) proximal femur 74
Anaemia in chronic diseases 75
Fracture of hip prosthesis due to trauma 76
Obstetrics/Gynaecology 77
Seprafilm® 78
Insulin pumps 79

Ref No: Q3276 | Published On: 15-Sep-2018 | Status: Updated | Updated On: 30-Jun-2019

Clot retention secondary to transurethral resection of the prostate (TURP)

Q:

What codes are assigned for clot retention and urinary retention secondary to transurethral resection of the prostate (TURP)?

A:

As per ACS 1904 *Procedural complications* a condition is classified as a procedural complication when:

- Documentation clearly states that the condition arose as a complication of the procedure (the terms 'secondary to' or 'due to' infer a causal relationship in contrast to terms such as 'postop', 'following' or 'associated with')

ACS 1904 *Procedural complications* also states:

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

- **it is related** to a body system, assign an appropriate code from the body system chapter

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

Therefore, when a patient is documented with urinary retention due to blood clots following a TURP (transurethral resection of the prostate), assign:

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

R33 *Retention of urine*

Y83.6 *Removal of other organ (partial)(total)*

Y92.23 *Place of occurrence, health service area, not specified as this facility*

or

Y92.24 *Place of occurrence Health service area, this facility*.

Follow the Alphabetic Index (Section I):

Complication(s) (from) (of)
- postprocedural
  - - urinary
    - - - specified NEC N99.89

Retention, retained
- urine R33

Follow the External causes of injury Alphabetic Index (Section II):

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

- removal of organ (partial) (total) NEC Y83.6

Place of occurrence of external cause

- health service area (not specified as this facility) NEC Y92.23

- - this facility Y92.24

Note: N32.8 *Other specified disorders of bladder* is not assigned as an additional diagnosis as it does not provide further specificity.

Published 15 September 2018,
for implementation 01 October 2018.

Ref No: Q3273 | Published On: 15-Jun-2018 | Status: Updated | Updated On: 15-Jun-2019

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* and assign codes for both the condition and the underlying cause.

Therefore, assign I23.0 *Haemopericardium as current complication following acute myocardial infarction* with either a code from category I21 *Acute myocardial infarction* or I22 *Subsequent myocardial infarction* (to identify the specific type of AMI/subsequent MI as the underlying condition).

Follow the Alphabetic Index:

Haemopericardium
- following acute myocardial infarction (current complication) I23.0

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

Amendments may be considered for a future edition.

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

References:

Singh, V 2017, *Pericardial effusion imaging*, Medscape, viewed 7 November 2017, https://emedicine.medscape.com/article/349447-overview

Published 15 June 2018,
for implementation 01 July 2018.

Ref No: Q3209 | Published On: 15-Mar-2018 | Status: Updated | Updated On: 30-Jun-2019

Acute urinary retention due to clot obstruction in urinary catheters

Q:

Is acute urinary retention due to clot obstruction in urinary catheters classified as a mechanical complication of the catheter?

A:

ACS 1904 *Procedural complications/Classification of procedural complications (Diagnosis codes)* states:

> Where a complication is related to a prosthetic device, implant or graft, assign T82–T85 *Complications of prosthetic devices, implants and grafts*, except where directed by an *Includes* note or the Alphabetic Index…
>
> An additional code from Chapters 1 to 19 may be assigned where it provides further specificity.

ICD-10-AM classifies obstruction of an indwelling urinary catheter (IDC) as a mechanical complication.

For urinary retention due to clot obstruction of an IDC, assign:

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

R33 *Retention of urine*

Y84.6 *Urinary catheterisation*

Y92.23 *Health service area, not specified as this facility* or Y92.24 *Health service area, this facility*

Follow the Alphabetic Index (Section I):

Obstruction, obstructed, obstructive

- device, implant or graft

- - catheter

- - - urinary (indwelling) T83.0

Retention, retained

- urine R33

Follow the External causes of injury Alphabetic Index (Section II):

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

- catheterisation

- - urinary Y84.6

Place of occurrence of external cause

- health service area (not specified as this facility) NEC Y92.23

- - this facility Y92.24

Note: N32.8 *Other specified disorders of bladder* is not assigned as an additional diagnosis as it does not provide further specificity.

Published 15 March 2018,
for implementation 01 April 2018.

Ref No: Q3160 | Published On: 15-Mar-2018 | Status: Updated | Updated On: 15-Jun-2019

Pre-op Workup

Q:

What principal diagnosis is assigned for pre-op workup?

A:

The aim of a preoperative workup is to identify and optimise conditions that increase perioperative morbidity and mortality (Feely et al. 2013), and decrease the perioperative risk.

The following are common examples of documentation pertaining to pre-op workup scenarios.

Note: (ACHI codes are not included in examples).

Example 1:

Patient planned for gastric bypass for obesity. Routine screening endoscopy to check the state of the oesophagus and to screen for the presence of H. pylori. No conditions found.

Follow the guidelines in ACS 0052 *Same-day endoscopy – surveillance* which states:

> This standard applies to patients who are admitted for endoscopic surveillance of any body system...
> For classification purposes endoscopic surveillance refers to:
> …
> - screening of other diseases and pre-cursors (risk factors) …
> - screening due to other factors…
>
> **CLASSIFICATION**
> Assign as principal diagnosis:
> - an appropriate code from categories Z11, Z12 and Z13 *Special screening examination for…* if screening for a disease pre-cursor (risk factor) or other factor and no disease is detected or has ever been detected

Assign:

Z13.83 *Special screening examination for digestive tract disorder*

ACHI codes as appropriate.

Example 2:

Patient planned for liver transplant for liver cirrhosis. Coronary angiography performed prior to transplant to screen for coronary artery disease due to the risk factors of hyperlipidaemia and family history of CAD. No coronary artery disease found.

The coronary angiography was performed because of the hyperlipidaemia (current condition) and family history of CAD (risk factor). Follow the guidelines and criteria in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses.*

Assign:

E78.5 *Hyperlipidaemia, unspecified*

Z82.4 *Family history of ischaemic heart disease and other diseases of the circulatory system*

ACHI codes as appropriate.

Example 3:

Patient planned for liver transplant for liver cirrhosis. Coronary angiography performed prior to transplant due to symptoms of shortness of breath and chest pain. No coronary artery disease found.

Follow the guidelines and criteria in ACS 0001 *Principal diagnosis.*

Assign:

R06.0 *Dyspnoea*

R07.4 *Chest pain, unspecified*

ACHI codes as appropriate.

Reference:

Feely, MA, Collins, CS, Daniels, PR, Kebede, EB, Jatoi, A, Mauck, KF 2013, 'Preoperative Testing Before Noncardiac Surgery: Guidelines and Recommendations', *American Family Physician*, vol. 87, no. 6, viewed 1 May 2017, http://www.aafp.org/afp/2013/0315/p414.pdf

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

Published 15 March 2018,
for implementation 01 April 2018.

Ref No: Q3215 | Published On: 15-Mar-2018 | Status: Updated | Updated On: 15-Jun-2019

Mollaret meningitis

Q:

What code is assigned for Mollaret meningitis?

A:

Mollaret (Mollaret's) meningitis, is also known as benign recurrent aseptic meningitis, recurrent benign lymphocytic meningitis, benign recurrent endothelial meningitis and benign recurrent endothelial-leukocytic meningitis (RBLM). It is a rare and painful, recurrent form of aseptic meningitis which is characterised by episodes of fever, stiff neck and myalgia lasting 2-5 days followed by spontaneous recovery. The time between these episodes and their frequency vary from person to person.

The exact cause of this disease is unknown. However, research suggests that the herpes simplex virus (HSV-2) may cause some, if not most cases (Mollaret's Meningitis Association, 2017; Genetic and Rare Diseases Information Center, 2017; Shalabi & Whitley, 2006).

Conventions used in the Tabular List of diseases/Multiple condition coding state:

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

Assign G03.2 *Benign recurrent meningitis [Mollaret]* for Mollaret meningitis NOS.

Note that G03.2 is listed in category G03 *Meningitis due to other and unspecified causes.*

Therefore, for Mollaret meningitis documented as due to HSV-2, assign G03.2 *Benign recurrent meningitis [Mollaret]* with B00.3 *Herpesviral meningitis* to classify the underlying cause.

Follow the Alphabetic Index:
Meningitis (basal) (cerebral) (spinal)
- Mollaret (benign recurrent) G03.2
- in (due to)
- - herpes (simplex) virus B00.3

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

References:

Genetic and Rare Diseases Information Center, Mollaret meningitis 2017, GARD, Gaithersburg, viewed 11 October 2017, https://rarediseases.info.nih.gov/diseases/10868/mollaret-meningitis

Mollaret's Meningitis Association, Mollaret's Meningitis Information 2017, MMA, Hayden, viewed 11 October 2017, https://www.mollarets.org/mollarets-meningitis-info.html

Shalabi, M & Whitley, RJ 2006, 'Recurrent Benign Lymphocytic Meningitis' *Clinical Infectious Diseases Journal*, vol. 43 (9), pp.1194-1197, https://academic.oup.com/cid/article/43/9/1194/425988/Recurrent-Benign-Lymphocytic-Meningitis

Published 15 March 2018,
for implementation 01 April 2018.

Ref No: Q3196 | Published On: 15-Mar-2018 | Status: Updated | Updated On: 15-Jun-2019

Assignment of specific sepsis codes with or without positive blood culture on pathology

Q:

Can a specific sepsis code be assigned in the absence of a positive blood culture?

A:

Where there is documentation of:

1. sepsis, with a positive blood culture for a specific organism on pathology (see ACS 0110 SIRS, *Sepsis, severe sepsis and septic shock* examples 2 and 5) or
2. sepsis by type of organism (for example Staph aureus sepsis)

assign an appropriate specific sepsis code (such as A41.0 *Sepsis due to Staphylococcus aureus*) by following the Alphabetic Index at *Sepsis/by type of organism*.

Where there is documentation of sepsis, without a positive blood culture on pathology (see ACS 0110 example 4), assign A41.9 *Sepsis, unspecified*.

Note that sepsis must be documented to assign a sepsis code (A00–B99, P36.- or P37.52), irrespective of positive or negative blood cultures. Do not assign a code for sepsis based on a positive blood culture without documentation of sepsis.

Amendments will be considered for a future edition.

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

Published 15 March 2018,
for implementation 01 April 2018.

Ref No: Q3204 | Published On: 15-Dec-2017 | Status: Updated | Updated On: 15-Jun-2019

Nicotine dependence tests

Q:

Is F17.2 *Tobacco dependence syndrome* assigned if a Fagerström Test for Nicotine Dependence has been completed in the clinical record, as the score provides a level of nicotine dependence?

A:

The Fagerström Test for Nicotine Dependence is a questionnaire commonly used to measure a smoker's level of dependence on nicotine, and uses a scoring mechanism to allocate a 'level of dependence'.

As per ACS 0010 *Clinial documentation and General abstraction guidelines/Findings that provide more specificity about a diagnosis:*

> Laboratory, x-ray, pathological and other diagnostic results should be coded where they clearly add specificity to already documented conditions that meet the criteria for a principal diagnosis.

The Fagerström Test for Nicotine Dependence is considered a diagnostic test, and therefore the results cannot be used exclusively to assign F17.2 *Tobacco dependence syndrome.*

Where there is no documentation of nicotine dependence in the clinical record to support the Fagerström Test, assign Z72.0 *Tobacco use, current.*

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

Published 15 December 2017,
for implementation 01 January 2018.

Ref No: Q3169 | Published On: 15-Dec-2017 | Status: Updated | Updated On: 15-Jun-2019

Short gut syndrome (short bowel syndrome)

Q:

What code is assigned for short gut syndrome (short bowel syndrome)?

A:

Short gut syndrome (short bowel syndrome) is a malabsorptive state characterised by loss of digestive and absorptive functions. Underlying causes include:

- extensive surgical resection of intestine for trauma, tumours, necrotising enterocolitis and Crohn's disease
- congenital/perinatal defects in the gastrointestinal tract, such as intestinal atresia, volvulus, necrotising enterocolitis
- diseases with associated loss of absorption of nutrients, such as inflammatory bowel disease or Crohn's disease
- radiation enteritis.

Short gut syndrome leads to an inability to maintain protein-energy, fluid, electrolyte, or micronutrient balances on a conventionally accepted, normal oral diet (Vipperla & O'Keefe 2014).

Assign K91.2 *Postprocedural malabsorption, not elsewhere classified* for postprocedural short gut syndrome.

Assign K90.9 *Intestinal malabsorption* for short gut syndrome not specified as postprocedural.

Follow the Alphabetic Index:
Malabsorption
- syndrome K90.9
- - postprocedural K91.2

Where there is documentation of an underlying cause, apply the guidelines in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses.*

Amendments will be considered for a future edition.

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

References:

Vipperla, K & O'Keefe, S 2014, Short bowel syndrome, First Consult, viewed 31 July 2117, https://www-clinicalkey-com-au.ezproxy1.library.usyd.edu.au/#!/content/medical_topic/21-s2.0-2001203

Published 15 December 2017,
for implementation 01 January 2018.

Ref No: Q3161 | Published On: 15-Dec-2017 | Status: Updated | Updated On: 15-Jun-2019

Drug-induced conditions

Q:

Many codes for drug-induced conditions list an *Instructional* note; *Use additional external cause code (Chapter 20) to identify cause.* Is it mandatory to assign an external cause code for these drug-induced conditions when they are due to harmful use?

A:

The assignment of an external cause code from Chapter 20 *External causes of morbidity and mortality* to identify the drug in a drug-induced condition is an ICD-10 (and hence ICD-10-AM) convention. These conventions are **mandatory** coding directives.

ICD-10-AM *Conventions used in the Tabular List* states*:*

> *Instructional notes/terms*
>
> > The *Use additional code* and *Code also* instructions indicate that an additional code should be assigned to fully describe the condition or injury…

ACS 0001 *Principal diagnosis* also states:

> …the coding directives in the ICD-10-AM manuals take precedence over all other guidelines.

Assignment of external cause codes for drug-induced conditions requires differentiation between 'poisoning' and 'adverse effect' cases.

Example 1:

Amphetamine induced cardiomyopathy, due to amphetamine use in the past. The patient no longer uses amphetamines: ICD-10-AM *Conventions used in the Tabular List* states*:*

Assign:
I42.7 *Cardiomyopathy due to drugs and other external agents*
F15.19 *Mental and behavioural disorders due to use of other stimulants, including caffeine, harmful use, other specified stimulants*

appropriate external cause codes. Check documentation in the medical record, or seek clinical clarification to determine if the cardiomyopathy is due to past recreational use (ie improper use – see ACS 1901 *Poisoning*) or adverse effect following therapeutic use (see ACS 1902 *Adverse effects*) of amphetamines.

Example 2:

Diarrhoea due to regular unprescribed overuse of laxatives:

Overuse (ie improper use) of a drug is classified as poisoning. ACS 1901 *Poisoning* states:

Poisoning by drugs includes wrong drug or dose given or taken in error, suicide and homicide, adverse effects of prescribed drugs taken in combination with self-prescribed drugs and intoxication. **Poisoning involves improper use**.

Assign:
T47.3 *Poisoning by… Saline and osmotic laxatives*
K52.1 *Toxic gastroenteritis and colitis*
Y14 *Poisoning by and exposure to other and unspecified drugs, medicaments and biological substances, undetermined intent*

Appropriate place of occurrence and activity codes

F55.1 *Harmful use of laxatives*

Note: ICD-10-AM Conventions used in the Tabular List states:

In classifying a problem with an underlying cause, if the Alphabetic Index … or *Excludes* note … results in a code for one of the clinical concepts not being assigned, follow the guidelines in ACS 0001 *Principal diagnosis* and assign codes for both the problem and the underlying cause. In this case, T36-T50 *Poisoning by drugs, medicaments and biological substances Excludes:* nondependence-producing substance use disorder (F55). Assign both the above poisoning codes and F55.1 to indicate that this episode of care classifies toxic gastroenteritis and colitis due to acute poisoning, in a patient with an underlying regular (harmful) use of laxatives.

See also ACS 0503 *Drug, alcohol and tobacco use disorders,* ACS 1901 *Poisoning*, ACS 1902 *Adverse effects,* and ACS 2005 *Poisonings and injuries – indication of intent.*

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

Published 15 December 2017,
for implementation 01 January 2018.

Ref No: Q3214 | Published On: 15-Dec-2017 | Status: Updated | Updated On: 15-Jun-2019

Endoscopic cystogastrostomy

Q:

What code is assigned for an endoscopic cystogastrostomy?

A:

Endoscopic cystogastrostomy is performed for pancreatic pseudocysts that often develop as a result of acute or chronic pancreatitis. Endoscopic cystogastrostomy is performed using endoscopic ultrasound (EUS) imaging to visualise the pancreatic pseudocyst. The pseudocyst is punctured, and a stent deployed to facilitate drainage into the stomach (Nelson et al. 2015).

Assign as a best fit the following codes for an endoscopic cystogastrostomy:

30375-14 **[976]** *Incision and drainage of pancreas*

30473-00 **[1005]** *Panendoscopy to duodenum*

30688-00 **[1949]** *Endoscopic ultrasound*

Follow the Alphabetical Index:

Drainage
- pancreas, pancreatic (by catheter) 30375-14 **[976]**

Panendoscopy (to duodenum) 30473-00 **[1005]**

Ultrasound
- endoscopic 30688-00 **[1949]**

See also Coding Rule Q2939 *Endoscopic ultrasound (EUS).*

Amendments will be considered for a future edition.

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

References:

Nelson E, Johnson E, Walker A, Pfau P & Gopal D 2015, *Endoscopic ultrasound-guided pancreatic pseudocyst cystogastrostomy using a novel self-expandable metal stent with antimigration system: a case series*, Endosc Ultrasound Journal, 2015 Jul-Sep; 4(3): 229–234, viewed 11 July 2017, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4568636/

Published 15 December 2017,
for implementation 01 January 2018.

Ref No: Q3188 | Published On: 15-Dec-2017 | Status: Updated | Updated On: 15-Jun-2019

Rectus sheath haematoma secondary to overwarfarinisation

Q:

What codes are assigned for a rectus sheath haematoma secondary to anticoagulation?

A:

A rectus sheath haematoma is an accumulation of blood in the sheath of the rectus abdominis muscle. When no precipitating event has caused the haematoma, it is referred to as spontaneous rectus sheath haematoma (SRSH). An increased use of antiplatelet and anticoagulant therapies has possibly led to an increase in SRSH (Galyfos et al. 2014; Venkata 2010).

ACS 0303 *Abnormal coagulation profile due to anticoagulants/Classification Point 3* states:

If bleeding occurs as the result of anticoagulant use, assign D68.3 *Haemorrhagic disorder due to circulating anticoagulants.* The causal relationship between the bleeding and the use of anticoagulant must be documented in the clinical record before D68.3 is assigned.

When a patient is admitted with a haematoma of the rectus sheath secondary to anticoagulation use, assign:
M79.88 *Other specified soft tissue disorders, other*
D68.3 *Haemorrhagic disorder due to circulating anticoagulants*
Y44.2 *Anticoagulants causing adverse effects in therapeutic use*
Y92.23 *Place of occurrence, health service area, not specified as this facility*
or
Y92.24 *Place of occurrence, health service area, this facility*

Follow the Alphabetic Index:
Haematoma (skin surface intact) (traumatic) *(see also Contusion)*
- muscle — *see also Contusion/by site*
- - nontraumatic M79.8-
- nontraumatic, due to circulating anticoagulants (heparin) (warfarin) D68.3

Contusion (skin surface intact) *(see also Injury/superficial)*
- abdomen, abdominal (muscle) (wall) S30.1

Follow the Table of drugs and chemicals:
Anticoagulant…(Adverse effect in therapeutic use) Y44.2

Follow the External causes of injury Alphabetic Index:
Place of occurrence of external cause
- health service area (not specified as this facility) NEC Y92.23
- - this facility Y92.24
This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

References:

Galyfos, G, Karantzikos G, Palogos K, Sianou, A, Filis K & Kavouras N 2014, 'Spontaneous Rectus Sheath Hematoma in the Elderly: An Unusual Case and Update on Proper Management', *Case Reports in Emergency Medicine*, pp. 1-4, viewed 10 April 2017, https://www.ncbi.nlm.nih.gov/pubmed/24839570f

Venkata MA, Karnam SM, Kaushik M & Porter J, 2010, 'Spontaneous Rectus Sheath Haematoma', *West J Emergency Medicine*, vol. 11, no. 1, pp. 76-79, viewed 13 April 2017, PMC https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2850860/

Published 15 December 2017,
for implementation 01 January 2018.

Ref No: Q3062 | Published On: 15-Sep-2017 | Status: Updated | Updated On: 30-Jun-2019

Recurrent post procedural wound infection due to mesh

Q:

What code is assigned for a recurrent wound infection due to mesh from a hernia repair?

A:

Deep wound infections due to the mesh used in hernia repair procedures are uncommon, but may occur years after the hernia repair and mesh implantation procedure. If the infection is recurrent, the infected mesh may be removed to eradicate the source of infection (Delikoukos et al. 2007; Maheshwari & Garg 2016).

As per ACS 1904 *Procedural Complications/Sequelae*:

> A sequela of a complication is a current condition that is the result of a previously occurring procedural complication.

While the infection is still receiving active treatment it is not classified as a sequela of a procedural complication.

Assign T85.78 *Infection and inflammatory reaction due to other internal prosthetic devices, implants and grafts* by following the Alphabetic Index:

Infection, infected (opportunistic)
- due to or resulting from
- - device, implant or graft NEC *(see also Complication(s)/by site and type)* T85.78

Also assign external cause of injury and place of occurrence codes:

Y83.1 *Surgical operation with implant of artificial internal device*

and

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

or

Y92.24 *Place of occurrence Health service area, this facility*.

Reference:

Delikoukos, S, Tzovaras, G, Liakou, P, Mantzos, F & Hatzitheofilou, C 2007, 'Late-onset deep mesh infection after inguinal hernia repair', *The World Journal of Hernia and Abdominal Wall Surgery,* vol. 11, no. 1, pp. 15-17, viewed 21 March 2017, https://www.ncbi.nlm.nih.gov/pubmed/16941077

Maheshwari, J & Garg, KM 2016, 'Mesh Infection after Inguinal Hernia Mesh Repair – Experience of Five Mesh Removal', *Journal of Dental and Medical Sciences*, vol.15, no. 4, pp. 78-80, viewed 21 March 2017, http://www.iosrjournals.org/iosr-jdms/papers/Vol15-Issue%204/Version-12/P1504127880.pdf

Published 15 September 2017,
for implementation 01 October 2017.

Ref No: Q3162 | Published On: 15-Sep-2017 | Status: Updated | Updated On: 15-Jun-2019

Acquired brain injury (ABI) NOS

Q:

What code is assigned for acquired brain injury (ABI) NOS?

A:

Acquired brain injury (ABI) is a general term for any damage to the brain that is not congenital. ABI may be caused by trauma (traumatic brain injury), stroke (cerebrovascular accident), anoxia/hypoxia, brain aneurysm or tumour, or a degenerative neurological disorder (AIHW 2007, Ciuffreda et al 2012).

ABI is inherent in codes for the underlying cause (eg S06.- *Intracranial injury*, G93.1 *Anoxic brain damage, not elsewhere classified,* P11.1 *Other specified brain damage due to birth trauma*). ABI is also classified in combination with codes for a number of manifestations (eg F06.8 *Other specified mental disorders due to brain damage and dysfunction and to physical disease or condition*).

Where acquired brain injury is not otherwise specified (NOS), and not elsewhere classified (NEC) (that is, the underlying cause is not known/documented), and where the ABI meets the criteria for code assignment in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*,

assign G93.9 *Disorder of brain, unspecified*, by following the Alphabetic Index:

Damage
- brain (nontraumatic) G93.9

Amendments will be considered for a future edition.

See also Coding Rule *Inappropriate behaviour due to acquired brain injury.*

References:

Australian Institute of Health and Welfare 2007, *Disability in Australia,* Bulletin 55, December 2007, viewed 7 February 2017, http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442453666%20

Ciuffreda, K, Kapoor, N 2012, *Visual diagnosis and care of the patient with special needs* in M B Taub, M Bartuccio, D Maino (eds.), viewed 7 February 2017, https://books.google.com.au/books?hl=en&lr=&id=e7vuKBfSCDQC&oi=fnd&pg=PA95&dq=acquired+brain+injury&ots=tq8pbuOW3p&sig=e6TK6tRjDKmEzLRZRkErNwP4vog#v=onepage&q=acquired%20brain%20injury&f=false

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

Published 15 September 2017,
for implementation 01 October 2017.

Ref No: Q3154 | Published On: 15-Sep-2017 | Status: Updated | Updated On: 15-Jun-2019

Mast Cell Activation Syndrome

Q:

What code is assigned for Mast Cell Activation Syndrome (MCAS)?

A:

Clinical advice indicates that Mast Cell Activation Syndrome (MCAS) is an immunological condition where there is activation of mast cells causing them to release mediators, resulting in a range of disorders including anaphylaxis. MCAS may be either idiopathic or secondary to a trigger (for example, an allergic reaction). There is no increase in the number of mast cells in MCAS while in other mast cell activation diseases such as systemic mastocytosis or mast cell leukaemia there is proliferation or overproduction of mast cells.

In the absence of a specific code or index entries for *mast cell activation syndrome*, clinical advice supports the assignment of the following code as a best fit:

D89.8 *Other specified disorders involving the immune mechanism, not elsewhere classified.*

U91 *Syndrome, not elsewhere classified*

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

References:

Molderings, G, Brettner, S, Homann, J and Afrin, L 2011, 'Mast cell activation disease: a concise practical guide for diagnostic workup and therapeutic options', Journal of Haematology & Oncology, vol. 4, no.10, pp. 2-8, viewed 5 May 2017, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3069946/

Published 15 September 2017,
for implementation 01 October 2017.

Ref No: Q3146 | Published On: 15-Sep-2017 | Status: Updated | Updated On: 15-Jun-2019

Neonatal hypoglycaemia in infant of diabetic mother

Q:

If neonatal hypoglycaemia is documented by the clinician, is it necessary to seek clarification as per ACS 1602 *Neonatal complications of maternal diabetes*?

A:

Neonatal hypoglycaemia is common in neonates where the mother has either pre-existing or gestational diabetes mellitus.

ACS 1602 *Neonatal complications of maternal diabetes* states*:*

> This diagnosis, code P70.1 *Syndrome of infant of diabetic mother* or P70.0 *Syndrome of infant of mother with gestational diabetes*, should be confirmed by laboratory reports and clarified with the clinician.

This guideline is provided for cases where there is documentation of a transient decrease in blood sugar in an infant of a diabetic mother, but no documentation of hypoglycaemia.

Where there is clear documentation of hypoglycaemia in a neonate and it meets the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*, there is no need to further clarify with the clinician.

Assign as appropriate:

P70.0 *Syndrome of infant of mother with gestational diabetes*

OR

P70.1 *Syndrome of infant of a diabetic mother*

Amendments to ACS 1602 may be considered for a future edition.

Published 15 September 2017,
for implementation 01 October 2017.

Ref No: Q3133 | Published On: 15-Sep-2017 | Status: Updated | Updated On: 15-Jun-2019

Osseointegration of limb implants on amputees

Q:

What is the principal diagnosis for osseointegration of limb implants on amputees?

A:

An osseointegration prosthesis for both upper and lower limb amputees consists of a titanium stem which is directly implanted into the bone. It is known as osseointegration because the biocompatibility of the titanium allows the implant to become integrated into the bone giving rise to stability and future bone ingrowth. The internal implant is connected to the external limb prosthesis through a dual adaptor which passes through a small opening in the skin (stoma). The procedure is performed either as a single surgery or in two stages. Stage one is where the implant is inserted into the residual bone. Stage two involves the creation of a stoma at the base of the amputated stump and connecting the dual adaptor to the titanium implant which is already integrated in the bone. The external limb prosthesis can then be attached (Burkett et al. 2014).

Osseointegration of limb implants are classified as reconstructive surgery, therefore in determining the diagnosis code assignment follow the guidelines in ACS 1204 Plastic surgery.

Where a patient is admitted for an osseointegration limb implant, regardless of whether the procedure is performed in a single stage or two stages, assign as principal diagnosis:

Z42.3 *Follow-up care involving plastic surgery of upper extremity*

or

Z42.4 *Follow-up care involving plastic surgery of lower extremity*

Follow the Alphabetic Index:

Surgery

- reconstructive (following healed injury or operation)

- - lower limb Z42.4

- - upper limb Z42.3.

Assign Z89.- *Acquired absence of limb* as an additional diagnosis.

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

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

References:

Burkett, B, Frossard, LA, Berg, D & Formosa, D 2014, The cost and time effectiveness of osseointegration compared to the traditional socket prosthesis, In *Research That Matters: Communicate Collaborate Celebrate, 2014 University Research Week*, University of the Sunshine Coast, Maroochydore, Australia, pp. 27, viewed 26 May 2017, http://eprints.qut.edu.au/84787/

Published 15 September 2017,
for implementation 01 October 2017.

Ref No: Q3100 | Published On: 15-Sep-2017 | Status: Updated | Updated On: 15-Jun-2019

Facial palsy due to lacunar syndrome, injury, tumours or other disorders

Q:

What codes are assigned for facial palsy due to lacunar syndrome, without documentation of current or previous (sequela of) cerebral infarct? How do you code facial palsy due to injury, tumours or other disorders?

A:

Lacunar syndrome is a clinical syndrome where a series of lacunar infarcts occur. They present as small, circumscribed cerebral infarcts in the territory of a single penetrating artery. Lacunar syndrome may occur with other forms of cerebrovascular disease such as vasculitis affecting the cerebral circulation. However, in the absence of another cause, lacunar syndrome is best classified as a cerebral vascular accident.

Clinical advice suggests that facial palsy due to lacunar syndrome is likely an upper motor neurone facial palsy (due to a central lesion), not a facial nerve lesion.

Assign:

G83.81 *Facial paralysis due to cerebrovascular accident*

I63.9 *Cerebral infarction, unspecified*

G46.7 *Other lacunar syndromes (I60–I67+)*

Follow the Alphabetic Index:

Paralysis, paralytic
- facial
- - due to
- - - cerebrovascular accident G83.81

Infarct, infarction (of)
- cerebral I63.9

Syndrome — *see also Disease*
- lacunar NEC I67.9† G46.7*

Note: G46.7* *Other lacunar syndromes (I60–I67+)* includes a range of codes from categories I60 to I67. Assign code combinations as per the discrete code ranges listed in the Tabular List following ACS 0001 *Principal diagnosis (the 'dagger and asterisk' system).*

To determine sequencing of the codes, follow the guidelines in ACS 0001 *Principal diagnosis*.

In addition to inflammation of the facial nerve (Bell's palsy), facial paralysis may occur in association with:

o skull fracture or injury to the face
o head or neck tumour
o middle ear infection or other ear damage
o Lyme disease
o multiple sclerosis
o Guillain-Barre Syndrome.

Assign G83.9 *Paralytic syndrome, unspecified* if facial paralysis occurring in these conditions meets the criteria in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses* following the Alphabetic Index:

Paralysis, paralytic (complete) (incomplete) (*see also Paresis*) G83.9

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

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

Published 15 September 2017,
for implementation 01 October 2017.

Ref No: Q3132 | Published On: 15-Jun-2017 | Status: Updated | Updated On: 15-Jun-2019

Y95 *Nosocomial condition*

Q:

Is Y95 *Nosocomial condition* a redundant code due to the use of the condition onset flag (COF)?

A:

Y95 *Nosocomial condition* is assigned to identify the external cause of any condition that is **documented** as nosocomial, hospital or healthcare acquired, excluding U92 *Health care associated Staphylococcus aureus bacteraemia.*

The condition onset flag (COF) is assigned to differentiate conditions that were present on admission (COF 2) from those that arose during an episode of care (COF 1).

An appropriate COF flag is assigned with Y95 as per the guidelines in ACS 0048 *Conditions onset flag/Guide for use/point 7*:

> The COF value assigned to external cause, place of occurrence and activity codes should match that of the corresponding injury or disease code.

Therefore, Y95 is assigned with:

- COF 1 when it is the external cause of a condition, documented as above, that arose during the admission
- COF 2 when it is the external cause of a condition, documented as above, that was present on admission.

Although the assignment of Y95 with COF 1 is redundant, the assignment of Y95 with a COF 2 provides additional information about a condition present on admission, that has been identified as acquired in a healthcare setting, for example, a transfer from one facility to another or a readmission to the same facility.

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

Published 15 June 2017,
for implementation 01 July 2017.

Ref No: Q3102 | Published On: 15-Mar-2017 | Status: Updated | Updated On: 30-Jun-2019

CPR related injuries

Q:

Are injuries (eg fractures) due to CPR (cardiopulmonary resuscitation) classified as procedural complications?

A:

Skeletal chest injuries (eg fracture of rib(s) and/or sternum) are an unintentional event (misadventure) due to cardiopulmonary resuscitation (CPR). Some patients (eg the elderly) are more susceptible to incurring fractures as a result of CPR. While special training is required to learn correct techniques for CPR, it may be performed by medical or nonmedical persons, and either within or outside of a health facility.

Skeletal chest injuries secondary to CPR meet the definition of a procedural complication/misadventure as per ACS 1904 *Procedural complications*:

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

Assign the following codes:

M96.8 *Other intraoperative or postprocedural disorders of musculoskeletal system*

Complication(s) (from) (of)
- musculoskeletal
- - intraoperative or postprocedural
- - - specified NEC M96.8

Also assign external cause of injury and place of occurrence codes:

Y65.8 *Other specified unintentional events during surgical and medical care*
Y92.- *Place of occurrence*

- Where the injury occurs in a clinical setting (eg ambulance, health facility), assign

Y92.23 *Place of occurrence, health service area, not specified as thisfacility*
OR
Y92.24 *Place of occurrence, health service area, this facility*

- Where the injury occurs in the community (ie a nonclinical setting), assign an appropriate place of occurrence code from the External Cause of Injury Alphabetic Index at the lead term *Place of occurrence of external cause*.

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

Published 15 March 2017,
for implementation 01 April 2017.

Ref No: Q3147 | Published On: 15-Mar-2017 | Status: Updated | Updated On: 15-Jun-2019

Selection of morphology codes from pathology reports

Q:

Should coders use the summary or the microscopic section of the pathology report to determine the correct morphology code?

A:

ACS 0010 *Clinical documentation and general abstraction guidelines/Findings that provide more specificity about a diagnosis* states:

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

A discharge summary is a summation of the whole episode of care; similarly the summary on a pathology report provides a brief summation of the body of the report. The entire pathology report must be used to abstract information for the purposes of clinical coding and therefore determine the correct morphology code.

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

Published 15 March 2017,
for implementation 01 April 2017.

Ref No: Q3116 | Published On: 15-Mar-2017 | Status: Updated | Updated On: 15-Jun-2019

Dialysis dysequilibrium syndrome

Q:

How do you code dialysis dysequilibrium syndrome?

A:

Dialysis dysequilibrium syndrome (DDS) is a rare complication of haemodialysis. DDS is a clinical syndrome of neurological deterioration. Presenting symptoms involve the neurological system (eg mental confusion, headache, muscle twitching) and are thought to be the result of increased intracranial pressure/cerebral oedema (following movement of water into the cerebrospinal fluid (CSF) due to CSF urea concentrations being higher than blood urea concentrations).

ACS 1904 *Procedural complications* states:

> Conditions…should be assigned procedural complication codes only if they meet the following criteria:
>
> - Certain conditions where the relationship is inherent in the diagnosis

As stated above, DDS is a known complication of haemodialysis.

Therefore, as DDS involves neurological symptoms, assign G97.8 *Other intraoperative or postprocedural disorders of nervous system* by following the Alphabetic Index:

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

Assign additional diagnoses for specific symptoms and U91 *Syndrome, not elsewhere classified*.

Also assign the following external cause codes:

Y84.1 *Kidney dialysis*
Y92.23 *Place of occurrence, health service area, not specified as this facility*
OR
Y92.24 *Place of occurrence, health service area, this facility*.

Do not follow the Alphabetic Index at *Complication(s)/dialysis/specified NEC* T80.8.

T80-T88 *Complications of surgical and medical care, not elsewhere classified* is a residual category, and lists an *Excludes* note: *specified complications classified elsewhere*.

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

References:

Mailloux, L 2016, Dialysis disequilibrium syndrome, UpToDate, viewed 13 October 2016, http://www.uptodate.com/contents/dialysis-disequilibrium-syndrome

Zepeda-Orozco, D & Quigley, R 2012, 'Dialysis disequilibrium syndrome', Pediatric nephrology, 2012 Dec; 27(12): 2205-2211, viewed 13 October 2016, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3491204

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

Published 15 March 2017,
for implementation 01 April 2017.

Ref No: Q3075 | Published On: 15-Mar-2017 | Status: Updated | Updated On: 01-Jul-2017

Lords plication of hydrocele

Q:

What code is assigned for Lord's plication of hydrocele?

A:

Lord's plication is undertaken on medium sized and thin walled hydroceles. The hydrocele is opened with a small skin incision, the testis lifted out and the hydrocele sac plicated (reduced) by suture to the junction of the testis and epididymis.

In the absence of index entries or a specific code for plication of hydrocele, assign 30631-00 **[1182]** *Excision of hydrocele* as a best fit.

Note: 37604-17 **[1171]** *Percutaneous aspiration or drainage of scrotum or tunica vaginalis* is not appropriate as Lord's plication opens the hydrocele sac for reduction.

Amendments will be considered for a future edition of ACHI.

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

Published 15 March 2017,
for implementation 01 April 2017.

Ref No: Q3112 | Published On: 15-Dec-2016 | Status: Updated | Updated On: 15-Jun-2019

Non accidental injury

Q:

Can an injury documented as 'non accidental' be classified as assault?

A:

In Chapter 20 *External causes of morbidity and mortality*, the category for *Assault* (X85–Y09) includes injuries inflicted by another person with the intent to injure or kill, by any means.

The *General arrangement of the ICD-10-AM Alphabetic Index* states that Section II (External causes of injury):

- priority modifiers include transport accidents, complications of medical and surgical procedures, intentional self-harm, assault, legal intervention, or war operations
- key words are 'Complication' (for medical and surgical procedures), 'Sequelae', 'Suicide', 'Assault', 'Legal intervention' and 'War operations':*Users should remember the presence of these special lists whenever they have difficulty locating index entries for the relevant conditions, problems or circumstances; by scrutinizing the indented terms, guidance can be found as to the code numbers of all the relevant categories* ***even if not reported in precisely the same words****.*

The term 'non-accidental' indicates purposeful intent. Therefore, a non-accidental injury inflicted by one person on another, is classified in ICD-10 and ICD-10-AM as *assault* (see also the *Instructional* notes at X85-Y09).

This is supported by the External causes of injury Alphabetic Index:

Injury, injured (accidental(ly)) NEC X59
- purposely (inflicted) by other person(s) *(see also Assault)* Y09.0-

Assault (by) (homicidal) (in) Y09.0-

The lead term *Assault* lists a number of subterms for mechanisms of injury (ie the cause of the injury, for example bite, fire, pushing). Where a non-accidental injury is inflicted by another person (ie an assault is perpetrated), assign:

- a code for the injury (S00-T98 – *see Alphabetic Index*)
- an external cause code for assault (see External causes of injury Alphabetic Index: *Assault*)
- Y92.- *Place of occurrence*
- U50-U73 *Activity*

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

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

Published 15 December 2016,
for implementation 01 January 2017.

Ref No: Q3073 | Published On: 15-Dec-2016 | Status: Updated | Updated On: 15-Jun-2019

Same-day admissions for chemotherapy/pharmacotherapy for neoplasm(s) and neoplasm related conditions

Q:

What are the correct codes to assign for same-day admissions for administration of Neulasta, IV hydration or other prophylactic pharmacotherapy?

A:

Neulasta is a drug used to treat or prevent neutropenia in patients with neoplasms or undergoing pharmacotherapy. It is administered subcutaneously and must be administered 24 hours post pharmacotherapy to avoid interaction.

Same-day episode of care for administration of intravenous (IV) hydration is also a common pharmacotherapy protocol to treat or prevent dehydration and/or kidney function disorders in patients undergoing pharmacotherapy, as these are common neoplasm/pharmacotherapy related conditions.

ACS 0044 *Pharmacotherapy* states:

> *For classification purposes, pharmacotherapy is defined as: "The administration of any therapeutic substance (usually a drug), excluding blood and blood products."*

Therefore, for a same-day episode of care for administration of Neulasta, IV hydration or other prophylactic pharmacotherapy (which meets the definition of pharmacotherapy as stated above) for a patient with a neoplasm or neoplasm related condition, assign:

- Z51.1 *Pharmacotherapy session for neoplasm* as principal diagnosis
- a code for the neoplasm being treated as the first additional diagnosis (see also ACS 0236 *Neoplasm coding and sequencing*)
- additional diagnosis code(s) for any neoplasm related condition or neoplasm treatment related conditions(s) meeting the criteria in ACS 0002 *Additional diagnoses.*
- Assign the appropriate ACHI code(s), for example:
- 96200-00 **[1920]** *Subcutaneous administration of pharmacological agent, antineoplastic agent* for administration of Neulasta
- 96199-00 **[1920]** *Intravenous administration of pharmacological agent, antineoplastic agent* for administration of IV hydration

Note: As per Example 2 in ACS 0044 *Pharmacotherapy* and the Instructional note at block **[1920]** *Administration of pharmacotherapy*, the extension -00 *Antineoplastic agent* is assigned for agents used in the treatment of neoplasms and/or neoplasm related conditions.

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

Published 15 December 2016,
for implementation 01 January 2017.

Ref No: Q3071 | Published On: 15-Dec-2016 | Status: Updated | Updated On: 01-Jan-2018

Retinal artery occlusion

Q:

What is the correct code to assign for retinal artery occlusion?

A:

Retinal artery occlusion occurs when a blood clot or fat deposits block the artery. The majority of retinal artery occlusions are caused by platelet fibrin thrombi and emboli as a result of atherosclerotic disease. It is also seen with conditions such as emboli from valvular heart diseases, diabetes mellitus, hypertension, atrial fibrillation and temporal arteritis. It is more likely to occur if there is atherosclerosis of the arteries in the eye.

ACS 0941 *Arterial disease/point 7 Occlusion* states:

> "The term 'occlusion' is used to describe complete blockage or obstruction of a vessel, usually due to atherosclerosis. Occlusion of arteries that is not documented as due to another cause should be assigned the appropriate atherosclerosis code."

Therefore, if retinal artery occlusion is documented and the underlying cause is unknown or not specified, assign I70.8 *Atherosclerosis of other arteries* following the Alphabetic index:

Atherosclerosis — *see Arteriosclerosis*
Arteriosclerosis, arteriosclerotic I70.9
- retina (vascular) I70.8

If the underlying cause of retinal artery occlusion is specified as a condition other than atherosclerosis, assign an appropriate code from H34 *Retinal vascular occlusions* with an additional code for the underlying cause.

For diabetes mellitus with retinal artery occlusion, follow the guidelines in ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia/General classification rules for DM and IH, Rule 3*.
Assign H34.2 *Other retinal artery occlusions* and E1-.39 ** diabetes mellitus with other specified ophthalmic complication* by following the Alphabetic Index:

Occlusion, occluded
- artery
- - retinal (branch) (partial) H34.2
and
Diabetes, diabetic (controlled) (mellitus) (without complication)
- with
- - occlusion, retinal
- - - artery E1-.39

Apply the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses* to determine code sequencing.

Amendments to the classification will be considered for a future edition.

Published 15 December 2016,
for implementation 01 January 2017.

Ref No: Q3072 | Published On: 15-Dec-2016 | Status: Updated | Updated On: 01-Jul-2017

Basilar artery coiling

Q:

What is the correct code assignment for coiling / stenting of basilar artery aneurysms?

A:

The basilar artery is a precerebral artery**,** which is an artery leading to the cerebrum, but not within the cerebrum.

A basilar artery aneurysm is classified in ICD-10-AM to I72.5 *Aneurysm and dissection of other precerebral arteries* following the Alphabetic Index:

Aneurysm (anastomotic) (artery) (cirsoid) (diffuse) (false) (fusiform) (micro) (multiple) (saccular)
- basilar (trunk) I72.5

Coiling of a basilar artery aneurysm is classified in ACHI to 35321-03 **[768]** *Transcatheter embolisation of blood vessels, face and neck* (as a best fit) following the ACHI Alphabetic Index:

Coiling
- aneurysm — *see Embolisation*

Embolisation
- aneurysm via surgical peripheral catheterisation — *see Embolisation/blood vessel, transcatheter/by site*
…
- blood vessel, transcatheter NEC
- - neck 35321-03 **[768]**

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

Published 15 December 2016,
for implementation 01 January 2017.

Ref No: Q3057 | Published On: 15-Sep-2016 | Status: Updated | Updated On: 15-Jun-2019

Cerebellar ataxia, neuropathy, vestibular areflexia syndrome (CANVAS)

Q:

What is the correct code to assign for CANVAS (cerebellar ataxia, neuropathy, vestibular areflexia syndrome)?

A:

CANVAS (cerebellar ataxia, neuropathy, vestibular areflexia syndrome) is a slowly progressive ataxic disorder of unknown aetiology. The main clinical features of CANVAS are cerebellar ataxia, (sensory) neuropathy and bilateral vestibulopathy.

ICD-10-AM does not have a unique code for CANVAS syndrome. Appropriate codes to classify the components of CANVAS syndrome are:

Ataxia, ataxy, ataxic
- cerebellar (hereditary) G11.9
G11.9 *Hereditary ataxia, unspecified*

Neuropathy, neuropathic
- peripheral (nerve) *(see also Polyneuropathy)* G62.9
G62.9 *Polyneuropathy, unspecified*

Disorder (of)
- vestibular function
- - specified NEC H81.8
H81.8 *Other disorders of vestibular function*

Assign codes for manifestations of CANVAS relevant to the patient, and U91 *Syndrome, not elsewhere classified* as an additional diagnosis.

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

Published 15 September 2016,
for implementation 01 October 2016.

Ref No: Q3098 | Published On: 15-Sep-2016 | Status: Updated | Updated On: 01-Jul-2017

Injection of sclerosing agent with aspiration of hydrocele

Q:

How should injection of sclerosing agent when performed with aspiration of hydrocele be coded?

A:

Hydrocele is an abnormal fluid collection between layers of the tunica vaginalis in the scrotum. Injection of sclerosing agents such as alcohol, phenol, tetracycline (doxycycline) into the hydrocele sac causes scarring of the sac lining and reduces fluid production. Sclerotherapy is usually performed in conjunction with percutaneous aspiration of hydrocele where the sclerosing agent is injected through the same catheter used for aspiration of the hydrocele fluid. Therefore it is regarded as a component of the aspiration procedure and a separate code for injection of sclerosing agent is not warranted.

Where injection of sclerosing agent is performed with aspiration of hydrocele, assign 37604-17 [**1171**] *Percutaneous aspiration or drainage of scrotum or tunica vaginalis* following the Alphabetic Index:

Aspiration
- hydrocele (percutaneous) 37604-17 **[1171]**

Amendments to ACHI will be considered for a future edition.

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

Published 15 September 2016,
for implementation 01 October 2016.

Ref No: Q3070 | Published On: 15-Sep-2016 | Status: Updated | Updated On: 01-Jul-2017

External cause code for complication of percutaneous angioplasty with stenting of coronary arteries

Q:

What is the external cause code assigned for complication of percutaneous angioplasty with stenting of coronary arteries?

A:

As per the Coding Rule *Catheter based cardiac intervention with angiogram* (September 2014) cardiac catheterisation may be:

- performed alone as a diagnostic procedure, where the catheter is inserted into the heart chambers and valves to perform various tests
- inserted into the coronary arteries to evaluate coronary artery disease (ie coronary angiography)
- performed with a catheter based interventional procedure, where the cardiac catheterisation serves as a guiding catheter (eg percutaneous coronary angioplasty with stenting).

Where the external cause of a procedural complication is diagnostic cardiac catheterisation (ie cardiac catheterisation performed alone or with coronary angiography for purely diagnostic purposes), assign Y84.0 *Cardiac catheterisation* by following the Alphabetic Index:

Complication(s) (delayed) (medical or surgical procedure) (of or following)
- catheterisation
- - cardiac Y84.0

Where the external cause is a catheter based interventional procedure (ie where cardiac catheterisation has been performed as a guiding catheter), assign a code from category Y83 *Surgical operation and other surgical procedures as the cause of abnormal reaction, or of later complication, without mention of unintentional events at the time of the procedure.*

For example, where the external cause is percutaneous coronary angioplasty with stenting, assign Y83.1 *Surgical operation with implant of artificial internal device* by following the Alphabetic Index:

Complication(s) (delayed) (medical or surgical procedure) (of or following)
- implant, implantation (of)
- - artificial
- - - internal device (cardiac pacemaker) (electrodes in brain) (heart valve prosthesis) (infusion port) (orthopaedic) (Port-A-Cath) (reservoir) (vascular access device) Y83.1

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

Published 15 September 2016,
for implementation 01 October 2016.

Ref No: Q3076 | Published On: 15-Sep-2016 | Status: Updated | Updated On: 15-Mar-2017

Insertion of leadless/transvenous pacemaker

Q:

What is the code assignment for insertion of a leadless/transvenous pacemaker?

A:

A leadless/transvenous pacemaker is a single chamber pacemaker device that does not require the use of wired leads to provide an electrical connection between the pulse generator and the heart. It is implanted directly in the right ventricle of the heart through a catheter via the femoral or jugular vein. The steroid eluting electrode that delivers pacing is located within the device.

There is no specific code in ACHI for this procedure. Clinical advice indicates that 38353-00 [**650**] *Insertion of cardiac pacemaker generator* does not fully reflect the procedure of placing a leadless pacemaker. The extra complexity, resources and potential risk for more complications in placing the pacemaker generator transvenously are similar to that reflected in 38350-00 [**648**] *Insertion of permanent transvenous electrode into other heart chamber(s) for cardiac pacemaker*.

Therefore for insertion of a leadless/transvenous pacemaker, assign:

38353-00 [**650**] *Insertion of cardiac pacemaker generator*

and

38350-00 [**648**] *Insertion of permanent transvenous electrode into other heart chamber(s) for cardiac pacemaker*

Improvements to ACHI will be considered for a future edition.

Published 15 September 2016,
for implementation 01 October 2016.

Ref No: Q3063 | Published On: 15-Jun-2016 | Status: Updated | Updated On: 15-Jun-2019

Lymph node neck dissection

Q:

What codes should be assigned for neck dissections described by levels rather than by the terms radical, modified radical and so on?

A:

Cancers in the head and neck commonly metastasise to cervical lymph nodes. Neck dissection refers to a surgical procedure in which the fibrofatty contents of the neck (including lymph nodes) are removed for treatment of cervical lymphatic metastases.

Neck lymph nodes are divided into seven different levels. There are five levels in the lateral compartment and two in the central compartment.

Radical neck dissection (also known as comprehensive neck dissection) involves the removal of all lymph nodes from levels I-V on one side of the neck, with sacrifice of internal jugular vein, spinal accessory nerve and sternocleidomastoid muscle.

Extended radical neck dissection involves radical neck dissection and removal of one or more lymph node groups or non-lymphatic structures not accounted for in the radical neck dissection.

Radical neck dissection has largely been replaced by the modified radical neck dissection.

Modified radical neck dissection involves removal of lymph node groups I to V, while sparing one or more of the three structures taken in the radical neck dissection (sternocleidomastoid muscle, internal jugular vein and spinal accessory nerve).

Assign 96245-01 **[806]** *Radical excision of lymphatic structure , neck* for a radical, extended radical or modified radical neck dissection (removal of lymph node levels I-V) following the Alphabetic Index:

Dissection
- lymph node — *see also Excision/lymphatic structure/by site*

Excision
- lymphatic structure (node)
- - neck (limited) (regional) (simple) (total)
- - - radical (complete) 96245-01 **[806]**

Selective neck dissection refers to a type of neck dissection in which one or more lymph node groups normally removed in a radical neck dissection are preserved. Selective neck dissections may be divided into the following categories: supraomohyoid neck dissection (levels I, II, III), lateral neck dissection (levels II, III, IV), anterior compartment neck dissection (VI), and posterolateral neck dissection (levels II, III, IV, V).

Assign 96244-01 **[806]** *Excision of lymphatic structure, neck* for a selective neck dissection following the Alphabetic Index:

Dissection
- lymph node — *see also Excision/lymphatic structure /by site*

Excision
- lymphatic structure (node)
- - neck (limited) (regional) (simple) (total) 96244-01 **[806]**

This advice has a minormodification to correspond with an update in a subsequent edition ofICD-10-AM/ACHI/ACS.

Published 15 June 2016,
for implementation 01 July 2016.

Ref No: Q3001 | Published On: 15-Jun-2016 | Status: Updated | Updated On: 15-Jun-2019

Incision and drainage of abscess with curettage

Q:

When curettage is performed with an incision and drainage of an abscess, should this be coded to debridement?

A:

During incision and drainage of an abscess, a curette may be used to remove slough and/or debris from the abscess cavity. This is a component of the procedure and does not require an additional code as per the guidelines in ACS 0016 *General procedure guidelines/Procedure components*.

The correct code to assign for incision and drainage of an abscess with or without curettage is 30223-01 **[1606]** *Incision and drainage of abscess of skin and subcutaneous tissue*, following the lead terms *Drainage* or *Incision.*

Amendments to ACHI will be considered for a future edition.

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

Published 15 June 2016,
for implementation 01 July 2016.

Ref No: Q3055 | Published On: 15-Jun-2016 | Status: Updated | Updated On: 15-Mar-2017

Conditions described as secondary to or due to

Q:

Is there a hierarchy within the subsections of ACS 0001 *Principal diagnosis*?

Are episodes of care where delirium is precipitated by infection/dehydration or where acute renal failure (ARF) is precipitated by dehydration examples where ACS 0001 *Principal diagnosis/Problems and underlying conditions* apply? Or does ACS 0001 *Principal diagnosis/ Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis* apply?

A:

The Introduction to the Australian Coding Standards states:
It is assumed that coding decisions are not made solely based on information provided on the clinical record front sheet and/or the discharge summary (or a copy of same) but that analysis of the entire clinical record is performed before code assignment.

If a clinical record is inadequate for complete, accurate coding, the clinical coder should seek more information from the clinician. When a diagnosis is recorded for which there is no supporting documentation in the body of the clinical record, it may be necessary to consult with the clinician before assigning a code.

Applying the above and gaining an understanding of the circumstances of an admitted episode of care should be sufficient in most instances to establish a principal diagnosis as per the definition in ACS 0001 *Principal diagnosis*. In addition, ACS 0001 provides specific guidelines for assignment of the principal diagnosis in various scenarios:

- Obstetrics
- Aetiology and manifestation (aka the 'dagger and asterisk' convention)
- Problems and underlying conditions
- Symptoms, signs and ill-defined conditions
- Acute and chronic conditions
- Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis
- Two or more diagnosis that equally meet the definition for principal diagnosis
- Codes from the Z03.0–Z03.9 series, medical observation and evaluation for suspected diseases and conditions
- Residual condition or nature of sequela

The points above are discrete guidelines for different circumstances and a hierarchy was not explicitly intended, therefore a flowchart is not appropriate.
The guidelines for *Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis* and *Two or more diagnoses that equally meet the definition for principal diagnosis* are not to be used as a default to assign 'the first mentioned condition' without applying the other criteria in ACS 0001.

Delirium precipitated by infection/dehydration and ARF secondary to dehydration, are examples where it is appropriate to apply ACS 0001 *Principal diagnosis/Problems and underlying conditions* as each describes a problem with an underlying condition ie there is a cause and effect (due to/secondary to) relationship. Codes for both the condition and its underlying cause may be assigned by applying the guidelines in ACS 0001 and ACS 0002 *Additional diagnoses/Problems and underlying conditions*, and specialty standards (where applicable).

Published 15 June 2016,
for implementation 01 July 2016.

Ref No: Q2998 | Published On: 15-Mar-2016 | Status: Updated | Updated On: 15-Jun-2019

External cause code for allergic reaction to over the counter hair dye

Q:

What is the correct external cause code to assign for an allergic reaction to personal use of over the counter hair dye?

A:

The Table of Drugs and Chemicals (ICD-10-AM Alphabetic Index) has the following index entries:

Hair

- dye	T49.4	X44	X64	Y14	Y56.4
- preparation NEC.....	T49.4	X44	X64	Y14	Y56.4

The appropriate external cause code for the scenario cited is Y37.8 *Allergy to other specified allergen*.

The code for adverse effect in therapeutic use, Y56.4 *Keratolytics, keratoplastics and other hair treatment drugs and preparations*, is only applicable for those indexed substances being used for therapeutic purposes. The scenario in the query does not indicate any therapeutic purpose.

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

Published 15 March 2016,
for implementation 01 April 2016.

Ref No: TN1037 | Published On: 03-Feb-2016 | Status: Updated | Updated On: 15-Jun-2018

Zika virus; use of WHO code for emergency use

Effective from 21 December 2015

Zika virus (synonymously known as Zika fever and Zika virus infection) is a mosquito-borne viral disease caused by Zika virus (ZIKV). Symptoms include mild fever, rash, headaches, arthralgia, myalgia, asthenia, and non-purulent conjunctivitis. Symptoms appear between three to twelve days after the mosquito vector bite. One in four people may not develop symptoms, but in those who are affected the disease is usually mild with symptoms that last between two and seven days, and usually clears from the blood within a week.

A recent concern has arisen due to an increase in the incidence of Zika virus internationally, with possible links between the infection in pregnant women and subsequent birth defects (including microcephaly). As a result, the WHO has advised that **effective from 21 December 2015** U06.9 *Emergency use of U06.9* is to be assigned to monitor Zika virus internationally.

Zika virus is currently classified to A92.8 *Other specified mosquito-borne viral fevers.* This is a residual code that classifies a number of disease concepts and so WHO have requested that U06.9 is assigned for all cases of Zika virus from 21 December 2015 to facilitate unique identification of Zika virus for global monitoring.

Therefore, in the event that cases of Zika virus are confirmed, assign both:

A92.8 *Other specified mosquito-borne viral fevers* and
U06.9 *Emergency use of U06.9.*

For confirmed Zika virus in pregnant patients, assign:

O98.5 *Other viral diseases in pregnancy, childbirth and the puerperium*
with A92.8 and U06.9 as additional diagnoses.

Assign P00.2 *Fetus and newborn affected by maternal infectious and parasitic diseases* if maternal infection with Zika virus is documented as affecting a fetus or newborn (meeting the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses)*. However, do not assign A92.8 or U06.9 to the infant's episode of care unless the infant has documentation of confirmed (congenital) Zika virus.

Where patients are transferred to another facility for *suspected Zika virus*, follow the guidelines in ACS 0012 *Suspected conditions* and assign:

A92.8 *Other specified mosquito-borne viral fevers*
Z75.6 *Transfer for suspected condition*

Do not assign U06.9 for patients transferred with unconfirmed cases of Zika virus.

References

Centers for Disease Control and Prevention 2016, *'Questions and answers for pediatric healthcare providers: infants and Zika virus infection,* viewed 2 February 2016 http://www.cdc.gov/zika/hc-providers/qa-pediatrician.html

Medew, J, Miletic, D & Flitton, D 2016, 'Six cases of Zika virus in Australia last year as pregnant women warned not to travel', *The Sydney Morning Herald,* 26 January, viewed 1 February 2016, http://www.smh.com.au/national/urgent-travel-warning-for-pregnant-australian-women-at-risk-of-zika-virus-20160125-gmdv5u.html

Pan American Health Organisation n.d. '*Zika virus infection',* viewed 17 December 2015 http://www.paho.org/hq/index.php?option=com_topics&view=article&id=427&Itemid=41484&lang=en

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

Published 03 February 2016,
for implementation 21 December 2015.

Ref No: Q2985 | Published On: 15-Dec-2015 | Status: Updated | Updated On: 01-Jul-2017

Elevated PSA

Q:

What is the principal diagnosis where elevated PSA is documented as the indication for a procedure, but the histopathological finding is BPH or adenocarcinoma?

A:

An elevated PSA is an abnormal test result that is commonly used as an indicator for a number of male urogenital disorders such as prostate cancer, benign prostatic hypertrophy (BPH), urinary tract infection (UTI) and prostatitis. If such conditions are identified or confirmed on histopathology, then these conditions should be coded and not the abnormal test result (elevated PSA) as per ACS 0001 *Principal diagnosis /Problems and underlying conditions*.

However, if no such condition is identified by the clinician or there was no clear finding confirmed on the histopathology report, assign R79.82 *Elevated prostate specific antigen* for the elevated prostate specific antigen (PSA) only, following the index pathway:

Elevated, elevation
- prostate specific antigen (PSA) R79.82

See also Coding Rule 'Clinical diagnosis versus histology'.

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

Published 15 December 2015,
for implementation 01 January 2016.

Ref No: Q2928 | Published On: 15-Sep-2015 | Status: Updated | Updated On: 15-Jun-2019

Coblation of the laryngotrachea

Q:

How do you code coblation of the laryngotrachea?

A:

Coblation (cold or controlled ablation) of the laryngotrachea is a destruction procedure most commonly performed for the treatment of papillomatosis.

Coblation of the laryngotrachea is an endoscopic procedure, usually performed with a microlaryngoscope, however it may also be performed using a bronchoscope extended to the laryngotracheal region.

Although there is no specific block for destruction procedures on the larynx and/or trachea in ACHI, endoscopic excision procedures on the larynx and/or trachea are classified to block **[523]** *Laryngoscopy with excision* (which includes tracheoscopy).

Therefore, where coblation of the laryngotrachea is performed, assign either:

41852-00 **[523]** *Laryngoscopy with removal of lesion*
OR
41864-00 **[523]** *Microlaryngoscopy with removal of lesion*
as a best fit, by following the index pathway:

Endoscopy, endoscopic
- larynx
- - with removal of lesion 41852-00 **[523]**

OR

Destruction
- lesion (tumour)
- - larynx
- - - with microlaryngoscopy 41864-00 **[523]**

Enhancements to ACHI will be considered for a future edition.

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

Published 15 September 2015,
for implementation 01 October 2015.

Ref No: Q2938 | Published On: 15-Jun-2015 | Status: Updated | Updated On: 15-Jun-2019

Drug-induced anaemia

Q:

How do you code drug-induced anaemia when the type of anaemia has not been specified?

A:

Drug-induced anaemia may manifest as haemolytic anaemia (due to erythrocyte injury in peripheral blood) or megaloblastic anaemia, ringed sideroblastic anaemia or pure red cell aplasia (due to damage of erythroid progenitor cells or erythroblasts). Pharmacotherapy (antineoplastic cytotoxic agents), particularly, may reduce haemoglobin levels by inducing a suppressive effect on bone marrow and toxic effects on erythrocytes.

ICD-10 and ICD-10-AM list a number of specific types of anaemia; some of the specific types are further specified as drug-induced (eg aplastic, haemolytic etc). These options should only be coded when the type of anaemia is documented.

Where drug-induced anaemia is documented without specification of the type of anaemia, assign:

D64.9 *Anaemia, unspecified*

with an additional code from Y40-Y59 *Drugs, medicaments and biological substances causing adverse effects in therapeutic use* to identify the external cause (see Alphabetic Index/Table of Drugs and Chemicals)

and

Y92.23 *Place of occurrence, health service area, not specified as this facility*
OR
Y92.24 *Place of occurrence, health service area, this facility*.

Reference:

Dan, K. (2008). Drug-induced anemia. Japanese Journal of Clinical Medicine [2008, 66(3):540-543]. Retrieved from http://europepmc.org/abstract/med/18326323

Wilson, S., Silberstein, P. and Aldoss, I. (2008). Chemotherapy-induced anaemia. *Asia-Pacific oncology & haematology,* 2008;1(1):24-6. Retrieved from http://www.touchoncology.com/articles/chemotherapy-induced-anaemia

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

Published 15 June 2015,
for implementation 01 July 2015.

Ref No: Q2906 | Published On: 15-Mar-2015 | Status: Updated | Updated On: 15-Jun-2019

Same-day chemotherapy for neoplasm; participant in clinical drug trial

Q:

A patient is admitted for same-day pharmacotherapy as part of a drug trial. What is the principal diagnosis?

A:

Where there is a clinical indication for same-day pharmacotherapy (for neoplasm), regardless of whether the pharmacotherapy was part of a drug trial, assign Z51.1 *Pharmacotherapy session for neoplasm* as principal diagnosis with an additional diagnosis code for the neoplasm.

Do not assign Z00.6 *Examination for normal comparison and control* for the above scenario. Z00.6 is located in category Z00 *General examination and investigation of persons without complaint or reported diagnosis*; codes from this category should not be assigned when there is a documented definitive diagnosis as the indication for pharmacotherapy.

Assign Z00.6 where the reason for admission is stated as being for a clinical trial for the purposes of research (without documentation of a clinical diagnosis).

Amendments to ACS 0026 may be considered for a future edition.

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

Published 15 March 2015,
for implementation 01 April 2015.

Ref No: Q2872 | Published On: 15-Mar-2015 | Status: Updated | Updated On: 15-Jun-2019

Gastroenteritis or diarrhoea due to Norovirus

Q:

What is the correct code assignment for gastroenteritis or diarrhoea due to Norovirus?

A:

Norovirus was previously referred to as “Norwalk-like viruses”, Norwalk viruses, and small round-structured viruses.

The World Health Organization (WHO) provides the following definition in the ICD-11 Beta version:

> The official genus name Noroviruses which is the group of viruses previously described as “Norwalk-like viruses” are a group of related, single-stranded RNA, non-enveloped viruses. Noroviruses cause self-limiting explosive acute gastroenteritis that last for 24-48 hours in humans. The most common symptoms of acute gastroenteritis are diarrhoea, vomiting, and stomach pain (WHO, 2015).

Therefore intestinal infections due to norovirus should be assigned A08.1 *Acute gastroenteropathy due to Norovirus,* following the index pathway:

Gastroenteritis
- viral
- - Norovirus (Norwalk agent) A08.1

Diarrhoea caused by Norovirus should also be assigned A08.1 *Acute gastroenteropathy due to Norovirus*, following the index pathway:

Diarrhoea, diarrhoeal
- due to
- - virus (see also Enteritis/viral)

and

Enteritis
- viral
- - small round structured A08.1

Improvements to the Alphabetic Index with respect to norovirus may be considered for a future edition of ICD-10-AM.

Reference:

World Health Organization (WHO) (2015). *ICD-11 Beta version, joint linearization for mortality and morbidity statistics*. Retrieved from http://apps.who.int/classifications/icd11/browse/l-m/en

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

Published 15 March 2015,
for implementation 01 April 2015.

Ref No: Q2887 | Published On: 15-Mar-2015 | Status: Updated | Updated On: 15-Jun-2019

E13 *Other specified diabetes mellitus*

Q:

Can you assign multiple codes when documentation indicates that a patient has type 1 or type 2 diabetes mellitus AND diabetes mellitus classifiable to E13?

A:

ICD-10-AM classifies diabetes mellitus to the following categories:
E10 *Type 1 diabetes mellitus*
E11 *Type 2 diabetes mellitus*
E13 *Other specified diabetes mellitus*
E14 *Unspecified diabetes mellitus*
E13 *Other specified diabetes mellitus* cannot be assigned in addition to E10 *Type 1 diabetes mellitus* or E11 *Type 2 diabetes mellitus,* as these codes are mutually exclusive.

E13.- is assigned by following the index pathway *Diabetes/specified NEC*. The NEC (not elsewhere classified) indicates that if the diabetes is classifiable to a specified category (E10 or E11), that category takes precedence over the 'other' (residual) category (E13).
Therefore, E13 should never be assigned when documentation confirms diabetes mellitus as type 1 or type 2.
See *Conventions and general arrangement of the ICD-10-AM Alphabetic Index/ NEC (not elsewhere classified)*.

Documentation issues
The above advice is applicable to cases where type 1 or type 2 diabetes mellitus are **correctly identified and documented** in the clinical record.
Clinicians may incorrectly document the type of diabetes and/or use terms interchangeably, especially in relation to insulin use. For example:

- patient with type 2 diabetes mellitus (T2DM) on insulin, incorrectly documented as IDDM (insulin dependent diabetes mellitus) or type 1 diabetes mellitus (T1DM)
- patient with T2DM on insulin, inconsistently documented as T1DM or T2DM within the one episode
- patient with diabetes mellitus due to a specified cause treated with insulin, incorrectly documented as T1DM or IDDM.

The following should be noted:

- IDDM and NIDDM (noninsulin dependent diabetes mellitus) are outdated terminology
- IDDM and NIDDM are not types of diabetes; they are descriptors of insulin usage
- IDDM does not always mean T1DM; it may mean T2DM treated with insulin or DM due to a specified cause (eg post pancreatectomy) treated with insulin.

Where documentation is conflicting or inconsistent within the current episode regarding the type of diabetes mellitus, coders should check previous admissions and/or correspondence and/or consult with the treating clinician to determine if the patient has T1DM, T2DM or diabetes mellitus due to a specified cause (meaning not type 1 or type 2).
See also ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia, 2. Specific classification principles for DM and IH*

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

Published 15 March 2015,
for implementation 01 April 2015.

Ref No: Q2882 | Published On: 15-Mar-2015 | Status: Updated | Updated On: 01-Jul-2017

Thrombectomy and embolectomy of multiple arteries

Q:

Should site specific procedure codes for thrombectomy/embolectomy be assigned when thrombectomy/embolectomy is performed on multiple vessels or does the second dot point of Point 2 *Multiple procedures* in ACS 0020 Bilateral/*multiple procedures* apply?

A:

Site specific procedure codes should be assigned when thrombectomies/embolectomies are performed on multiple vessels as the procedures are performed on different lesion, for example thrombus of tibial artery and thrombus of femoral artery. The second dot point of Point 2 *Multiple procedures* in ACS 0020 *Bilateral/multiple procedures* which states 'embolisation of left and right uterine arteries' applies to treating the same condition/lesion which is uterine fibroid.

Q:

What is the correct code to assign thrombectomy/embolectomy of one artery and stent of another for atherosclerosis?

A:

A code for insertion of stent should be assigned in addition to the thrombectomy/embolectomy code in this scenario as two different conditions/lesions; thrombus/embolus of one artery and atherosclerosis of another artery were treated. The includes note 'that with stenting' at block **[702]** *Arterial embolectomy or thrombectomy* only applies if the stenting is performed to the same artery.

Improvements to ACHI will be considered for a future edition.

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

Published 15 March 2015,
for implementation 01 April 2015.

Ref No: P182 | Published On: 15-Dec-2014 | Status: Updated | Updated On: 15-Jun-2019

Middle East Respiratory Syndrome (MERS)

Q:

How do you code Middle East Respiratory Syndrome (MERS)?

A:

Middle East respiratory syndrome (MERS) is a condition caused by an infection with a new virus; Middle East Respiratory Syndrome coronavirus (MERS-CoA) (also known as novel coronavirus (nCoV) and human coronavirus-EMC (for Erasmus Medical Center)). It is suspected that some cases have originated from exposure to dromedary camels that were infected by carrier bats. Person-to-person transmission has also occurred, especially in healthcare settings.

The condition was first reported in the Middle East in 2012 and all cases to date have lived in or travelled to the Middle East, or have had close contact with people who acquired the infection in the Middle East (eg family members and healthcare personnel). Cases have been treated in the United Kingdom, Europe, the Netherlands, Egypt, Malaysia, the Phillipines and the United States of America. There have been no cases identified in Australia.

The syndrome usually manifests as a severe acute respiratory illness, such as pneumonia or acute respiratory distress syndrome (ARDS). Patients may also develop manifestations such as acute kidney injury, gastrointestinal symptoms, pericarditis or septic shock. Many of those who manifested with severe respiratory illness required admission to intensive care units, mechanical ventilation or extracorporeal membrane oxygenation.

There is no specific code for MERS in ICD-10 or ICD-10-AM; classification requires assignment of codes for any documented manifestations with an additional code for the aetiological organism (ie coronavirus).

For example:

J12.8 *Other viral pneumonia*

B97.2 *Coronavirus as the cause of diseases classified to other chapters*

and

U91 *Syndrome, not elsewhere classified*.

References:

Australian Government Department of Health. (2014). Information for clinicians, laboratories and public health personnel on MERS coronavirus. Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/Content/ohp-mers-cov-info-clphp.htm

Australian Government Department of Health. (2014). Middle East Respiratory Syndrome Coronavirus (MERS-CoV). Retrieved from http://www.health.gov.au/MERS-coronavirus

Centers for Disease Control and Prevention. (USA). (2014). Middle East Respiratory Syndrome (MERS). Retrieved from http://www.cdc.gov/coronavirus/MERS/index.html

McIntosh, K. (2014). Middle East respiratory syndrome coronavirus. Retrieved from http://www.uptodate.com/contents/middle-east-respiratory-syndrome-coronavirus (Topic 89705 Version 46.0).

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

Published 15 December 2014,
for implementation 01 January 2015.

Ref No: Q2802 | Published On: 15-Sep-2014 | Status: Updated | Updated On: 15-Jun-2019

Paediatric Autoimmune Neuropsychiatric Disorders (PANDAS)

Q:

What codes should be assigned for a principal diagnosis of PANDAS, admitted for IV Intragam?

A:

PANDAS is an acronym for Paediatric Autoimmune Neuropsychiatric Disorders associated with group A ß-haemolytic streptococcal infections. Children and adolescents present with rapid onset of Obsessive-Compulsive Disorder (OCD) and/or tic disorders. Treatment includes Cognitive Behavioural Therapy and pharmacotherapy with antibiotics to treat the streptococcal infection, intravenous immunoglobulin therapy and neuropsychiatric drugs. Symptoms usually persist for weeks to months with a slow, gradual improvement with some patients placed on prophylactic antibiotic therapy to prevent further streptococcal infections.

There is no specific code in ICD-10-AM for Paediatric Autoimmune Neuropsychiatric Disorders (PANDAS), therefore, follow ACS 0005 *Syndromes* and assign codes based on the documentation in the clinical record.

Diagnoses that may be assigned in these cases include:

- M35.9 *Systemic involvement of connective tissue, unspecified*
- F06.8 *Other specified mental disorders due to brain damage and dysfunction and to physical disease or condition*
- F42. - *Obsessive-compulsive disorders*
- F95. - *Tic disorders*
- B94.8 *Sequelae of other specified infectious and parasitic diseases* (where there is clear documentation of the association and not specified as current)

OR

- B95.0 *Streptococcus, group A, as the cause of diseases classified to other chapters* (if current).

For the scenario cited where the principal diagnosis is PANDAS and the admission is for IV administration of Intragam, assign the following:

M35.9 *Systemic involvement of connective tissue, unspecified*, as the principal diagnosis following the index pathway:

Disease, diseased — see also Syndrome

- autoimmune (systemic) NEC M35.9

and

F06.8 *Other specified mental disorders due to brain damage and dysfunction and to physical disease or condition* as an additional diagnosis following the index pathway:

Disorder (of) — see also Disease

- cognitive

- - due to (secondary to) general medical condition F06.9

- - - mixed F06.8

and

U91 *Syndrome, not elsewhere classified*.

References:

U.S. National Institute of Mental Health (NIMH), Pediatrics and Developmental Neuroscience branch. (2012). Intramural Research Program. Retrieved from http://intramural.nimh.nih.gov/pdn/web.htm

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

Published 15 September 2014,
for implementation 01 October 2014.

Ref No: Q2863 | Published On: 15-Sep-2014 | Status: Updated | Updated On: 01-Jul-2015

Catheterisation and cannulation in neonates

Q:

Is there a difference between catheterisation and cannulation in terms of ACS 1615? Does it refer only to catheterisation?

A:

There is no difference between these terms in ACS 1615 *Specific diseases and interventions related to the sick neonate*; it refers to both catheterisation and cannulation. Clinical advice has confirmed that the terms catheterisation and cannulation are used interchangeably and for classification purposes they are assigned to the same code.

Q:

For administration of IV antibiotics or other substance in a neonate, is it the expectation that a code would automatically be assigned for the catheterisation as an additional code?

A:

Where the catheter is used to administer antibiotics or other substance and meets the criteria in ACS 1615, two codes would be assigned, for example documentation of IV antibiotics via scalp vein would have the following codes assigned:

13300-01 **[738]** *Scalp vein catheterisation/cannulation in neonate*

96199-02 **[1920]** *Intravenous administration of pharmacological agent, anti-infective agent*

(96199-02 **[1920]** should only be assigned when antibiotics are given for >24 hours as per ACS 1615).

Where the site of the catheter is not specified and clinical confirmation cannot be sought, then a code for the catheterisation cannot be assigned.

Documentation of the site of the catheterisation is required as only the following catheterisations are to be coded as per ACS 1615:

13300-01 **[738]** *Scalp vein catheterisation/cannulation in neonate*

13300-02 **[738]** *Umbilical vein catheterisation/cannulation in neonate*

13319-00 **[738]** *Central vein catheterisation in neonate*

13303-00 **[694]** *Umbilical artery catheterisation/cannulation in neonate*

34524-00 **[694]** *Catheterisation/cannulation of other artery*

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

Published 15 September 2014,
for implementation 01 October 2014.

Ref No: Q2720 | Published On: 15-Jun-2014 | Status: Updated | Updated On: 15-Jun-2019

Excision of neuroblastoma

Q:

Should the specific ACHI codes for neuroblastomas always be used when a neuroblastoma is removed, or can other more anatomically correct codes be used such as 40309-00 **[53]** *Removal of spinal extradural lesion*?

A:

The following site specific codes are available in ACHI for removal of neuroblastomas:

- 43987-01 **[989]** *Excision of intra-abdominal neuroblastoma*
- 43987-00 **[563]** *Excision of intrathoracic neuroblastoma*

For excision of neuroblastomas of other sites, assign 43987-02 **[80]** *Excision of neuroblastoma, not elsewhere classified*, following the index pathway:

Excision
- neuroblastoma NEC 43987-02 **[80]**

As per the definition in the Conventions used in the ACHI Alphabetic Index, the NEC indicates that this is the default option if the site of the neuroblastoma is not intra-abdominal or intrathoracic. It does not indicate that another index pathway can be selected to achieve a more site specific code.

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

Published 15 June 2014,
for implementation 01 July 2014.

Ref No: Q2830 | Published On: 15-Jun-2014 | Status: Updated | Updated On: 01-Jul-2017

Necrotic leg ulcer with diabetes mellitus and peripheral vascular disease (PVD)

Q:

What is the correct code assignment for a principal diagnosis of leg (not foot) ulcer with necrotic tissue, on a background of type 2 diabetes with PVD; where the PVD meets the criteria for code assignment as per ACS 0002 *Additional diagnoses*, but there is no documentation of a clear relationship between the ulcer, gangrene and PVD. Should L97 or I70.23 be assigned as the principal diagnosis?

A:

The Alphabetic Index provides a 'with' association for peripheral vascular disease and ulceration of the extremities, so there is no need to identify a relationship between the ulcer, gangrene and PVD. The appropriate codes to assign for a leg ulcer with necrotic tissue, on a background of type 2 diabetes mellitus with peripheral vascular disease (PVD) are:

I70.23*Atherosclerosis of arteries of extremities with ulceration*
E11.69 *Type 2 diabetes mellitus with other specified complication*
E11.52 *Type 2 diabetes mellitus with peripheral angiopathy with gangrene*
following the Alphabetic Index:

Arteriosclerosis, arteriosclerotic
…
- extremities
- - with
- - - ulceration I70.23

Diabetes, diabetic
- with
…
- - angiopathy, peripheral – *seeDiabetes/with/arterial disease, peripheral*
…
- - arterialdisease, peripheral (without gangrene) E1-.51
- - - with
- - - - footulcer — *see ACS 0401 Diabetes mellitusand intermediate hyperglycaemia/6 Diabetic foot*
- - - - gangreneE1-.52
- - - - - and foot ulcer — *see ACS 0401 Diabetes mellitus and intermediate hyperglycaemia/6Diabetic foot*
…
- - peripheral vascular disease (PVD) — *see Diabetes/with/arterial disease, peripheral*
…
- - ulcer, skin
- - - lower extremity E1-.69

Diabetes with peripheral vascular disease with necrosis is classified to E11.52 *Type 2 diabetes mellitus with peripheral angiopathy, with gangrene*.

Peripheral vascular disease with ulceration is classified to I70.23 *Atherosclerosis of arteries of extremities with ulceration*.

E11.69 *Type 2 diabetes mellitus with other specified complication* is assigned following Rule 4a in ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* to classify diabetes with leg ulcer.

Neither I70.24 *Atherosclerosis of arteries of extremities with gangrene* or L97 *Ulcer of lower limb, not elsewhere classified* are assigned as per Rule 6 of ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia.*

Also note, that I70.2- codes are not mutually exclusive, more than one can be assigned where multiple manifestations of PVD are documented.

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

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

Published 15 June 2014,
for implementation 01 July 2014.

Ref No: Q2768 | Published On: 15-Jun-2014 | Status: Updated | Updated On: 01-Jul-2017

Contrast induced acute kidney failure (injury)

Q:

What is the correct code to assign for contrast induced Acute Kidney Failure (AKF) or contrast-induced Acute Kidney Injury (AKI)?

A:

Contrast induced AKF (now commonly known as AKI) refers to an abrupt deterioration in kidney function which occurs after exposure to contrast media. The codes below are commonly assigned for this condition by following the index pathway ***Failure****/kidney/acute* and reinforced by Example 6 in ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia:*

N17.9 *Acute kidney failure, unspecified*

Y57.5 *X-ray contrast medium causing adverse effects in therapeutic use*

Y92.23 *Place of occurrence, health service area, not specified as thisfacility*

OR

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

However, assignment of N17.9 is incorrect if the excludes note (which is consistent with ICD-10) at N17-N19 *Kidney failure* is followed:

"***Excludes:*** *drug- and heavy-metal-induced tubulo-interstitial and tubular conditions* (N14.-)"

Analysis of code assignment in the data suggests it would be a major change in coding practice to assign N14.1 *Nephropathy induced by other drugs, medicaments and biological substances* rather than N17.9 *Acute kidney failure, unspecified* for contrast induced acute kidney failure (injury), therefore clinical coders should continue to assign N17.9 until further notice.

The classification for contrast induced AKI will be reviewed for a future edition of ICD-10-AM.

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

Published 15 June 2014,
for implementation 01 July 2014.

Ref No: Q2649 | Published On: 15-Mar-2014 | Status: Updated | Updated On: 15-Jun-2019

Confusion or delirium with dementia

Q:

How do you code confusion, acute confusion, confusional state and acute confusional state?

A:

Confusion NOS and delirium NOS are classified separately in ICD-10-AM.
Confusion NOS is a symptom of dementia and therefore where both of these conditions are documented, only a code for the dementia should be assigned.

A code for delirium should only be assigned when this condition is documented OR when acute confusional state is specifically documented, as per the index pathway:
State (of)
…
- confusional (psychogenic) F44.88
- - acute or subacute (see also Delirium) F05.9

A code for confusion, acute confusion, confusional state and acute confusional state should only be assigned when the condition meets the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*. Where:
CONFUSION NOS or **ACUTE CONFUSION** are documented: assign R41.0 *Disorientation, unspecified*

ACUTE CONFUSIONAL STATE is documented: assign F05.9 *Delirium, unspecified* (as a default – see also Delirium)

CONFUSIONAL STATE is documented: care should be taken before assigning F44.88 *Other specified dissociative [conversion] disorders.*
This code should not be assigned unless documentation within the clinical record indicates that the patient has a dissociative [conversion] disorder. Where documentation is inadequate, advice should be sought from the treating clinician to determine if the patient has confusion, acute confusional state (ie delirium) or a true dissociative [conversion] disorder.

Where **ACUTE CONFUSIONAL STATE/DELIRIUM** is specifically documented:

- **due to another medical condition**, assign F05.0 *Delirium not superimposed on dementia, so described* in addition to the medical condition
- in a patient who **also has dementia**, assign F05.1 *Delirium superimposed on dementia*
- in a patient who **also has dementia** AND documentation states that the acute confusional state/delirium is due to a general medical condition, assign F05.8 *Other delirium* in addition to the general medical condition (other than dementia)

by following the index pathways:

State (of)
… - confusional (psychogenic) F44.88
- - acute or subacute (see also Delirium) F05.9
- - - with senility or dementia F05.1

Delirium, delirious (acute or subacute) (not alcohol- or drug-induced) F05.9
…
- due to (secondary to)
…
- - general medical condition F05.0
…
- mixed origin (dementia and other) F05.8
…
- superimposed on dementia F05.1

Note: the documentation does not have to specify superimposed on dementia. The term superimposed implies delirium **with** dementia.

If the documentation in the clinical record is unclear as to whether the patient has confusion or delirium, verification should be sought from the treating clinician.

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

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

Published 15 March 2014,
for implementation 01 April 2014.

Ref No: Q2786 | Published On: 15-Mar-2014 | Status: Updated | Updated On: 15-Jun-2019

Intraoperative floppy iris syndrome (IFIS)

Q:

What is the correct code to assign for intraoperative floppy iris syndrome?

A:

Intraoperative floppy iris syndrome (IFIS) is mainly encountered during cataract surgery and is characterised by a flaccid iris, the tendency for the iris to prolapse out of the incision and progressive intraoperative pupillary constriction. This triad of conditions although found during surgery is commonly related to alpha 1 adrenergic antagonist prescribed for relief of lower urinary tract symptoms of benign prostatic hypertrophy (Friedman, 2009). Other drugs associated with IFIS include saw palmetto, finasteride, antipsychotic drugs, angiotensin antagonists, and some beta-blockers with particular alpha-blocking properties.

Therefore, IFIS should be classified as an adverse effect of drug therapy and the following codes assigned:

H21.8 *Other specified disorders of iris and ciliary body*
H57.0 *Anomalies of pupillary function*

following the Alphabetic Index:

Prolapse, prolapsed
- iris (traumatic)
- - nontraumatic H21.8

Anomaly, anomalous (congenital) (unspecified type)
- pupil
- - function H57.0
and
U91 *Syndrome, not elsewhere classified*.

If a causal link is documented add:
Y40–Y59 *Drugs, medicaments and biological substances causing adverse effects in therapeutic use*
Y92.23 *Place of occurrence, health service area, not specified as thisfacility*
OR
Y92.24 *Place of occurrence, health service area,this facility*

Indexing improvements may be considered for a future edition of ICD-10-AM.

Bibliography:

Friedman, AH. (2009). Tamsulosin and the Intraoperative Floppy Iris Syndrome. Journal of American Medical Association: 301(19):2044-2045. doi:10.1001/jama.2009.704.

Liaboe, L., Baker, M. & Oetting, T. (2013). Floppy Iris Syndrome. EyeRounds.org.Retrieved from: http://webeye.ophth.uiowa.edu/eyeforum/cases/169-IFIS.htm

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

Published 15 March 2014,
for implementation 01 April 2014.

Ref No: Q2813 | Published On: 15-Dec-2013 | Status: Updated | Updated On: 01-Jul-2017

Donor Lymphocyte Infusion

Q:

Is a donor lymphocyte infusion considered a stem cell transplant or is it a transfusion of a blood product?

A:

Donor lymphocyte infusion (DLI) is the administration of donated lymphocytes to patients who have previously received stem cell transplantation and have either residual disease or relapse of their leukaemia, lymphoma or myeloma. The donor lymphocytes recognise the patient's cells as foreign and attack them, causing a condition called graft versus host disease (GvHD). The benefit of this immune response is that the donor cells also kill any leukaemia cells present.

DLI is classified as 13706-04 **[1893]** *Administration of leukocytes* by following the Alphabetic Index:

Administration
- type of agent
- - donor leukocytes 13706-04 **[1893]**

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

Published 15 December 2013,
for implementation 01 January 2014.

Ref No: Q2659 | Published On: 15-Dec-2013 | Status: Updated | Updated On: 01-Jul-2017

Skin Necrosis

Q:

Should skin necrosis be coded the same as gangrene? When there is documentation of necrotic ulcer should both R02 and L97.- be assigned and if yes, in what order?

A:

ICD-10-AM classifies skin necrosis without further specification to R02 *Gangrene NEC* as per ICD-10. The above query does not specifically mention the wound site, but as L97.- *Ulcer of lower limb* is cited, the NCCH assumes the query relates to a lower limb necrotic/gangrenous ulcer.

When an ulcer is described as necrotic, gangrenous or with areas of skin necrosis it is appropriate to assign a code for the ulcer (L97.- in the case of lower limb ulcers) and R02 (except for pressure areas where necrosis is inherent in the staging) even though L97.- excludes R02 *Gangrene* (i.e. skin necrosis).

Code sequencing is determined by following the principles in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses* (see also *Note* at the beginning of Chapter 18 *Symptoms, signs and abnormal clinical findings, not elsewhere classified*).

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

Published 15 December 2013,
for implementation 01 January 2014.

Ref No: Q2788 | Published On: 15-Jun-2013 | Status: Updated | Updated On: 15-Jun-2019

Removal of urethral sling following male stress incontinence procedure

Q:

What is the correct code to use for removal of urethral sling following male stress incontinence procedure?

A:

There is no specific procedure code for removal of urethral sling following previous stress incontinence procedure for male patients. ACHI does not distinguish between removal and revision procedures for male stress incontinence. The appropriate code for removal of a urethral sling for a male stress incontinence procedure is 37044-03 **[1109]** *Revision of retropubic procedure for stress incontinence, male* following index pathways:

Revision (partial) (total)
- sling procedure for stress incontinence
- - female 35599-01 [1110]
- - male 37044-03 [1109]

Or

Sling procedure
- for
- - stress incontinence
- - - male 37044-00 [1109]
- - - - revision 37044-03 [1109]
- - - revision
- - - - female 35599-01 [1110]
- - - - male 37044-03 [1109]

Amendments may be considered for a future edition.

Published 15 June 2013,
for implementation 01 July 2013.

Ref No: Q2782 | Published On: 15-Dec-2012 | Status: Updated | Updated On: 15-Jun-2019

CIN III as principal diagnosis and indication for LLETZ procedure

Q:

What should be assigned as principal diagnosis when CIN III is documented on a Pap smear as the indication for LLETZ procedure, however histopathology after the procedure reveals CIN II or CIN I?

A:

A Large Loop Excision of the Transformation Zone (LLETZ) procedure of the cervix is performed after an abnormal Pap smear to treat pre-cancerous cells (CIN II/CIN III or high grade squamous intraepithelial lesions (HSIL/HGSIL)). This procedure uses an electric current passed through a fine wire loop electrode to shave abnormal tissue from the transformation zone of the cervix. This tissue is then sent for pathological analysis.

Clinical advice confirms that a code for the higher grade lesion (CIN III) should be assigned as the principal diagnosis. This is also supported by the advice in ACS 0236 *Neoplasm coding and sequencing/Primary neoplasm as a current condition* which states:

"A primary neoplasm is classified as a **current condition** if the episode of care is for:

- treatment aimed at stopping progression of the neoplasm..."

Bibliography:

Australian Government Department of Health and Ageing (2006), *National Cervical Screening Program resources - "An abnormal Pap smear result: What this means for you?",* accessed: September 2012, available: http://www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/EFAA19DECAA2111ACA2574EB007F73AF/$File/pap-smear.pdf.

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

Published 15 December 2012,
for implementation 01 January 2013.

Ref No: Q2687 | Published On: 15-Dec-2012 | Status: Updated | Updated On: 15-Jun-2019

Principal diagnosis for prophylactic PEG insertion prior to oropharyngeal radiation therapy

Q:

When a patient is admitted for prophylactic PEG insertion prior to undergoing oropharyngeal radiation therapy for a malignant neoplasm of the tonsil, would the principal diagnosis be a code for the neoplasm or Z51.4 *Preparatory care for subsequent treatment, not elsewhere classified*?

A:

It is acknowledged there may be inconsistency in the assignment of Z51.4 *Preparatory care for subsequent treatment, not elsewhere classified*, and recently developed a discussion paper regarding the assignment of 'Z' codes as a principal diagnosis. However, the feedback received in response to the discussion paper provided no definitive outcome to the issue for inclusion in ICD-10-AM Eighth Edition, and ongoing evaluation is required to determine changes for a future edition.

In the interim, the neoplasm should be assigned as the principal diagnosis where the reason for admission is related to the treatment of the neoplasm. This follows the principle of the coding advice published by the NCCH in *Coding Matters* (2010) which states "...assign the condition as the principal diagnoses for brachytherapy planning..." as 'planning' is considered part of the treatment of the neoplasm.

Therefore, in the scenario cited assign the neoplasm of the tonsil as the principal diagnosis.

Reference:

National Centre for Classification in Health (2010), *Coding Matters, The 10-AM Commandments*, Vol. 16, No. 4.

Published 15 December 2012,
for implementation 01 January 2013.

Ref No: Q2645 | Published On: 15-Jun-2012 | Status: Updated | Updated On: 15-Jun-2019

Z03 *Medical observation and evaluation for suspected diseases and conditions*

Q:

Is it appropriate to assign a code from Z03 *Medical observation and evaluation for suspected diseases and conditions, ruled out* according to ACS 1617 *Neonatal sepsis/risk of sepsis* in the following scenarios:

Scenario 1: Mother has a PPROM, baby is born prematurely and antibiotics are administered. However 'risk of sepsis' is not documented. **Scenario 2**: Mother goes into spontaneous premature labour without PPROM, and baby is born prematurely and antibiotics are administered. Again, 'risk of sepsis' is not documented.

A:

Clinical coders should not assume 'risk of sepsis' in the scenarios described and should instead seek clinical confirmation that antibiotics are being administered for 'risk of sepsis' in order to assign Z03 *Medical observation and evaluation for suspected diseases and conditions, ruled out*.

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

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: Q2712 | Published On: 15-Jun-2012 | Status: Updated | Updated On: 15-Jun-2019

Ultrasound guided compression of pseudoaneurysm

Q:

Can you please clarify how to code ultrasound guided compression of a pseudoaneurysm?

A:

Ultrasound guided compression meets the definition of a procedure as per ACS 0016 General Procedure Guidelines, as it:

- carries a procedural risk
- may carry an anaesthetic (sedation) risk
- requires specialised training

The correct code to assign for repair of cubital fossa pseudoaneurysm using ultrasound guided compression is 92205-00 **[1908]** *Noninvasive therapeutic intervention, not elsewhere classified*, following the pathway:

Procedure
- therapeutic NEC 92205-00 **[1908]**

Where the compression is performed under sedation, an appropriate code for the ultrasound and sedation should also be assigned, as per ACS 0042 *Procedures normally not coded.*

This advice supersedes the previous advice published in Coding Matters, September 2005 (Volume 12, Number 2), Ultrasound guided compression of a false femoral artery aneurysm, which will be retired on 30 June 2012. The classification of Interventional radiology and ultrasound is outdated in ACHI and has been flagged for review in a future edition.

Bibliography:

Esfe, A, Bozorg, S and Yazdi, H (2009), 'Pseudoaneurysm of a high origin radial artery treated by ultrasound-guided compression', Singapore Medical Journal, Vol. 50, No. 7, pp. 250-252. Hendricks, N and Wael, E (2012), 'Ultrasound-guided management of vascular access pseudoaneurysms', Ultrasound Clinics, corrected proof, accessed: 24/5/12, MD Consult Database. National Centre for Classification in Health (2005), 'The 10-AM Commandments, ultrasound guided compression of a false femoral artery aneurysm', Coding Matters, Vol. 12, No.2 , p. 1. Saad, N, Saad, W, Davies, M, Waldman, D, Fultz P and Rubens, D (2005), 'Pseudoaneurysms and the role of minimally invasive techniques in their management', RadioGraphics, Vol. 25, Supp. 1, pp. 173-189.

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: Q2770 | Published On: 15-Jun-2012 | Status: Updated | Updated On: 15-Jun-2019

Alternating hemiplegia of childhood

Q:

What is the correct code to assign for alternating hemiplegia of childhood (AHC)?

A:

Alternating hemiplegia of childhood is a rare neurological disorder of uncertain aetiology, also referred to as AHC or alternating hemiplegia syndrome. Current research indicates that the disorder may be caused by a gene mutation. AHC is characterised by recurrent hemiplegic attacks that alternate in laterality, paroxysmal attacks including dystonic spells, oculomotor abnormalities or autonomic symptoms, global neurological impairment or neurologic findings such as ataxia, dystonia or choreoathetosis. Symptoms usually manifest before eighteen months of age and can be resolved by sleep. Where alternating hemiplegia of childhood is documented, assign G98 *Other disorders of nervous system, not elsewhere classifie*d, following the Alphabetic Index:

Disorder
- nervous system
- - specified NEC G98
and
U91 *Syndrome*, *not elsewhere classified.*

Refer to ACS 0005 *Syndromes* for guidelines with regards to coding manifestations.

References:

National Organisation for Rare Disorders, Inc. (NORD) (2012), *Rare Diseases database*, accessed: May 2012, available: http://www.rarediseases.org/rare-disease-information/rare-diseasesOrphanet (2012), *Orphanet: The portal for rare diseases and orphan drugs*, accessed: May 2012, available: http://www.orpha.net

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

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: Q2763 | Published On: 15-Jun-2012 | Status: Updated | Updated On: 15-Jun-2019

Banding of GAVE at gastroscopy

Q:

What procedure code should be assigned for gastroscopy with banding of the vascular lesions in a patient with gastric antral vascular ectasia (GAVE)? The only banding code available is for banding of gastric varices.

A:

GAVE, or watermelon stomach, is a form of gastrointestinal vascular malformation where oozing haemorrhages, resembling red watermelon stripes, are seen in the gastric antrum on endoscopy. Endoscopic band ligation (EBL), which is routinely used for the treatment of oesophageal and gastric varices, has also been found to be effective in controlling bleeding from nonvariceal gastrointestinal disorders such as GAVE.

The correct code to assign for EBL of GAVE lesions is 30476-03 **[874]** *Endoscopic banding of gastric varices*.

Although this code title specifies 'gastric varices' it is the same procedure as that used to treat GAVE.

Amendments may be considered for a future edition.

Bibliography:

National Centre for Classification in Health 2006, 'Gastric antral vascular ectasia (GAVE)', Coding Matters, vol.13, no.1, p.5

Selinger, C and Ang, Y 2008, 'Gastric Antral Vascular Extasia (GAVE): An update on clinical presentation, pathophysiology and treatment', Digestion, International Journal of Gastroenterology, vol.77, no.2, pp.131-137

Wells, C, Harrison, M, Gurudu, S, Crowell, M, Byrne, T, DePetris, G, and Sharma, V 2008, 'Treatment of gastric antral vascular ectasia (watermelon stomach) with endoscopic band ligation', Gastrointestinal Endoscopy, vol.68, no.2, pp.231-236

Zepeda-Gomez, S and Marcon, N 2008, 'Endoscopic band ligation for nonvariceal bleeding: A review', Canadian Journal of Gastroenterology, vol.22, no.9, pp.748-752

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: Q2721 | Published On: 15-Dec-2011 | Status: Updated | Updated On: 15-Jun-2019

Same-day admission for both radiotherapy and chemotherapy

Q:

What is the correct principal diagnosis to assign in a same day episode of care when both radiotherapy under general anaesthetic and intravenous pharmacotherapy is given for treatment of a neoplasm?

A:

For the scenario cited assign the principal diagnosis according to the guidelines in ACS 0001 *Principal diagnosis*, which states:

> *"**Two or more diagnoses that equally meet the definition for principal diagnosis** When two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic work-up and/or therapy provided, and the Alphabetic Index, Tabular List or the standard does not provide sequencing direction, the clinician should be asked to indicate which diagnosis best meets the principal diagnosis definition. If no further information is available, code as the principal diagnosis the first mentioned diagnosis."*

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

Published 15 December 2011,
for implementation 01 January 2012.

Ref No: Q2627 | Published On: 15-Dec-2011 | Status: Updated | Updated On: 15-Jun-2019

Healthcare associated *Staphylococcus aureus* bacteraemia (HA SAB) (2 of 2)

Q:

Is a condition onset flag (COF) of 1 assigned in the first admitted episode of care where HA SAB is diagnosed and a COF of 2 assigned for any subsequent admitted episode of care relating to the previously diagnosed HA SAB?

A:

ACS 0048 *Condition onset flag* states, "The condition onset flag is a means of differentiating those conditions which arise during, or arose before, an admitted patient episode of care." Therefore, it is agreed that a condition onset flag of 1 should be assigned in the episode of care where *Healthcare associated Staphylococcus aureus bacteraemia* (HA SAB) first arose and that a condition onset flag of 2 should be assigned in any subsequent episode of care relating to the previously diagnosed HA SAB, as it arose before the current admitted patient episode of care.

Published 15 December 2011,
for implementation 01 January 2012.

Ref No: Q2686 | Published On: 15-Dec-2011 | Status: Updated | Updated On: 15-Jun-2019

Clinical diagnosis versus histology

Q:

A patient is admitted for excision of a 'dermal cyst' from the arm. The clinician documents 'dermal cyst' both pre and post surgery, however, the histology shows the lesion to be an angiomyoma. Should the guideline in ACS 0010 *Clinical documentation and general abstraction guidelines*, be followed, which states, "In the event that an investigation result varies from the clinical documentation, such as a clinical diagnosis of gastric ulcer with 'no evidence of ulcer' reported on histopathology, the case should be referred to the clinician." Or should the ACS 0010 guideline, be followed, which states, "Laboratory, x-ray, pathological and other diagnostic results should be coded where they clearly add specificity to already documented conditions."

A:

In the scenario cited, the clinician has documented a clinical diagnosis of 'dermal cyst' in the absence of histological examination. However, histology reveals an 'angiomyoma', which appears contradictory to the original clinical diagnosis. If the clinician was asked to confirm the diagnosis with the benefit of the histology report, the question is, would the documentation be 'dermal cyst' or 'angiomyoma'? As per the guidelines in ACS 0010 *Clinical documentation and general abstraction guidelines*, "In the event that an investigation result varies from the clinical documentation..., the case should be referred to the clinician."

ACS 0010 also states, "It is important to seek clinical advice where necessary for clarification of discrepancies between investigation results and clinical documentation." Therefore, where there is discrepancy between the clinical diagnosis and histology, as cited in this scenario, clinical verification should be sought prior to code assignment.

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

Published 15 December 2011,
for implementation 01 January 2012.

Ref No: Q2737 | Published On: 15-Dec-2011 | Status: Updated | Updated On: 15-Jun-2019

Morphology of recurrent mediastinal tumour

Q:

What is the appropriate morphology code to assign in the following scenario? Patient admitted with recurrence of mediastinal tumour where original biopsy revealed "malignant cystic histiocytoma - M8830/3". Supplementary histology report states morphology to be "malignant ossifying fibromyxoid tumour - M8842/3". Note only /0 and /1 are contained in Appendix A: *Morphology of neoplasms*. Approximately a year later, the recurrence is resected and histology now states "high grade undifferentiated sarcoma - M8805/3". Clinician states it is a recurrence of original tumour.

A:

Where there is doubt about the correct morphology code to assign due to ambiguous documentation in the clinical record, clinical coders should be guided by the principles in ACS 0010 *Clinical documentation and general abstraction guidelines*, which state:

"It is important to seek clinical advice where necessary for:

- verification of diagnoses recorded on the front sheet and/or the discharge summary which are not supported in the clinical record, **and**
- clarification of discrepancies between investigation results and clinical documentation"
- For the scenario cited:
- the original morphology code (M8830/3 *Malignant fibrous histiocytoma*) should not be assigned as it appears to have been superseded by the supplementary report.
- in the first instance, confirmation should be sought from the clinician as to the correct morphology code to assign.
- where clinical confirmation is not possible clinical coders should be guided by the histopathology report in the current episode of care and assign M8805/3 *Undifferentiated sarcoma*.

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

Published 15 December 2011,
for implementation 01 January 2012.

Ref No: Q2620 | Published On: 15-Apr-2011 | Status: Updated | Updated On: 15-Jun-2019

Principal diagnosis for insertion of fiducial markers (use of Z51.4 *Preparatory care for subsequent treatment, not elsewhere classified*)

Q:

What is the correct principal diagnosis code to assign in an admission for insertion of fiducial markers? Should the principal diagnosis be the condition necessitating insertion of fiducial markers or Z51.4 *Preparatory care for subsequent treatment, not elsewhere classified*?

A:

It is acknowledged there may be inconsistency in the assignment of Z51.4 *Preparatory care for subsequent treatment, not elsewhere classified*. The issue arises where there is uncertainty as to the correct selection of principal diagnosis. Should Z51.4 be assigned as the principal diagnosis, indicating the episode of care is primarily for preparatory care, or should the condition necessitating the preparatory care be assigned as the principal diagnosis e.g. the neoplasm? The answer to this question has wider implications for the assignment of 'Z' codes in other episodes of care. These implications require further analysis and review, which will be considered for a future edition of ICD-10-AM. In the interim follow the principle of the advice issued by the NCCH in Coding Matters, Volume 16, Number 4, March 2010, which states:

> "...assign the condition as the principal diagnosis for brachytherapy planning..."

Therefore, for the scenario cited, assign the condition necessitating the insertion of fiducial markers as the principal diagnosis.

Published 15 April 2011,
for implementation 01 May 2011.

Ref No: Q2622 | Published On: 15-Apr-2011 | Status: Updated | Updated On: 15-Jun-2019

Hypertensive kidney disease with kidney failure (I12.0)

Q:

Is I12.0 Hypertensive kidney disease with kidney failure intended for use when hypertensive kidney disease is present with acute kidney failure?

A:

Clinical advice states that:

- Hypertension can be associated with all forms of renal disease. However, it is unlikely that sustained hypertension per se will arise from, and be the cause of, chronic kidney disease (CKD) if acute kidney failure/injury fully resolves.
- Clinically acute kidney failure/injury is a separate condition from chronic kidney disease (CKD), though it may result in CKD if it does not fully resolve.
- Hypertension can pre-date acute kidney failure/injury, of course, and may well outlast it.
- Hypertension can also persist, having arisen due to the acute kidney failure/injury, if the acute kidney failure/injury does not fully resolve.
- Many forms of acute kidney failure/injury are associated with hypertension.
- Rapidly progressive hypertension (and malignant hypertension) can cause acute kidney failure/injury and result in CKD (and/or permanent complete loss of renal function).

Lawrence McMahon, Professor of Nephrology, Monash University (personal communication, 16 September 2010).
So, clinically, while there is an association between acute kidney failure/injury and hypertension and unresolved acute kidney failure/injury may progress to CKD, there is no direct cause and effect relationship between acute kidney failure/injury and hypertensive kidney disease. Category I12 Hypertensive kidney disease does not include the concept of acute renal failure and specifies only those conditions where there is a causal relationship between certain kidney conditions and hypertension, specifically:

> "any condition in N00-N07, N18.-, N19 or N26 due to hypertension arteriosclerosis of kidney arteriosclerotic nephritis (chronic)(interstitial) hypertensive nephropathy nephrosclerosis"

This is further confirmed in ACS 1438 Chronic kidney disease, Definition where it states:
"Note: Prior to the defining of chronic kidney disease, the term 'chronic renal failure' described both 'failing' and 'failed' kidneys and no further description was required when classifying. Under the new definition of chronic kidney disease, 'kidney failure' in a chronic context, is not described until the kidneys have ceased to function, that is, failed. This is CKD stage 5, as measured by the glomerular filtration rate (GFR) or the requirement for ongoing kidney replacement therapy, or by documentation of 'end-stage' kidney failure. Therefore, 'failure' status must be validated by documentation and/or GFR (eGFR) level before assigning codes qualified by 'with kidney failure', for example, I12.0 Hypertensive kidney disease with kidney failure."

In summary, I12.0 Hypertensive kidney disease with kidney failure does not include the concept of acute renal failure, and can only be assigned with acute renal failure in instances where acute on chronic renal failure is documented.

Amendments may be considered for a future edition.

Published 15 April 2011,
for implementation 01 May 2011.

Ref No: TN126 | Published On: 15-Apr-2011 | Status: Updated | Updated On: 01-Jul-2017

Pelvic collection

Q:

What is the correct disease code for 'pelvic collection'?

A:

'Pelvic collection' is not a diagnosis but a sign of other conditions. For example, it may be a sign of pelvic inflammatory disease, or a sign of malignancy, or a sign of infection after procedures on pelvic organs (such as pus collection in the Pouch of Douglas after vaginal hysterectomy). The 'collection' itself may be of blood, peritoneal fluid, bowel contents, pus or an abscess. To assign the correct code(s) for 'pelvic collection' follow the guidelines below:

1. First seek further documentation/clinical advice to determine a diagnosis or to establish the nature of the sign (eg infection, abscess, blood), then code accordingly, for example:
- pelvic inflammatory disease (N73.9 *Female pelvic inflammatory disease, unspecified*)
- postprocedural abscess of peritoneum (T81.4 *Wound infection following a procedure, not elsewhere classified*).

2. In instances where the collection is stated as due to a procedure follow direction provided in ACS 1904 *Procedural Complications.*

3. If further documentation/clinical advice is not available, assign:R19.89 *Other specified symptoms and signs involving the digestive system and abdomen* following the Alphabetic Index:

Symptoms specified NEC
- involving
- - pelvis NEC R19.89

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

Published 15 April 2011,
for implementation 01 May 2011.

Ref No: Q2611 | Published On: 15-Oct-2010 | Status: Updated | Updated On: 15-Jun-2019

Open reduction and internal fixation (ORIF) proximal femur

Q:

The index lookup below assigns ORIF femur to 47528-01 *Open reduction of fracture of femur with internal fixation*, which has an excludes note 'for that of proximal femur (47519-00 **[1479]**)'. However, 47519-00 **[1479]** *Internal fixation of fracture of trochanteric or subcapital femur* does not capture that this was an open reduction. Is this excludes in the correct spot? Is it correct that for ORIF of the proximal femur (subcapital, trochanteric etc) that code 47519-00 be assigned instead of 47528-01? The indexing doesn't seem to support the excludes notes as the proximal femur sites are not indexed under the open reduction?

Reduction
- fracture (bone) (with cast) (with splint)
- - femur (closed) 47516-01 **[1486]**
- - - with internal fixation (cross) (intramedullary) 47531-00 **[1486]**
- - - - neck 47519-00 **[1479]**
- - - - pertrochanteric 47519-00 [**1479**]
- - - - proximal 47519-00 **[1479]**
- - - - subcapital 47519-00 **[1479]**
- - - - subtrochanteric 47519-00 [**1479**]
- - - - trochanteric 47519-00 **[1479]**
- - - epiphysis (capital) (slipped) 47525-00 **[1493]**
- - - open 47528-00 **[1486]**
- - - - with internal fixation (cross) (intramedullary) 47528-01 **[1486]**
- - - - epiphysis (capital) (slipped) 47525-01 **[1493]**

A:

This is an example of where the *Conventions used in the ACHI Alphabetic Index* are applied:
"PREPOSITIONAL TERMS Wherever a preposition from the list below immediately follows a lead term or subterm, they always take precedence over symbols, numbers and the alphabetic sequence of subterms:

- as
- by
- for
- with
- without"

Therefore, the correct code assignment for ORIF of the proximal femur (subcapital, trochanteric etc) is 47519-00 **[1479]** *Internal fixation of fracture of trochanteric or subcapital femur*, following the prepositional subterm 'with' in the index pathway:

Reduction
- fracture (bone) (with cast) (with splint)
- - femur (closed) 47516-01 **[1486]**
- - - with internal fixation (cross) (intramedullary) 47531-00 **[1486]**
- - - - proximal 47519-00 **[1479]**

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

Published 15 October 2010,
for implementation 01 November 2010.

Ref No: TN184 | Published On: 15-Oct-2010 | Status: Updated | Updated On: 15-Jun-2019

Anaemia in chronic diseases

Q:

When can code D63* *Anaemia in chronic diseases classified elsewhere* be assigned?

A:

This code can only be assigned for the following indexed conditions:

Anaemia
- brickmaker's B76.9+ D63*
- Diphyllobothrium (Dibothriocephalus) B70.0+ D63*
- due to
- - myxoedema E03.9+ D63*
- Egyptian B76.9+ D63*
- hookworm B76.9+ D63*
- malarial *(see also Malaria)* B54+ D63*
- marsh *(see also Malaria)* B54+ D63*
- miner's B76.9+ D63*
- paludal *(see also Malaria)* B54+ D63*
- syphilitic (acquired) (late) A52.7+ D63*
- tropical B76.9+ D63*
- tuberculous A18.8+ D63*

Chlorosis
- Egyptian B76.9+ D63*
- miner's B76.9+ D63*

Syphilis, syphilitic (acquired)
- anaemia (late) A52.7+ D63*

Tuberculosis, tubercular, tuberculous (caseous) (degeneration) (gangrene) (necrosis)
- anaemia A18.8+ D63*

Follow coding guidelines relating to aetiology and manifestation (dagger and asterisk) convention in ACS 0001 *Principal diagnosis.*

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

Published 15 October 2010,
for implementation 01 November 2010.

Ref No: TN199 | Published On: 15-Jun-2010 | Status: Updated | Updated On: 30-Jun-2013

Fracture of hip prosthesis due to trauma

Q:

ACS 1309 *Dislocation or complication of hip prosthesis* states:

> 'Assign the code S73.0- *Dislocation of hip* with an additional diagnosis code of Z96.64 *Presence of hip implant* when a patient sustains a dislocation of a hip prosthesis...'

Does this ACS also apply to fractures of hip prostheses due to trauma, ie should an injury code be assigned or is T84.0 *Mechanical complication of internal joint prosthesis* the correct code?

A:

The guidelines in ACS 1309 *Dislocation or complication of hip prosthesis* do apply to fractures of hip prostheses due to trauma. Appropriate injury and external cause of injury codes should be assigned to reflect the trauma. T84.0 *Mechanical complication of internal joint prosthesis* should be assigned where the conditions listed in T82.0 are specified as due to the joint prosthesis, as per the inclusion term at T84.0 and also following the criteria in ACS 1309 *Dislocation or complication of hip prosthesis*.

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

Published 15 June 2010,
for implementation 01 July 2010.

Ref No: TN203 | Published On: 15-Sep-2008 | Status: Updated | Updated On: 01-Jul-2017

Obstetrics/Gynaecology

Q:

Does anaemia and pre-existing anaemia need to meet ACS 0002 for the combined code to be assigned?

A:

For a code to be assigned from category O99.0- *Anaemia complicating pregnancy, childbirth and the puerperium*, the 'anaemia' firstly needs to meet ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*. However, as per the ICD-10-AM index:

Anaemia D64.9
- in pregnancy, childbirth or puerperium O99.00
-- affecting fetus or newborn P00.8
- - childbirth or puerperium NEC O99.03
- - - with mention of pre-existing anaemia O99.04
-- pregnancy O99.01
-- - with mention of pre-existing anaemia O99.02
- - puerperal, postpartum NEC O99.03
- - - with mention of pre-existing anaemia O99.04

Once it has been determined that anaemia requires coding in accordance with ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*, the 'pre-existing anaemia' component only needs to be 'mentioned' and therefore does not itself have to meet ACS 0001 or ACS 0002 for the appropriate fifth character code to be assigned.

Q:

Why wasn't 'postpartum' removed from 16564-00 *Postpartum evacuation of uterus by dilation and curettage* and 16564-01 *Postpartum evacuation of uterus by suction curettage* in block **[1345]** given that the diagnostic detail was removed from the other D&C codes?

A:

The term 'postpartum' could not be removed from the above codes in block [1345] as these are specific procedures which are performed in the postpartum period for retained products of conception and need to be distinguished from other evacuation of uterus codes in block **[1265]**.

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

Published 15 September 2008,
for implementation 01 October 2008.

Ref No: TN204 | Published On: 15-Jun-2008 | Status: Updated | Updated On: 01-Jul-2017

Seprafilm®

Q:

Is it necessary to assign a code for Seprafilm® inserted during a procedure?

A:

To reduce the occurrence of adhesions following surgery, surgeons can use adhesion barriers to separate tissue and organs while the body heals. Seprafilm® is a type of adhesion barrier composed of chemically modified sugars, some of which occur naturally in the human body. It is a clear film that sticks to the tissues to which it is applied and is slowly absorbed into the body over a period of seven days. It is placed at sites of tissue injury during surgery (commonly abdominal and pelvic surgery) to help prevent the formation of adhesions between tissues and organs. The insertion of Seprafilm® is a prophylactic measure which is completely absorbed into the body and does not require removal. It is unnecessary to assign a code for this procedure.

Bibliography

Fazio, VW, Cohen, Z, Fleshman, JW, van Goor, H, Bauer, JJ, Wolff, BG, Corman, M, Beart, RW Jr, Wexner, SD, Becker, JM, Monson, JR, Kaufman, HS, Beck, DE, Bailey, HR, Ludwig, KA, Stamos, MJ, Darzi, A, Bleday, R, Dorazio, R, Madoff, RD, Smith, LE, Gearhart, S, Lillemoe, K and Gohl, J (2006), Reduction in adhesive small-bowel obstruction by Seprafilm adhesion barrier after intestinal resection, Diseases of the colon and rectum, Vol. 49, No. 1, pp. 1-11.Genzyme Corporation (2012), Seprafilm Adhesion Barrier, accessed: 22 April 2013, available: www.seprafilm.com.

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

Published 15 June 2008,
for implementation 01 July 2008.

Ref No: TN207 | Published On: 15-Sep-2007 | Status: Updated | Updated On: 15-Jun-2019

Insulin pumps

Q:

What is the correct code to assign for insulin delivered via an insulin pump?

A:

An insulin pump is not implanted in the body. It is a small, pager-sized device you wear or carry. It is made up of a pump reservoir (like a regular syringe) filled with insulin, one or more small batteries, and a simple programmable interface. It is connected to the body via a thin tube, called an infusion set, which delivers small, constant amounts of insulin via a subcutaneous cannula attached to a small needle. In most cases patients insert and change the cannula/needle themselves, every 2-3 days, at home. The insulin pump is programmed (by the user) to administer a basal rate of insulin continuously throughout the day and night, depending on individual needs. Patients activate the pump to deliver a bolus dose of insulin during meals.

Patients may also administer a bolus dose in response to high blood glucose levels. Insulin pumps contain ultra short acting insulin only. Patients may be admitted to hospital for fitting/commencement of an insulin pump or conversion to a new pump. Administration of insulin via an insulin pump is not normally coded as per ACS 0042 *Procedures normally not coded*:

Drug treatment should not be coded except if:

- the substance is given as the principal treatment in same-day episodes of care
- drug treatment is specifically addressed in a coding standard (see ACS 0044 *Pharmacotherapy*, ACS 1316 *Cement spacer/beads* and ACS 1615 *Specific diseases and interventions related to the sick neonate*)

However, where insulin is administered via an insulin pump as the principal treatment in same-day episodes of care, assign:

96200-06 **[1920]** *Subcutaneous administration of pharmacological agent, insulin*
96209-06 **[1920]** *Loading of drug delivery device, insulin*.

If the patient's pump is loaded with insulin but they do not receive a dose during the episode of care, assign only:

96209-06 **[1920]** *Loading of drug delivery device, insulin*

Bibliography

Accu-Check, What is an insulin pump? Roche Diagnostics. Accessed 14 August 2007. http://www.accu-chek.com.au/index.asp

Diabetes 123 and Children with Diabetes, Pump Basics. Accessed 14 August 2007. http://www.diabetes123.com/pumps/basics.htm

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

Published 15 September 2007,
for implementation 01 October 2007.