Contents

Ref No: Q3464 | Published On: 20-Mar-2020 | Status: Current

Periodic limb movement disorder

Q:

What code is assigned for periodic limb movement disorder?

A:

Periodic limb movement disorder (PLMD) is a sleep disorder characterised by repetitive cramping or jerking of the limbs (most commonly the legs) during sleep (Ondo 2019; WebMD n.d.). PLMD is related to, but not the same as, restless leg syndrome (Anderson 2019).

Historically, PLMD was called nocturnal myoclonus. This name is no longer used as PLMD movements are not myoclonic (ie rapid, rhythmic contraction of a group of muscles similar to that seen in seizures) (WebMD n.d.).

Assign G47.8 *Other sleep disorders* for periodic limb movement disorder.

Follow the ICD 10 AM Alphabetic Index:

Disorder (of)
…
- sleep
…
- - specified NEC G47.8

or

Parasomnia G47.8

Amendments will be considered for a future edition.

References:

Anderson, W. 2019, *Periodic limb movement disorder*, Medscape, viewed 9 January 2020, <https://emedicine.medscape.com/article/1188558-overview>.
Ondo, W. 2020, *Clinical features and diagnosis of restless legs syndrome and periodic limb movement disorder in adults*, UpToDate, viewed 9 January 2020, https://www.uptodate.com/contents/clinical-features-and-diagnosis-of-restless-legs-syndrome-and-periodic-limb-movement-disorder-in-adults.
WebMD n.d., *Periodic limb movement disorder*, WebMD, viewed 19 December 2019, https://www.webmd.com/sleep-disorders/periodic-limb-movement-disorder#1.

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Insertion of Fetal Pillow®

Q:

What code is assigned for insertion of Fetal Pillow®?

A:

Fetal Pillow® is a balloon device used to assist with disimpacting an engaged fetal head at full dilation immediately prior to caesarean section.

The balloon device is inserted vaginally and placed beneath the fetal head. Inflation of the balloon with saline lifts and dislodges the fetal head from the maternal pelvis (Bisht 2019; Safe Obstetric Systems n.d.).

Where insertion of a Fetal Pillow® is documented with an emergency caesarean section, assign a code for the emergency caesarean section from block **[1340]** *Caesarean section*. Insertion of the Fetal Pillow® is a procedure component and therefore is not coded as per the guidelines in ACS 0016 *General procedure guidelines/Procedure components*. This is consistent with the *Includes* note at block **[1340]**, which identifies other procedures inherent in caesarean section (ie forceps, manual removal of placenta, suture of uterine lacerations/tears).

Amendments will be considered for a future edition.

References:

Bisht, S. 2019, *Fetal Pillow – Guidelines to use (GL1046)*, Royal Berkshire NHS Foundation Trust, viewed 11 November 2019, https://www.royalberkshire.nhs.uk/Downloads/GPs/GP%20protocols%20and%20guidelines/Maternity%20Guidelines%20and%20Policies/Intrapartum/Fetal%20pillow_V2.0_GL1046_APR19.pdf.

Safe Obstetric Systems Limited n.d., *Fetal Pillow*, Safe Obstetrics Systems Limited, viewed 11 November 2019, https://www.safeob.com/fetalpillow.html.

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Hypothenar fat pad and nerve wrap performed with a revision procedure for carpal tunnel syndrome

Q:

What codes are assigned for revision decompression surgery for carpal tunnel syndrome involving a hypothenar fat pad flap or isolated nerve wrap?

A:

Surgical treatment for recurrent or persistent carpal tunnel syndrome may use a number of techniques, including revision decompression, collagen nerve wrap and adipofascial flap (Konopka et al. 2017). Isolated (collagen) nerve wraps are used in revision surgery to prevent scars from recurring (Konopka et al. 2017).

The hypothenar fat pad flap (HTFPF) uses fat tissue from the hypothenar eminence as a pedicle flap to cover the median nerve (Kanchanathepsak et al. 2017). The flap provides protection to the median nerve by stopping structures within the carpal tunnel from adhering to it and allowing the nerve to glide freely (Kanchanathepsak et al. 2017).

CLASSIFICATION

When an isolated (collagen) nerve wrap is performed during the revision decompression surgery for carpal tunnel syndrome, it is not necessary to assign a separate code as it is inherent in the decompression procedure.

HTFPF is not inherent in revision decompression surgery. Assign:

39331-01 **[76]** *Release of carpal tunnel*
45563-00 **[1673]** *Island flap with vascular pedicle*

Follow the ACHI Alphabetic Index:

Release
- carpal tunnel (open) 39331-01 **[76]**

Flap (repair)
- island
- - with
- - - vascular pedicle (noninnervated) 45563-00 **[1673]**

References:
Kanchanathepsak, T., Wairojanakul, W., Phakdepiboon, T., Suppaphol, S., Watcharananan, I. & Tawonsawatruk, T. 2017, 'Hypothenar fat pad flap vs conventional open release in primary carpal tunnel syndrome: a randomized controlled trial', *World Journal of Orthopedics*, vol. 8, no. 11, pp. 846–852, viewed 23 January 2020, https://www.wjgnet.com/2218-5836/full/v8/i11/846.htm.
Konopka, G., Mundra, L.S., Perez, E.N. & Panthaki, Z.J. 2017, 'Revision decompression, collagen nerve wrap, and adipofascial flap for recurrent and persistent carpal tunnel syndrome', *Plastic and Reconstructive Surgery*, vol. 5, issue 9S, pp. 208–209, viewed 23 January 2020, https://journals.lww.com/prsgo/FullText/2017/09001/Abstract___Revision_Decompression,_Collagen_Nerve.310.Aspx.

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Aspiration pneumonia or ventilation associated pneumonia (VAP) with a specified infectious agent

Q:

What codes are assigned for aspiration pneumonia or VAP with a specified infectious organism?

A:

Codes from category B95–B97 *Bacterial, viral and other infectious agents* are assigned as additional diagnosis codes to identify the infectious agent(s) in diseases classified elsewhere.

The *Note* at B95–B97 states:

> *A code from these categories must be assigned if it provides more specificity about the infectious agent. Do not assign a code from these categories if the same agent has been identified in the infection code (eg streptococcal sepsis in A40.-).*

Therefore, where there is documentation of either *aspiration* pneumonia or *ventilation associated* pneumonia and cytology confirms an organism as an infectious agent, assign J69.0 *Pneumonitis due to food or vomit* or J95.82 *Ventilation associated pneumonia* with an additional code (B95–B97) to identify the infectious agent.

For example, for aspiration pneumonia with *Pseudomonas* documented as the infectious agent, assign:

J69.0 *Pneumonitis due to food or vomit*
B96.5 *Pseudomonas (aeruginosa) as the cause of diseases classified to other chapters*

Follow the ICD-10-AM Alphabetic Index:

Pneumonia (acute) (double) (migratory) (purulent) (septic) (unresolved)
- aspiration J69.0

Infection, infected (opportunistic)
- Pseudomonas, pseudomonad NEC
- - as cause of disease classified elsewhere B96.5

Amendments will be considered for a future edition.

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Ref No: Q3426 | Published On: 20-Mar-2020 | Status: Current

Large or grade 3 tonsils

Q:

Are ‘large’ or ‘grade 3’ tonsils synonymous terms for enlarged or hypertrophied?

A:

Tonsillar enlargement may be documented using a grading classification (eg Brodsky grading scale, Friedman grading scale, Modified 3-grade scale or Modified 5 grade scale). These size grading systems categorise the size of the tonsils based on the percentage/area of the oropharyngeal airway that is occupied by the two tonsils. Large tonsils may require surgical removal if they have an impact on health (eg swallowing difficulties, airflow limitation or obstructive sleep apnoea) (Jara & Weaver 2018; Kumar et al. 2014).

Where ‘large’ or ‘grade 3’ tonsils are documented and meet the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses* (eg as the indication for tonsillectomy), assign J35.1 *Hypertrophy of tonsils* or J35.3 *Hypertrophy of tonsils with hypertrophy of adenoids*.

Follow the ICD-10-AM Alphabetic Index:

Enlargement, enlarged — *see also Hypertrophy*
- tonsils J35.1
- - with adenoids J35.3

or

Hypertrophy
- tonsils (faucial) (infective) (lingual) (lymphoid)
- - with adenoids J35.3

Amendments may be considered for a future edition.

References:

Jara, S.M. & Weaver, E.M. 2018, ‘Association of palatine tonsil size and obstructive sleep apnea in adults’, *The Laryngoscope*, vol. 128, no. 4, viewed 30 October 2019, https://onlinelibrary.wiley.com/doi/abs/10.1002/lary.26928.
Kumar, D.S., Valenzuela, D., Kozak, F.K., Ludemann, J.P., Lea, J. & Chadha, N.K. 2014, ‘The reliability of clinical tonsil size grading in children’, *JAMA Otolaryngology-Head & Neck Surgery*, vol. 140, no. 11, viewed 30 October 2019, https://www.ncbi.nlm.nih.gov/pubmed/25317509.

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Ref No: Q3432 | Published On: 20-Mar-2020 | Status: Current

Assignment of F17.3 with Z72.0

Q:

Can Z72.0 *Tobacco use, current* be assigned with F17.3 *Mental and behavioural disorders due to use of tobacco, withdrawal state* in the same episode of care?

A:

While there is nothing in the ICD-10-AM Tabular List or Alphabetic Index, or the guidelines in ACS 0503 *Drug, alcohol and tobacco use disorders* to specify that F17.3 *Mental and behavioural disorders due to use of tobacco, withdrawal state* is not assigned concurrently with Z72.0 *Tobacco use, current*, withdrawal from tobacco (ie nicotine) is not clinically possible unless the patient is a current (chronic) user.

Therefore, as current tobacco (nicotine) use is inherent in F17.3, do not assign both of these codes in the same episode of care.

Where there is documentation that a patient is a current user and withdrawing from tobacco (nicotine), and meets the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*, assign F17.3 *Mental and behavioural disorders due to use of tobacco, withdrawal state*.

Follow the ICD-10-AM Alphabetic Index:

Tobacco (nicotine)
- withdrawal state F17.3

Amendments will be considered for a future edition.

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Ref No: Q3463 | Published On: 20-Mar-2020 | Status: Current

Detorsion of ovary

Q:

What code is assigned for detorsion of the ovary?

A:

Ovarian detorsion is a surgical intervention performed to treat torsion (ie twisting) of the ovary.

Detorsion may be performed with or without fixation (ie transposition/oophoropexy) of the ovary.

Assign a code for repair of the ovary:
35729-00 **[1245]** *Laparoscopic transposition of ovary*
35729-01 **[1245]** *Transposition of ovary*
90430-00 **[1246]** *Other laparoscopic repair of ovary*
90430-01 **[1246]** *Other repair of ovary*

Follow the ACHI Alphabetic Index:

Repair
- ovary
- - laparoscopic NEC 90430-00 **[1246]**
- - - by transposition 35729-00 **[1245]**
- - via laparotomy NEC 90430-01 **[1246]**
- - - by transposition 35729-01 **[1245]**

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Autoimmune lymphoproliferative syndrome (ALPS)

Q:

What codes are assigned for autoimmune lymphoproliferative syndrome?

A:

Autoimmune lymphoproliferative syndrome (ALPS) is a primary lymphoproliferative disorder. Lymphoproliferative disorders originate when the mechanisms that control lymphocytes break down, resulting in the uncontrolled increase of immune cells leading to lymphocytosis and lymphadenopathy, often involving extranodal sites (Justiz Vaillant & Stang 2019).

ALPS can manifest as lymphadenopathy, hepatomegaly or splenomegaly (van der Werff ten Bosch cited in Teachey et al. 2009). Other manifestations of ALPS include peripheral lymphocytosis, hypergammaglobulinemia, autoimmune cytopenias and rarely autoimmune glomerulonephritis and hepatitis (Lim & Elenitoba-Johnson 2004).

As per the guidelines in ACS 0005 *Syndromes*, in the absence of a single ICD-10-AM code to classify all the elements of ALPS, assign:

- code(s) for the manifestations that are relevant for the patient, and meet the criteria in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*

and

- U91 *Syndrome, not elsewhere classified*, as an additional diagnosis to flag that the manifestations are related to a syndrome.

Where no manifestation is documented or meets the criteria in ACS 0001 or ACS 0002, assign D89.8 *Other specified disorders involving the immune mechanism, not elsewhere classified* as a default, with U91.

Follow the ICD-10-AM Alphabetic Index:

Disorder (of)
- immune mechanism (immunity)
- - specified type NEC D89.8

Syndrome NEC *(see also Disease)* U91

Note that ALPS is not neoplastic; therefore, do not assign a neoplasm code by following the ICD-10-AM Alphabetic Index at *Disease, diseased/immunoproliferative.*

Amendments will be considered for a future edition.

References:

Justiz Vaillant, A.A. & Stang, C.M. 2019, 'Lymphoproliferative disorders', *StatPearls*, viewed 29 October 2019, https://www.ncbi.nlm.nih.gov/books/NBK537162/.
Lim, M.S. & Elenitoba-Johnson, K.S.J. 2004, 'The molecular pathology of primary immunodeficiencies', *The Journal of Molecular Diagnostics*, vol. 6, no. 2, pp. 59–83, viewed 9 October 2019, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1867474/.
Teachey, D.T., Seif, A.E. & Grupp, S.A. 2009, 'Advances in the management and understanding of autoimmune lymphoproliferative syndrome (ALPS)', *British Journal of Haematology*, vol. 148, no. 2, pp. 205–216, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2929682/.

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Ref No: Q3494 | Published On: 20-Mar-2020 | Status: Current

Body lift procedure

Q:

What code is assigned for body lift procedure?

A:

A body lift is a form of body contouring surgery that involves removing loose skin folds and extra fat, which results in improved shape and tone of the underlying tissue (Better Health Channel 2019). This procedure is also known as a lipectomy (Merriam Webster n.d.).

Assign multiple ACHI codes when body lift procedures are performed on multiple body regions.

Follow the ACHI Alphabetic Index at *Lipectomy/by site*.

For example, brachioplasty is classified in ACHI to *Lipectomy/arm*.

Follow the ACHI Alphabetic Index:

Brachioplasty — *see Lipectomy/arm*

Lipectomy
- arm (circumferential) (wedge)
- - 1 excision 30168-00 **[1666]**
- - 2 excisions 30171-00 **[1666]**
- - suction 45584-00 **[1666]**

Where there is no documentation of the number of excisions performed, follow the guidelines in ACS 0038 *Procedures distinguished on the basis of size, time, number of lesions or sites*; default to *Lipectomy/arm/1 excision*:

> *Where there is no documentation in the clinical record, no further information can be obtained from the clinician and there is no default in the index, assign the code for the smallest size, the least duration, the least number of lesions or sites, as appropriate.*

Amendments will be considered for a future edition.

References:

Better Health Channel 2019, *Body contouring surgery*, Department of Health and Human Services, Victoria, viewed 10 December 2019, https://www.betterhealth.vic.gov.au/health/ConditionsAndTreatments/body contouring surgery.
Merriam-Webster n.d., *Lipectomy*, Merriam-Webster, viewed 3 January 2020, https://www.merriam webster.com/medical/lipectomy.

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Clarification of code assignment for procedures assisting delivery

Amendments were made to procedures assisting delivery for ACHI and the ACS for Eleventh Edition. The guidelines in ACS 1505 *Delivery and assisted delivery codes* and the advice below will assist clinical coders in assigning codes for these episodes.

1.

- As per the table in ACS 1505, when O83 *Other assisted single delivery* or O84.81 *Multiple delivery, all assisted, not elsewhere classified* are assigned, one of the following ACHI codes must be assigned:
  90470-01 **[1339]** *Assisted breech delivery* OR
  90470-03 **[1339]** *Breech extraction* OR
  90477-01 **[1343]** *Assisted vertex delivery*
  ACHI codes for procedures to assist delivery are assigned in addition to one of the above codes.

  Example 1
  Patient admitted in labour (39/40). McRoberts manoeuvre performed, followed by vaginal delivery of health infant. Assign:
  O83 *Other assisted single delivery*
  Z37.0 *Single live birth*
  90477-01 **[1343]** *Assisted vertex delivery*
  90477-00 **[1343]** *Other procedures to assist delivery*

  Follow the ACHI Alphabetic Index:
  Delivery (spontaneous) (vertex)
  - assistance procedure (McRobert's manoeuvre) NEC *(see also specific interventions)* 90477-00 **[1343]**
  - assisted 90477-01 **[1343]**

  Note that an exception to the above guidelines is the rare scenario where an infant is delivered before arrival at a hospital, but delivery is completed during the admission (ie delivery of the placenta) – see ACS 1548 *Puerperal/postpartum condition or complication* Example 7.

1.

- The *Note* in ACS 1505 lists interventions that may be performed without affecting the assignment of O80 *Single spontaneous delivery*:
  Note: *Spontaneous delivery may include*:
  - *administrationof Syntocinon in third stage labour*
  - *controlled cord traction (CCT)*
  - *epidural injection/infusion*
  - *episiotomy with repair*
  - *fetal monitoring*
  - *medical or surgical:*
    - *augmentation of labour*
    - *induction*
  - *suture of obstetric perineal laceration*

  For classification purposes, once an assistance procedure (not listed above) is performed during the delivery episode of care (eg McRoberts manoeuvre, version, breech extraction), the delivery is ***not classified as spontaneous***

  Therefore, assign O80 if the delivery is assisted by one of the interventions listed above. If an assistance procedure is performed and it is not in the list above, do not assign O80.

Example 2
Patient admitted in labour (39/40). Internal fetal monitoring performed, followed by vaginal delivery of healthy infant. Assign:
O80 *Single spontaneous delivery*
Z37.0 *Single live birth*
90467-00 **[1336]** *Spontaneous vertex delivery*
16514-00 **[1341]** *Internal fetal monitoring*

Follow the ACHI Alphabetic Index:
Delivery (spontaneous) (vertex) 90467-00 **[1336]**
- assistance procedure (McRobert's manoeuvre) NEC *(see also specific interventions)*
…
- - fetal monitoring — *see Monitoring/fetal*

Monitoring
- fetal (CTG) (external)
- - internal (scalp) (via electrode(s)) 16514-00 **[1341]**

Example 3
Episiotomy performed to facilitate vaginal delivery of single term infant. Assign:
O80 *Single spontaneous delivery*
Z37.0 *Single live birth*
90467-00 **[1336]** *Spontaneous vertex delivery*
90472-00 **[1343]** *Episiotomy*

Follow the ACHI Alphabetic Index:
Delivery (spontaneous) (vertex) 90467-00 **[1336]**
- assistance procedure (McRobert's manoeuvre) NEC *(see also specific interventions)*
- - episiotomy 90472-00 **[1343]**

Example 4
Manual removal of placenta performed for retained placenta following spontaneous vaginal delivery (39/40) of a single fetus, assign:
O83 *Other assisted single delivery*
O73.0 *Retained placenta*
Z37.0 *Single live birth*
90477-01 **[1343]** *Assisted vertex delivery*
90482-00 **[1345]** *Manual removal of placenta*

Follow the ACHI Alphabetic Index:
Delivery (spontaneous) (vertex)
- assisted 90477-01 **[1343]**
…
- placenta NEC
- - postpartum — *see Removal/placenta*

Removal
- placenta
- - by
- - - manual (part) (whole) 90482-00 **[1345]**

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Encephaloduroarteriosynangiosis (EDAS)

Q:

What code is assigned for encephaloduroarteriosynangiosis (EDAS)?

A:

Encephaloduroarteriosynangiosis (EDAS) is an indirect cerebral revascularisation intervention where a section of a superficial scalp artery is redirected through the dura mater onto the brain.

New blood vessels grow from this artery into the brain to provide a source of blood to an ischaemic area. EDAS is performed for Moyamoya disease and symptomatic intracranial atherosclerosis (Columbia University Department of Neurological Surgery 2019; Laiwalla et al. 2017).

Assign 39818-00 **[21]** *Extracranial to intracranial bypass with superficial temporal artery graft* as a best fit for encephaloduroarteriosynangiosis.

Follow the ACHI Alphabetic Index:

Bypass
- extracranial to intracranial
- - with graft
- - - temporal artery (superficial) 39818-00 **[21]**

References:
Columbia University Department of Neurological Surgery 2019, *Encephaloduroarteriosynangiosis (EDAS)*, New York, viewed 18 December 2019, https://www.columbianeurosurgery.org/treatments/encephaloduroarteriosynangiosis-edas/.
Laiwalla, A.N., Kurth, F., Leu, K., Liou, R., Pamplona, J., Ooi, Y.C., Salamon, N., Ellingson, B.M. & Gonzalez, N.R. 2017, 'Evaluation of encephaloduroarteriosynangiosis efficacy using probabilistic independent component analysis applied to dynamic susceptibility contrast perfusion MRI', *American Journal of Neuroradiology*, vol. 38, no. 3, pp. 507–514, viewed 18 December 2019, http://www.ajnr.org/content/38/3/507.

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Fine needle aspiration (FNA) without documentation of biopsy

Q:

Is fine needle aspiration, without documentation of biopsy, classified in ACHI as a biopsy?

A:

Biopsy is a diagnostic intervention performed to extract a sample of tissue, fluid or cells for laboratory analysis. Fine needle aspiration (FNA) is a type of biopsy that involves a long, thin needle inserted into the target site with a syringe used to draw out tissue, fluid or cells.

A fine needle aspiration is usually performed via a percutaneous approach, and may be performed in a radiological department using image guidance.

The terms *percutaneous and needle* are inconsistently listed under the lead term *Biopsy*, and in the ACHI Tabular List. Where FNA of a particular site is not specifically indexed, follow the lead term *Biopsy* and assign a code for closed (percutaneous) needle biopsy. For example:

- 30094-05 **[977]** *Percutaneous needle biopsy of pancreas* for FNA of the pancreas and
- 30094-10 **[112]** *Percutaneous [needle] biopsy of thyroid gland* for FNA of the thyroid.

Follow the ACHI Alphabetic Index:

Biopsy (brush) (with brushing(s)) (with washing(s) for specimen collection)
- pancreas (open) 30075-16 **[977]**
- - percutaneous (closed) 30094-05 **[977]**
- thyroid gland (closed) (needle) (percutaneous) 30094-10 **[112]**

As aspiration may also be performed as a therapeutic intervention (ie drainage), documentation of aspiration without mention of biopsy or fine needle cannot be assumed to be a biopsy.

Where it is not clear in the documentation if an aspiration has been performed for diagnostic or therapeutic purposes, seek clarification from the clinician.

Amendments will be considered for a future edition.

References:
Mayo Clinic Staff 2019, *Biopsy: types of biopsy procedures used to diagnose cancer*, viewed 27 September 2019, https://www.mayoclinic.org/diseases conditions/cancer/in depth/biopsy/art 20043922.

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Ref No: Q3466 | Published On: 20-Mar-2020 | Status: Current

Ligament Augmentation and Reconstruction System (LARS)™

Q:

What code is assigned for gluteal tendon reconstruction using the Ligament Augmentation and Reconstruction System™?

A:

The Ligament Augmentation and Reconstruction System (LARS)™ uses tightly woven synthetic material designed to repair soft tissue injury or weakness, provide joint stability and promote healing after surgery (Bucher et al. 2014; Ebert et al. 2018).

During surgical repair of gluteal tendon tears, a tunnel is created through the greater trochanter.

One end of the LARS™ is sutured onto the under surface of the gluteus medius muscle. The free end of the LARS™ is drawn through the tunnel bringing the gluteal tendon in to where it normally inserts. Then, an interference screw is placed into the bone tunnel to secure the tension in the ligament–bone interface (Australian New Zealand Clinical Trials Registry 2016; Corin Group 2013).

Assign 47954-00 **[1572]** *Repair of tendon, not elsewhere classified*.

Follow the ACHI Alphabetic Index:

Repair
- tendon 47954-00 **[1572]**

Amendments will be considered for a future edition.

References:

Australian New Zealand Clinical Trials Registry 2016, *Surgical reconstruction of gluteal tendon tears*, ANZCTR, viewed 12 February 2020, https://www.anzctr.org.au/Trial/Registration/TrialReview.aspx?id=371934.
Bucher, T.A., Darcy, P., Ebert, J.R., Smith, A. & Janes, G. 2014, 'Gluteal tendon repair augmented with a synthetic ligament: surgical technique and a case series', *Hip International*, vol. 24, no. 2, pp. 187–193, viewed 12 February 2020, https://www.ncbi.nlm.nih.gov/pubmed/24186680.
Corin Group 2013, *LARS™ gluteal tendon repair and reinforcement surgical technique*, viewed 18 December 2019, https://www.coringroup.com/assets/product-resources/LARS/Resources-Product-Literature-LARS-Gluteal-Tendon-Repair-and-Reinforcement-Surgical-Technique.pdf.
Ebert, J.R., Bucher, T.A., Mullan, C.J. & Janes, G.C. 2018, 'Clinical and functional outcomes after augmented hip abductor tendon repair', *Hip International*, vol. 28, no. 1, pp. 74–83, viewed 12 February 2020, https://www.ncbi.nlm.nih.gov/pubmed/28967055.

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Malignant and metastatic melanotic neuroectodermal tumour

Q:

What codes are assigned for malignant and metastatic melanotic neuroectodermal tumour?

A:

Melanotic neuroectodermal tumour of infancy (MNTI) is a rare neoplasm of early infancy. Lesions most commonly affect the maxilla of infants in the first year of life, but may also occur in the mandible, skull, brain, epididymis and other rare locations. Most MNTIs are benign, but may be locally invasive. Malignant transformation and metastases may occur but are extremely rare (Kruse Lösler et al. 2006).

Two morphology codes for melanotic neuroectodermal tumour are included in the ICD-10-AM Tabular List Appendix A: *Morphology of neoplasms/Coded nomenclature for morphology of neoplasms*:

Coded nomenclature of morphology of neoplasms
M9363/0 Melanotic neuroectodermal tumour
✪*M9363/1 Melanotic neuroectodermal tumour, uncertain whether benign or malignant*

In the absence of morphology codes for melanotic neuroectodermal tumour with behaviours /3 *Malignant, primary site* or /6 *Malignant, metastatic site*, assign as a best fit:

- Topography code(s) from blocks:
  - C00–C75 *Malignant neoplasms, stated or presumed to be primary, of specified sites, except of lymphoid, haematopoietic and related tissue*
  - C76–C80 *Malignant neoplasms of ill-defined, secondary and unspecified sites*
- M9363/1 *Melanotic neuroectodermal tumour, uncertain whether benign or malignant*.

Amendments will be considered for a future edition.

References:

Kruse-Lösler, B., Gaertner, C., Bürger, H., Seper, L., Joos, U. & Kleinheinz, J. 2006, 'Melanotic neuroectodermal tumor of infancy: systematic review of the literature and presentation of a case', *Oral Surgery, Oral Medicine, Oral Pathology, Oral Radiology, and Endodontology*, vol. 102, issue 2, pp. 204–216, viewed, 30 October 2019, https://www.sciencedirect.com/science/article/pii/S1079210405006992?via%3Dihub.

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Ref No: Q3433 | Published On: 20-Mar-2020 | Status: Current

Mesorectal lymph nodes

Q:

What code is assigned for metastatic mesorectal lymph nodes?

A:

The mesorectum is the fatty tissue envelope of the rectum containing blood and lymph vessels, lymph nodes and autonomic nerves (Havenga et al. 2007). It is a subsection of the mesentery attached to the upper third of the rectum (Joseph 2018).

Where metastatic mesorectal lymph nodes not otherwise specified (NOS) is documented, seek clinical clarification as to the anatomic location of the lymph node. Where clinical consultation is not possible, assign C77.2 *(Secondary and unspecified malignant neoplasm of) Intra-abdominal lymph nodes* as a best fit.

Follow the ICD-10-AM Alphabetic Index:

Neoplasm, neoplastic
- lymph, lymphatic
- - gland (secondary)
- - - mesenteric (inferior) (superior) C77.2

References:

Havenga, K., Grossmann, I., DeRuiter, M. & Wiggers, T. 2007, 'Definition of total mesorectal excision, including the perineal phase: technical considerations', *Digestive Diseases*, vol. 25, pp. 44–50, viewed 5 December 2019, https://www.karger.com/Article/PDF/99169.
Joseph, R. 2018, *The mesentery*, TeachMeAnatomy, viewed 5 December 2019, https://teachmeanatomy.info/abdomen/viscera/mesentery/.

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Petersen's defect with or without hernia

Q:

What codes are assigned for Petersen's defect with and without hernia?

A:

Petersen's defect is defined as the potential space between the small bowel limbs and the transverse mesocolon after any type of gastrojejunostomy, especially the Roux-en-Y anastomosis (Hirahara et al. 2015). The internal herniation of the small intestine through this potential space is called a Petersen's hernia, which is a type of internal trans-mesenteric hernia (Hirahara et al. 2015; Crispin-Trebejo et al. 2014).

In adults, the predisposing factors for the differing types of internal trans-mesenteric hernias include previous gastrointestinal surgery, abdominal trauma, intraperitoneal inflammation and congenital abnormalities (Crispin-Trebejo et al. 2014).

Clinical advice confirms that Petersen's defect, by definition, is a procedural complication, which means it meets the ACS 1904 *Procedural complications* criteria below:

> *Qualifying terms such as 'intraoperative', 'postoperative' or 'postprocedural' may be documented in the clinical record, however these terms may only refer to the timing of an event that occurred during, or after, the procedure. Conditions described in this way should be assigned procedural complication codes only if they meet the following criteria:*
> …
> - *Certain conditions where the relationship is inherent in the diagnosis (eg infection or bleeding of a surgical wound, stoma or anastomosis, wound dehiscence, transfusion related acute lung injury)*
>
> …

CLASSIFICATION
As per the guidelines in ACS 1904:

- Where Petersen's defect without hernia is documented, assign:
  K91.89 *Other intraoperative and postprocedural disorders of digestive system, not elsewhere classified*
  K66.8 *Other specified disorders of peritoneum*
  Appropriate external cause and place of occurrence codes.

- Where Petersen's defect with hernia is documented, assign:
  K91.89 *Other intraoperative and postprocedural disorders of digestive system, not elsewhere classified*
  K45.8 *Other specified abdominal hernia without obstruction or gangrene*
  Appropriate external cause and place of occurrence codes.

Follow the ICD-10-AM Alphabetic Index:

Complication(s) (from) (of)
- gastrointestinal
- - intraoperative or postprocedural
- - - specified NEC K91.89

Disease, diseased
- peritoneum
- - specified NEC K66.8

Hernia, hernial (acquired) (recurrent)
- abdomen, abdominal
- - specified site NEC K45.8

Note that where clinical documentation specifies that the cause of Petersen's defect or hernia is not a procedural complication (ie it is due to another specified cause such as congenital malformation), do not apply the guidelines in ACS 1904.

For closure of Petersen's defect, assign 90329-03 **[1000]** *Other repair of mesentery*. Also assign 90307-00 **[903]** *Other procedure on small intestine* where Petersen's hernia is reduced prior to closure of the defect.

Follow the ACHI Alphabetic Index:

Repair
- mesentery 90329-03 **[1000]**

Procedure
- intestine
- - small NEC 90307-00 **[903]**

Amendments may be considered for a future edition.

References:
Crispin-Trebejo, B., Robles-Cuadros, M.C., Orendo-Velasquez, E. & Andrade, F.P. 2014, 'Internal abdominal hernia: intestinal obstruction due to trans-mesenteric hernia containing transverse colon', *International Journal of Surgery Case Reports*, vol. 5, no. 7, pp. 396–398, viewed 2 September 2019, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4064401/.
Hirahara, N., Matsubara, I., Hayashi, H., Takai, K., Fujii, Y. & Tajima, Y. 2015, 'Easy and secure closure of Petersen's defect after laparoscopic distal gastrectomy with Roux-en-Y reconstruction', *Journal of Laparoendoscopic & Advanced Surgical Techniques*, vol. 25, no. 1, pp. 55–59, viewed 2 September 2019, https://www.ncbi.nlm.nih.gov/pubmed/25531205.

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Positive human papillomavirus (HPV) test result as indication for colposcopy

Q:

What code is assigned for human papillomavirus (HPV) with no other findings at colposcopy?

A:

On 1 December 2017, Australia moved to a new National Cervical Screening Program (NCSP), which uses primary human papillomavirus (HPV) nucleic acid testing (NAT), followed by reflex liquid-based cytology, to detect high-grade cervical disease (Hawkes 2018). Screening for HPV strains that cause cervical cancer has proven to be more sensitive than screening for abnormal cytology (Pap test). Women with abnormal cytology results often require a colposcopy to confirm if they need treatment (Porras et al. 2012).

Where a positive HPV test result is documented as the indication for colposcopy, but no associated condition is detected, apply the guidelines in ACS 0051 *Same day endoscopy – diagnostic/Classification*:

> …
> ***1.3 If there are no findings*** *at diagnostic endoscopy, assign a code for the indication/symptom as the principal diagnosis.*
> …

and assign R87.5 *Abnormal findings in specimens from female genital organs, abnormal microbiological findings*.

Follow the ICD-10-AM Alphabetic Index:

Abnormal, abnormality, abnormalities
- specimen
- - female genital organs (secretions) (smears) R87.-

The fourth character .5 *abnormal microbiological findings* is located in the ICD-10-AM Tabular List under block R83–R89 *Abnormal findings on examination of other body fluids, substances and tissues, without diagnosis*.

References:

Hawkes, D. 2018, 'Human papillomavirus testing as part of the renewed National Cervical Screening Program', *Australian Journal of General Practice*, vol. 47, issue 7, viewed 29 November 2019, https://www1.racgp.org.au/ajgp/2018/july/national cervical screening program.
Porras, C., Wentzenen, N., Rodriguez, A.C., Morales, J., Burk, R.D., Alfaro, M., Hutchinson, M., Herrero, R., Hildesheim, A., Sherman, M.E., Wacholder, S., Solomon, D. & Schiffman, M. 2012, 'Switch from cytology-based to HPV-based cervical screening: implications for colposcopy', *International Journal of Cancer*, vol. 130, no. 8, pp. 1879–1887, viewed 29 November 2019, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3162132/.

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Multiple heart valve diseases

Q:

Can codes from categories I34–I38 be assigned with codes from category I08 *Multiple valve diseases* in the same episode of care?

A:

Follow the classification convention for the prepositional term 'with' in the ICD-10-AM Alphabetic Index, which is based on ICD-10. Before assigning a code, users of ICD-10-AM must also apply the *Instructional* notes in the ICD-10-AM Tabular List and the Australian Coding Standards (ACS) (eg ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*).

The *Instructional* notes at category I08 *Multiple valve diseases* states:

> ***Includes:*** *whether specified as rheumatic or of unspecified origin*
> ***Excludes:*** *…*
> *multiple valve diseases of specified origin other than rheumatic heart diseases (use appropriate codes in I34–I38, Q22–Q23 and Q24.87)*

Scenario 1
Patient admitted with aortic stenosis. There is documented history of mitral valve regurgitation. The cause of the aortic stenosis or mitral valve regurgitation is not specified.

Assign I08.0 *Disorders of both mitral and aortic valves*.

Follow the ICD-10-AM Alphabetic Index:

Stenosis (cicatricial)
- aortic (valve) I35.0

Follow the *Excludes* note at category I35 *Nonrheumatic aortic valve disorders*:

> ***Excludes:*** *unspecified cause but with mention of diseases of mitral valve (I08.0)*

Scenario 2
Patient admitted with aortic stenosis due to previous endocarditis. There is documented history of mitral valve insufficiency.

Assign I35.0 *Aortic (valve) stenosis*.

Follow the ICD-10-AM Alphabetic Index:

Stenosis (cicatricial)
- aortic (valve) I35.0

The *Excludes* note at category I35 does not apply to scenario 2 because the aortic stenosis is documented as due to a specified cause (ie endocarditis). A code for mitral valve regurgitation is not assigned because it does not meet the criteria in ACS 0002 *Additional diagnoses*.

Scenario 3
Patient admitted for treatment of mitral and aortic valve insufficiency due to calcium deposits.

Assign I34.0 *Mitral (valve) insufficiency* and I35.1 *Aortic (valve) insufficiency*.

Follow the ICD-10-AM Alphabetic Index:

Insufficiency, insufficient
- mitral
- - with
- - - aortic valve disease (unspecified origin) I08.0

The mitral and aortic valve insufficiencies are due to a specified origin (ie calcium deposits).

Therefore, follow the *Excludes* note at category I08 and assign appropriate codes from the range I34–I38 (specifically I34.0 and I35.1).

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Surgically assisted maxillary expansion (SAME) or surgically assisted rapid maxillary expansion (SARME)

Q:

What ACHI code is assigned for a surgically assisted maxillary expansion (SAME) or surgically assisted rapid maxillary expansion (SARME)?

A:

Surgically assisted maxillary expansion (SAME) and surgically assisted palatal expansion (SAPE) combine surgical and orthodontic techniques for management of transverse maxillary discrepancies in mature patients (Robiony et al. 2007). SAME and SAPE can also be undertaken in 'rapid' form (ie SARME and SARPE). The procedures allow surgeons to achieve effective maxillary expansion in a skeletally mature patient and decrease unwanted effects of orthopaedic or orthodontic expansion (Suri & Taneja 2008).

The procedure consists of various components including multiple osteotomies combined with application of a fixed orthodontic appliance. An ostectomy can also be performed to assist expansion (Suri & Taneja 2008).

Assign an appropriate code from blocks **[1705]** *Osteotomy or ostectomy of mandible or maxilla* or **[1707]** *Osteotomy or ostectomy of mandible or maxilla, procedures in combination*, where SAME procedure is documented.

Follow the ACHI Alphabetic Index:

Osteotomy
- maxilla
- - bilateral 45726-01 **[1705]**
…
- - multiple procedures (multiple ostectomies or osteotomies of maxilla, in combination) — *see block* **[1707]**
…
- - unilateral 45720-01 **[1705]**

Also assign 97843-01 **[480]** *Insertion of fixed maxillary or mandibular expansion appliance* for the application of the maxillary expansion device.

Follow the ACHI Alphabetic Index:

Application
- orthodontic appliance
- - fixed (expansion)
- - - maxillary 97843-01 **[480]**

References:
Robiony, M., Polini, F., Costa, F., Zerman, N. & Politi, M. 2007, 'Ultrasound bone cutting for surgically assisted rapid maxillary expansion under local anesthesia. Preliminary results.', *Minerva Stomatologica*, vol. 56, no. 6, pp. 359–368, viewed 7 January 2020, https://www.ncbi.nlm.nih.gov/pubmed/17625493.
Suri, L. & Taneja, P. 2008, 'Surgically assisted rapid palatal expansion: a literature review', *American Journal of Orthodontics and Dentofacial Orthopedics*, vol. 133, no. 2, pp. 290–302, viewed 17 December 2019, https://bbo.org.br/bbo/files/bibliografia/artigos/12_Suri_Surgically_assisted_rapid_palatal_expansion.pdf.

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S09.0 Unspecified injury of head and S00 Superficial injuries of head

Q:

Can codes for ‘abrasion’ or ‘contusion’ classified to category S00 *Superficial injuries of head* be assigned with S09.9 *Unspecified injury of head*?

A:

ACS 1905 *Closed head injury/loss of consciousness/concussion* states:

> *It is recognised that ‘head injury’ is a state or ‘condition’ in its own right and should be coded where appropriate, in addition to (any) lacerations or open wounds of the head.*

That is, assign S09.9 *Unspecified injury of head* with codes from category S01 *Open wound of head*, where ‘head injury’ and ‘open wound/laceration of head’ are both documented in the episode of care.

There is nothing in ICD-10-AM or the ACS to preclude the assignment of S09.9 with codes for ‘abrasion’ or ‘contusion’ classified to category S00 *Superficial injuries of head*.

However, note that as per the guidelines in ACS 1907 *Multiple injuries* and ACS 1916 *Superficial and soft tissue injuries*:

> *Superficial injuries, such as abrasions or contusions, are not coded when associated with more severe injuries of the same site.*

That is, do not assign codes from category S00 *Superficial injuries of head* with more severe injuries of the head classified to categories S01–S08 and S09.0–S09.2.

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Supplementary U code for obesity

Q:

Can a supplementary U code for obesity be assigned when body mass index (BMI) is documented on a malnutrition screening tool document?

A:

Malnutrition screening tools such as the Malnutrition Universal Screening Tool (MUST) categorise the risk of malnutrition for individual patients by calculating a numerical score. Patients with a high nutritional risk score are then referred for a formal clinical assessment.

ACS 0010 *Clinical documentation and general abstraction guidelines* states:

> *Clinical documentation of accurate diagnoses is the responsibility of the clinician.*
> *…*
> *Before classifying any documented clinical concept, the clinical coder must verify information on the front sheet and/or the discharge summary (or equivalent) by reviewing pertinent documents/data within the body of the current episode of care.*
> *…*
> *Do not use test result value, descriptions, medication charts, symbols and abbreviations in isolation to inform code assignment.*
> *…*

Diagnoses and procedures must be documented by a clinician before assigning a code. This principle also applies to the assignment of supplementary codes for chronic conditions.

Documented components of a malnutrition screening tool, including body mass index (BMI), are not considered diagnoses for classification purposes. Therefore, in the absence of supporting clinical documentation, a supplementary U code is not assigned based on a BMI value alone from a nutritional screening tool.

See also Q3384 ‘BMI from calculated EMR fields’ published on 15 March 2019.

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Trapeziectomy with abductor pollicis longus (APL) suspensionplasty

Q:

What code is assigned for trapeziectomy with abductor pollicis longus (APL) suspensionplasty?

A:

Trapeziectomy is indicated for painful osteoarthritis of the carpometacarpal (CMC) joint of the thumb (Healthdirect Australia 2019). It involves removal of the trapezium, which is a cube-shaped bone in the wrist that sits beneath the base of the thumb (Healthdirect Australia 2019).

An abductor pollicis longus (APL) suspensionplasty is performed to stop the CMC joint from deforming and preserve thumb function. It uses a part of the flexor carpi radialis or APL tendons and binding it to strong suture material to suspend the base of the first metacarpal bone to the second metacarpal bone (Leclerq 2015; Renfree et al. 2017; Soejima et al. 2006).

For classification purposes, trapeziectomy with APL suspensionplasty are inherent components of arthroplasty. Therefore, assign 46324-00 **[1468]** *Arthroplasty of carpal bone* alone.

Follow the ACHI Alphabetic Index:

Arthroplasty
- wrist
- - carpal bone
- - - for joint replacement (with resection) 46324-00 **[1468]**

Amendments will be considered for a future edition.

References:

Healthdirect Australia 2019, *Trapeziectomy*, Healthdirect Australia, viewed 10 January 2020, https://www.healthdirect.gov.au/surgery/trapeziectomy.
Leclerq, C. 2015, 'Thumb CMCJ arthritis: a new technique of suspensionplasty (Mini tightrope)', *BMC Proceedings*, viewed 19 December 2019, https://bmcproc.biomedcentral.com/articles/10.1186/1753-6561-9-S3-A51.
Renfree, K.J., Odgers, R.A., Zhang, N. & Tillinghast, C. 2017, 'Long-term outcomes of APL suspensionplasty with no, partial, or complete trapezoid excision', *Journal of Hand Surgery*, vol. 42, issue 9, supplement, p. S30, viewed 10 January 2020, https://www.jhandsurg.org/article/S0363-5023(17)31061-4/fulltext.
Soejima, O., Hanamura, T., Kikuta, T., Iida, H. & Naito, M. 2006, 'Suspensionplasty with the abductor pollicis longus tendon for osteoarthritis in the carpometacarpal joint of the thumb', *Journal of Hand Surgery*, vol. 31, issue 3, pp. 425–428, viewed 10 January 2020, https://www.jhandsurg.org/article/S0363-5023(05)00925-1/abstract.

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Utilisation of multiple machine perfusion units for organ transplantation

Q:

How many times is 96231-00 **[1886]** *Machine perfusion for organ transplantation* assigned, when machine perfusion is utilised multiple times for separate organs?

A:

The *Code first* instructional note at 96231-00 **[1886]** *Machine perfusion for organ transplantation* implies that multiple procurement codes may be assigned with machine perfusion. Although ACS 0030 *Organ, tissue and cell procedure and transplantation* is not specific, the intention is that a single machine perfusion code is assigned when multiple organ procurements are performed.

Therefore, where machine perfusion is utilised, assign 96231-00 **[1886]** *Machine perfusion for organ transplantation* once only during an episode of care.

The guidelines in ACS 0020 *Bilateral/multiple procedures* do not apply to machine perfusion because it is not performed during different visits to theatre or via entry points/approaches to the body (ie machine perfusion is not performed directly on a patient).

Amendments will be considered for a future edition.

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