National coding rules (Effective 1 January 2021)

Contents

Ref No: Q3522 | Published On: Dec-2020 | Status: Current

B95–B97 *Bacterial, viral and other infectious agents*

Q:

Can a code from block B95–B97 be assigned with another code from Chapter 1 to add specificity?

A:

Codes in block B95–B97 *Bacterial, viral and other infectious agents* are assigned to identify certain organisms *as the cause of diseases classified to other chapters*. Therefore, they are never assigned with another code from Chapter 1 *Certain infectious and parasitic diseases* to classify a single clinical concept (ie a single infection).

For example:

- Sepsis due to *Klebsiella pneumoniae* is a single clinical concept. Assign A41.58 *Sepsis due to other Gram-negative organisms*.

  Follow the ICD-10-AM Alphabetic Index:

  Sepsis (generalised)
  - Gram-negative (organism)
  - - specified NEC A41.58

- Bacteraemia due to *Klebsiella pneumoniae* is a single clinical concept. Assign A49.8 *Other bacterial infections of unspecified site*.

  Follow the ICD-10-AM Alphabetic Index:

  Bacteraemia *(see also Infection/by type)*

  Infection, infected (opportunistic)
  - Klebsiella (K.) pneumoniae NEC A49.8

Note also that the *Conventions used in the ICD-10-AM Tabular List* state:

> *If, by following the Alphabetic Index, a residual code is assigned (ie other or unspecified), do not assign an additional code to further classify the condition unless directed by an Instructional note/term in the Tabular List or an Australian Coding Standard.*

For guidelines regarding multiple clinical concepts (ie multiple infections) see Coding Rule Q3332 *E. coli* UTI and *E. coli* bacteraemia.

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Ref No: Q3620 | Published On: Dec-2020 | Status: Current

Cholestasis in pregnancy

Q:

What codes are assigned for cholestasis in pregnancy?

A:

Cholestasis is described as decreased or impaired secretion of bile (hepatocellular, metabolic, functional or nonobstructive cholestasis) or mechanical obstruction of bile flow, which clinically leads to retention of the constituents of bile (eg bilirubin and bile acids) in blood (Shah & John 2020). Intrahepatic cholestasis (functional cholestasis) can be due to a disease involving the liver parenchymal cells and/or the intrahepatic bile ducts. Extrahepatic cholestasis (obstructive cholestasis) is due to excretory block outside of the liver, along with the extrahepatic bile ducts (Shah & John 2020).

Obstetric cholestasis

Obstetric cholestasis (intrahepatic cholestasis of pregnancy (ICP)) is a cholestatic disorder characterised by pruritus with onset in the second or third trimester of pregnancy, elevated serum aminotransferases and bile acid levels, and spontaneous relief of signs and symptoms within two to three weeks after delivery. Genetic and hormonal factors, as well as environmental effects, may contribute to the pathogenesis of ICP (WHO 2020).

ACS 1521 *Conditions and injuries in pregnancy* states:

> *Chapter 15* Pregnancy, childbirth and the puerperium *lists codes for conditions that:*
>
> - *exclusively or predominantly occur only in a pregnant patient (ie obstetric conditions/complications).*
>
> *Assign codes for these conditions/complications that meet the criteria for assignment as per ACS 0001* Principal diagnosis*, ACS 0002* Additional diagnoses *and ACS 1500* Diagnosis sequencing in obstetric episodes of care*.*
>
> - *may occur in any patient, but may or may not cause complications in a pregnant patient (ie nonobstetric conditions/complications).*

Obstetric cholestasis is a condition that occurs exclusively in a pregnant patient.

Assign O26.6 *Liver disorders in pregnancy, childbirth and the puerperium* alone for obstetric cholestasis.

Follow the ICD-10-AM Alphabetic Index:

Cholestasis
- in pregnancy, childbirth or puerperium (intrahepatic) O26.6

Do not assign K83.1 *Obstruction of bile duct* in addition to O26.6:

- Obstetric cholestasis is not clinically caused by obstruction of the bile duct.
- The *Instructional* note at O26.6 (*Code also specific liver disorder, if known*) does not apply as K83.1 is not classified as a liver disorder (ie K70–K77).

Obstructive / extrahepatic cholestasis in pregnancy

Obstructive cholestasis is a nonobstetric condition that may complicate pregnancy. Assign multiple codes for nonobstetric cholestasis in accordance with the guidelines in ACS 1521:

- *Assign a code from Chapter 15* Pregnancy, childbirth and the puerperium *for a nonobstetric condition complicating pregnancy as per the Alphabetic Index (eg* Pregnancy / complicated by or condition / in pregnancy or condition / in pregnancy, childbirth or puerperium*)*
- *Assign as an additional diagnosis a code from another chapter to add specificity to the Chapter 15 code*

Therefore, where a pregnant patient is admitted with cholestasis and documentation indicates that it is due to obstruction of the (extrahepatic) bile ducts, assign:

O99.6 *Diseases of the digestive system in pregnancy, childbirth and the puerperium*

K83.1 *Obstruction of bile duct*

Follow the ICD-10-AM Alphabetic Index:

Pregnancy (single) (uterine)
- complicated by
- - conditions in
- - - K00–K93 O99.6
- - diseases of
- - - digestive system (conditions in K00–K66, K80–K93) NEC O99.6

Cholestasis NEC K83.1

Where it is unclear from documentation if cholestasis in a pregnant patient is obstructive (nonobstetric) or is intrahepatic (obstetric ie is caused exclusively by the pregnancy), seek clinical clarification. When clinical advice is unavailable, assign O26.6 alone.

Amendments will be considered for a future edition.

References:
Shah, R. & John, S. 2020, 'Cholestatic jaundice', *StatPearls*, viewed 14 July 2020, <https://www.ncbi.nlm.nih.gov/books/NBK482279/>.

World Health Organization (WHO) 2020, *Intrahepatic cholestasis of pregnancy,* ICD-11 Foundation, viewed 14 July 2020, <https://icd.who.int/dev11/f/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f1576251337>.

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Ref No: Q3498 | Published On: Dec-2020 | Status: Current

Clarification of ACS 0236 *Neoplasm coding and sequencing*

Q:

Can the primary neoplasm be coded when a patient is admitted for a late complication of the neoplasm treatment, or subsequently develops a complication of neoplasm treatment during an episode of care for treatment of a nonmalignant condition?

A:

ACS 0236 *Neoplasm coding and sequencing/Primary neoplasm as a current condition* states:

> *A primary neoplasm is classified as a current condition if the episode of care is for:*
>
> - *diagnosis or treatment of the primary neoplasm, in any of the following circumstances:*
>   - *initial diagnosis of the primary neoplasm*
>   - *treatment of complications of the primary neoplasm or neoplasm treatment*
>   - *operative intervention to remove the primary neoplasm*
>   - *medical care related to the primary neoplasm, including palliative care (see also ACS 2116* Palliative care*)*
>   - *recurrence of the primary neoplasm previously eradicated from the same organ or tissue (see also ACS 0237* Recurrence of malignancy*)*
>
> …
>
> *If the episode of care is for treatment of another nonmalignant condition, the malignancy may be classified as a current condition only if it meets the criteria for code assignment as per ACS 0002* Additional diagnoses*.*

The term 'neoplasm treatment' in ACS 0236 (above) relates to interventions specifically targeting the neoplasm, such as pharmacotherapy or radiotherapy. Complications of surgical interventions performed for treatment of a neoplasm are assigned in accordance with the guidelines in ACS 1904 *Procedural complications*.

Therefore, a primary neoplasm code is assigned in an episode of care when there is treatment of a primary neoplasm, neoplasm related condition, or a pharmacotherapy or radiotherapy related complication.

When a nonmalignant condition is the principal diagnosis in an episode of care, a primary neoplasm code is assigned as an additional diagnosis when:

- it meets the criteria in ACS 0002 *Additional diagnoses*; or
- a neoplasm related condition, or pharmacotherapy or radiotherapy related complication, meets the criteria in ACS 0002 *Additional diagnoses*.

Where documentation confirms a neoplasm is completely resolved and none of the above points applies, and the history is relevant to the current episode of care, assign a code from category Z85 *Personal history of malignant neoplasm*.

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Ref No: Q3579 | Published On: Dec-2020 | Status: Current

Clarification of nursing scope of practice and use of nursing documentation to inform code assignment

The Australian Coding Standards (ACS) *How to use this document* states:

> …
>
> *The term 'clinician' is used throughout the ACS and refers to the treating medical officer but may refer to other clinicians such as allied health professional, midwives, and nurses. Generally, medical officer documentation is the primary source for clinical coders to use for classification purposes. The following example indicates that clinical coders can also use documentation from other clinicians if the documented information is appropriate to the clinician's scope of practice.*
>
> *EXAMPLE 1:*
>
> - *Malnutrition documented by a dietitian*
> - *Pressure injuries documented by a wound specialist (Clinical Nurse Specialist) or a registered nurse*
> - *Post-partum haemorrhage documented by a midwife*
> - *Dysphagia documented by a speech pathologist*

It is impractical to define the scope of practice of every clinician, particularly nursing, because of the wide variability in practice across metropolitan and rural regions, jurisdictions, clinical settings and governance policies.

Ultimately, responsibility for documentation lies with the treating clinician. Nursing documentation is not precluded from informing code assignment. In particular, specialist nurses, midwives, diabetes educators, mental health nurses, lactation consultants and wound consultants will document within the scope of their practice, problems and conditions that may or may not be documented by the treating medical officer.

Nursing documentation has the potential to provide specificity but needs to be balanced against what is corroborated in the clinical episode as a whole and must not rely on patient completed forms.

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Ref No: Q3602 | Published On: Dec-2020 | Status: Current

Code assignment for a staged percutaneous coronary intervention (PCI) within four weeks of an acute myocardial infarction

Q:

What codes are assigned for a staged PCI within four weeks from the onset of an acute myocardial infarction?

A:

A staged percutaneous coronary intervention (PCI) may be planned for various reasons. One common clinical reason is following acute myocardial infarction (AMI) with multi-vessel coronary artery disease (CAD). The second stage of the PCI is performed for revascularisation of noninfarct arteries to achieve an optimal outcome when this is not possible in a single stage PCI (Zhou et al. 2017). A staged PCI may also be planned for non-clinical reasons such as the facility setting and administration (Spitzer et al. 2018). The time frame between the initial PCI and the subsequent PCI may vary significantly between facilities, ranging from weeks to months (Spitzer et al. 2018).

Where a patient is re-admitted for a staged PCI or bypass graft following a recent AMI, select the principal diagnosis based on documentation in the clinical record and in accordance with ACS 0001 *Principal diagnosis*. In episodes where CAD is documented as the indication for the PCI, assign a code for the CAD as principal diagnosis. Assign a code from category I21 *Acute myocardial infarction* as an additional diagnosis, if the admission is within 4 weeks (28 days) from onset of the AMI. This is consistent with the guidelines in ACS 0940 *Ischaemic heart disease/3. Acute myocardial infarction (I21)/Classification* that states:

> *Codes from category I21* Acute myocardial infarction *should be assigned for a patient that is either admitted or transferred for treatment of the infarction within four weeks (28 days) or less from onset of the infarction.*

Amendments will be considered for a future edition.

References:

Li, Z., Zhou, Y., Xu, Q. & Chen, X. 2017, 'Staged versus one-time complete revascularization with percutaneous coronary intervention in STEMI patients with multivessel disease: A systematic review and meta-analysis', *PLOS One*, vol. 12, no. 1, viewed 18 August 2020, <https://doi.org/10.1371/journal.pone.0169406>.

Spitzer, E., McFadden, E., Vranckx, P., de Vries, T., Ren, B., Collet, C., Onuma, Y., Garcia-Garcia, H.M., Lopes, R.D., Stone, G.W., Cutlip, D.E. & Serruys, P.W. 2018, 'Defining staged procedures for percutaneous coronary intervention trials: A guidance document', *JACC: Cardiovascular Interventions*, vol. 11, no. 9, pp. 823–832, viewed 18 August 2020, <https://www.jacc.org/doi/full/10.1016/j.jcin.2018.03.044>.

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Ref No: Q3484 | Published On: Dec-2020 | Status: Current

Guedel airway and intubation

Q:

Is insertion of 'Guedel airway' coded as intubation?

A:

A Guedel airway (or oropharyngeal airway), is an airway adjunct commonly used during cardiopulmonary resuscitation (CPR) to maintain airway patency, or used in conjunction with intubation to prevent the endotracheal tube from being bitten (Moses 2020). Under these circumstances (ie CPR and endotracheal intubation), insertion of a Guedel airway is not coded in accordance with ACS 0042 *Procedures normally not coded* and ACS 1006 *Ventilatory support.*

A Guedel airway may sometimes be used for improvement of airway hygiene (eg to facilitate airway suctioning for sputum clearance). This is an expected or inherent part of the routine nursing care plan. Where a Guedel airway is used for airway suctioning, the procedure is not coded in accordance with ACS 0016 *General procedure guidelines*, which states:

> *Many procedures may meet the …AIHW definition of a clinical intervention but if they are routine in the treatment of the diagnosis being coded, it may not be necessary to code them.*

Amendments will be considered for a future edition.

References:
Moses, S. 2020, *Oropharyngeal airway*, Family Practice Notebook, viewed 09 September 2020, <https://fpnotebook.com/er/Procedure/OrphrynglArwy>.

Saskatoon Health Region Nursing Practice Committee 2016, *Airway – oropharyngeal insertion, maintenance, suction, removal*, Saskatoon Health Region Nursing Practice Committee Policies and Procedures, viewed 09 September 2020, <https://www.saskatoonhealthregion.ca/about/NursingManual/1159.pdf>.

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IHPA

NZ Note: this may be a change in coding practice

Ref No: Q3626 | Published On: Dec-2020 | Status: Current

Inflammatory bowel disease

Q:

What code is assigned for inflammatory bowel disease (of unknown aetiology)?

A:

ICD-11 Mortality and Morbidity Statistics (MMS) includes a category for inflammatory bowel disease (IBD), described as 'a group of inflammatory conditions of the intestine of unknown aetiology', and classifies specific types including Crohn disease, ulcerative colitis and indeterminate colitis. Indeterminate colitis is described as:

> *a chronic inflammatory disorder of the colon, for which a definitive diagnosis of neither Crohn's disease or ulcerative colitis can be made* (WHO 2020).

IBD unclassified and IBD NOS (not otherwise specified) are synonymous terms for indeterminate colitis (Odze 2015).

Where there is documentation of IBD, assign:

- a code from category K50 *Crohn's disease [regional enteritis]* OR
- a code from category K51 *Ulcerative colitis* OR
- K52.3 *Indeterminate colitis*

Assign K52.3 *Indeterminate colitis* for unspecified inflammatory bowel disease.

Follow the ICD-10-AM Alphabetic Index:

Colitis (acute) (catarrhal) (haemorrhagic) *(see also Enteritis)*
- indeterminate K52.3

References:
Odze, R.D. 2015, 'A contemporary and critical appraisal of "indeterminate colitis"', *Modern Pathology*, vol. 28, pp. S30–S46, viewed 30 September 2020, <https://www.nature.com/articles/modpathol2014131>.

World Health Organization (WHO) 2020, *Inflammatory bowel diseases*, viewed 30 September 2020, <https://icd.who.int/dev11/l-m/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f598093212>.

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NZ Note: this may be a change in coding practice

Ref No: Q3465 | Published On: Dec-2020 | Status: Current

Insertion of minimally invasive glaucoma surgery (MIGS) device without concurrent cataract extraction

Q:

What code is assigned for insertion of a minimally invasive glaucoma surgery (MIGS) device without concurrent cataract extraction?

A:

Minimally invasive glaucoma surgery (MIGS) is an alternative surgical method that provides a medication-sparing approach to reduce intra-ocular pressure for patients with mild to moderate glaucoma (Richter & Coleman 2016). A number of MIGS devices such as iStent®, XEN® gel stent or CyPass have been developed for micro-bypass stenting for open angle glaucoma to drain fluid from the anterior chamber (Glaucoma Australia n.d.).

Assign 90075-00 [191] *Other procedures for glaucoma* when a MIGS device is inserted as a standalone procedure (ie without concurrent cataract extraction).

Follow the ACHI Alphabetic Index:

Procedure
- glaucoma NEC 90075-00 [191]

An update is being progressed for Twelfth Edition to incorporate a new dedicated MBS item number now available for MIGS.

References:
Richter, G.M. & Coleman, A.L. 2016, 'Minimally invasive glaucoma surgery: current status and future prospects', *Clinical Ophthalmology*, vol. 10, pp. 189–206, viewed 24 February 2020, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4734795/pdf/opth-10-189.pdf>.

Glaucoma Australia n.d., *Minimally invasive glaucoma surgery fact sheet*, viewed 24 February 2020, <https://www.glaucoma.org.au/media/1179/minimally-invasive-glaucoma-surgery-mw-1114144.pdf>.

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Ref No: Q3588 | Published On: Dec-2020 | Status: Current

Malignant pericardial effusion

Q:

What is the correct code to assign for malignant pericardial effusion?

A:

Malignant pericardial effusion is generally caused by tumours of the pericardium, are usually metastatic, and rarely primary pericardial tumours (Adler et al. 2015).

Malignant pericardial effusion due to primary neoplasm is classified to C38.0 *Malignant neoplasm of heart*. Malignant pericardial effusion due to secondary neoplasm of the pericardium is classified to C79.88 *Secondary malignant neoplasm of other specified sites*.

Follow the ICD-10-AM Alphabetic Index in the Table of Neoplasms at lead term *Neoplasm, neoplastic*:

	Malignant	
	Primary	Secondary
Neoplasm, neoplastic		
- pericardium	C38.0	C79.88

It is not appropriate to assign I31.3 *Pericardial effusion (noninflammatory)* as per the *Excludes* note at the beginning of Chapter 9 *Diseases of the circulatory system (I00–I99)* which states:

Excludes: neoplasms (C00–D48)

Amendments will be considered for a future edition.

References:
Adler, Y., Charron, P., Imazio, M., Badano, L., Baron-Esquivias, G., Bogaert, J., Brucato, A., Gueret, P., Klingel, K., Lionis, C., Maisch, B., Mayosi, B., Pavie, A., Ristic, A.D., Sabate Tenas, M., Seferovic, P., Swedberg, K. & Tomkowski, W. 2015, '2015 ESC guidelines for the diagnosis and management of pericardial diseases: The task force for the diagnosis and management of pericardial diseases of the European Society of Cardiology (ESC), *European Heart Journal*, vol. 36, issue 42, pp. 2921–2964, viewed 28 August 2020, <https://doi.org/10.1093/eurheartj/ehv318>.

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Ref No: Q3476 | Published On: Dec-2020 | Status: Current

Oral pharmacotherapy for neoplasm and neoplasm (treatment) related conditions

Q:

Can all oral pharmacotherapy be coded for the treatment of neoplasm and neoplasm (treatment) related conditions?

A:

The instruction in previous versions of ACS 0044 *Pharmacotherapy* to not code oral chemotherapy in admitted episodes of care was deleted in Eleventh Edition to allow the assignment of 96203-00 [1920] *Oral administration of pharmacological agent, antineoplastic agent* for the treatment of neoplasms, neoplasm related conditions and neoplasm treatment related conditions. It was never intended that this code be assigned for agents that are not chemotherapeutic (eg oral hydration, paracetamol, steroids, antihistamines, antiemetics).

Therefore, assign 96203-00 [1920] *Oral administration of pharmacological agent, antineoplastic agent* for oral chemotherapy only.

Follow the ACHI Alphabetic Index:

Pharmacotherapy (systemic effect)
- oral 96203 [1920]

Note that this guideline relates to both same-day and multi-day episodes of care.

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Ref No: Q3507 | Published On: Dec-2020 | Status: Current

Place of occurrence for adverse effect of drug

Q:

What place of occurrence code is assigned where there has been an adverse effect of a prescribed drug?

A:

The *Note* at Y92 *Place of occurrence* states:

> *The following category is for use with categories V00–Y89, to identify the place where the injury or poisoning (external cause) occurred.*

All prescribed drugs are considered to be prescribed within the health system, so where there is an adverse reaction from a drug prescription completed outside of the hospital network (ie through a GP), it is considered 'within' the health service area.

For an adverse effect of a prescribed drug, the place of occurrence code is assigned according to where the drug was prescribed (the health facility) not where the drug was administered or where the manifestation occurred, similar to a postoperative wound infection where the place of occurrence is the health facility and not the place where the manifestation is exhibited. Assign:

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

OR

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

Example 1

Patient prescribed and administered a new antihypertensive drug in hospital A, then transferred to hospital B. In hospital B the patient developed a rash, which the clinician assessed and diagnosed as an allergic reaction to the antihypertensive drug and ordered its discontinuation.

Assign place of occurrence code Y92.23 *Health service area, not specified as this facility.*

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

Example 2

Patient had been using a prescribed antihypertensive drug for a number of years and was admitted to hospital to investigate unrelated abdominal pain. Due to high blood pressure readings during the episode of care, the patient's antihypertensive drug was changed. The patient subsequently developed a rash that the clinician assessed and diagnosed as an allergic reaction to the new antihypertensive drug and ordered it to be discontinued.

Assign place of occurrence code Y92.24 *Health service area, this facility.*

Follow the External Causes of Injury Alphabetic Index:

Place of occurrence of external cause
- health service area
- - this facility Y92.24

Where a patient has presented to multiple facilities between initial prescription and commencement of a drug, assign a place of occurrence code based on where the drug was prescribed.

Amendments will be considered for a future edition.

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Ref No: Q3515 | Published On: Dec-2020 | Status: Current

Plantar plate injury and repair

Q:

What codes are assigned for a plantar plate injury and repair?

A:

The plantar plate is a fibrocartilaginous structure. Its distal attachment is the base of the proximal phalanx and medial and lateral attachments are the collateral ligaments (Baravarian 2016). It is the primary static stabiliser of the second metatarsophalangeal joint (MPJ) performing the main role in maintaining joint stability (Nery et al. 2015). Plantar plate tear is mainly caused by abnormally high pressure on the connected MPJ region (Baravarian 2016). A plantar plate repair reconstructs the anatomic structures to restore the normal alignment of the joint (Coughlin et al. 2011).

Assign S93.5 *Sprain and strain of toe(s)* for a plantar plate injury.

Follow the ICD-10-AM Alphabetic Index:

Sprain, strain (joint) (ligament)
- metatarsophalangeal S93.5

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

ACHI code assignment is determined by the specific procedure performed. For example, assign 50106-00 [1571] *Joint stabilisation, not elsewhere classified* where stabilisation of the MPJ is performed.

Follow the ACHI Alphabetic Index:

Stabilisation
- joint
- - specified site NEC 50106-00 [1571]

Where repair of the plantar plate without further specification is documented, assign:

90595-00 [1579] *Other procedures on musculoskeletal system, not elsewhere classified*

Follow the ACHI Alphabetic Index:

Procedure
- musculoskeletal NEC 90595-00 [1579]

Amendments will be considered for a future edition.

References:
Baravarian, B. 2016, 'Expert insights on treating plantar plate tears', *PodiatryToday*, vol. 29, no. 3, viewed 16 April 2020, <https://www.podiatrytoday.com/expert-insights-treating-plantar-plate-tears>.

Coughlin, M.J., Baumfeld, D.S. & Nery, C. 2011, 'Second MTP joint instability: Grading of the deformity and description of surgical repair of capsular insufficiency.', *Physician and Sportsmedicine*, vol. 39, no. 3, pp. 132–141, viewed 16 April 2020, <https://www.ncbi.nlm.nih.gov/pubmed/22030949>.

Nery, C., Coughlin, M., Baumfeld, D., Mann, T.S. & Catena, F. 2015, 'How to classify plantar plate injuries: parameters from history and physical examination', *Revista Brasileira de Ortopedia*, vol. 50, no. 6, pp. 720–728, viewed 16 April 2020, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4868080/#bib0150>.

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NZ Note: this is a change in coding practice. NZCA coding query retired.

Ref No: Q3564 | Published On: Dec-2020 | Status: Current

Postpartum haemorrhage due to caesarean section, episiotomy or perineal laceration

Q:

What codes are assigned for postpartum haemorrhage due to caesarean section (incision), episiotomy or perineal laceration?

A:

Primary postpartum haemorrhage (PPH) is described as a condition characterised by excessive loss of blood within the first 24 hours after completion of the third stage of labour for a vaginal delivery, or after a caesarean section (WHO 2019).

Secondary PPH is described as a condition characterised by excessive loss of blood between 24 hours and 12 weeks after delivery (WHO 2019).

Causes of PPH include delivery by caesarean section, perineal tear and episiotomy (Royal College of Obstetricians and Gynaecologists 2016).

Assign one of the following codes for postpartum haemorrhage, based on clinical documentation:

O72.1 *Other immediate postpartum haemorrhage*

O72.2 *Delayed and secondary postpartum haemorrhage*

Follow the ICD-10-AM Alphabetic Index:

Haemorrhage, haemorrhagic
- postpartum (≤ 24 hours following delivery of placenta) NEC O72.1
- - delayed or secondary O72.2

<u>PPH due to caesarean section (incision) or episiotomy</u>

In addition to the PPH code, where there is documentation that PPH is due to caesarean section (incision) or episiotomy, assign:

O90.8 *Other complications of the puerperium, not elsewhere classified*

Y83.8 *Other surgical operation*

Place of occurrence code

Follow the ICD-10-AM Alphabetic Index Section I:

Complication(s) (from) (of)
- caesarean section wound (puerperal) NEC O90.8
- obstetric
- - surgical wound (puerperal) NEC O90.8

Section II External Causes of Injury:

Complication(s) (delayed) (medical or surgical procedure) (of or following)
- surgical operation
- - specified NEC Y83.8

PPH due to perineal tear

In addition to the PPH code, where there is documentation that PPH is due to a perineal tear, assign a code from category O70 *Perineal laceration during delivery*.

Follow the ICD-10-AM Alphabetic Index:

Tear, torn (traumatic)
- perineum, perineal
- - during delivery NEC O70.9
- - - 1st degree O70.0
- - - 2nd degree O70.1
- - - 3rd degree O70.2
- - - 4th degree O70.3

See also ACS 1500 *Diagnosis sequencing in obstetric episodes of care*, 1548 *Puerperal/postpartum condition or complication* and 1551 *Obstetric perineal lacerations/grazes*.

References:

Royal College of Obstetricians and Gynaecologists 2016, *Heavy bleeding after birth (postpartum haemorrhage),* viewed 7 May 2020, <https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/pregnancy/pi-heavy-bleeding-after-birth-postpartum-haemorrhage.pdf>.

World Health Organization 2019, *ICD-11 Mortality and Morbidity Statistics (MMS),* WHO, viewed 7 May 2020, <https://icd.who.int/dev11/l-m/en>.

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Ref No: Q3527 | Published On: Dec-2020 | Status: Current

Surgery for gender dysphoria

Q:

What principal diagnosis is assigned for a patient admitted for chest masculinisation surgery?

A:

Individ atch
their g re
import ustralia
2019)

Gende nder
dysph

Therefe nipple
graft (i
cosme c
surger

Follow

Surge
- plasti
- - cos

Also assign the relevant code from category F64 *Gender identity disorders*.

Amendments maybe considered for a future edition.

References:
Healthdirect Australia 2019, *Gender confirmation surgery*, Healthdirect Australia, viewed 2 March 2020, <https://www.healthdirect.gov.au/gender-confirmation-surgery>.

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Ref No: Q3534 | Published On: Dec-2020 | Status: Current

Terms synonymous with adhesiolysis

Q:

When adhesions are referred to as being dissected or taken down are these terms synonymous with adhesiolysis?

A:

The Australian Classification of Health Interventions (ACHI) Alphabetic Index includes a number of lead terms that are synonymous with adhesiolysis. There are also cross references directing users to alternate indexed lead terms or subterms.

Adhesiolysis — *see also Division/adhesions*

Division (freeing)
- adhesions

Freeing
- adhesions — *see Division/adhesions*

Lysis — *see also Division*
- adhesions — *see Division/adhesions*

Release
- adhesions

Dissection is the technique used for adhesiolysis. Although neither *dissection* or *taken down* are indexed terms for adhesiolysis both are synonymous with adhesiolysis, with *taken down* used colloquially.

In circumstances where the documented terms are not indexed it may be necessary to identify the clinical concept or procedures performed from the clinical documentation and then select the most appropriate index terms to locate the correct codes.

Amendments will be considered for a future edition.

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Ref No: Q3628 | Published On: Dec-2020 | Status: Current

Thrombophlebitis due to central vein catheter (CVC) or intravenous catheter (IVC)

Q:

What codes are assigned for thrombophlebitis due to central vein catheter (CVC) or intravenous catheter (IVC)?

A:

In accordance with the guidelines in ACS 1904 *Procedural complications,* where a complication is related to a prosthetic device, implant or graft, assign a code from block T82–T85 *Complications of prosthetic devices, implants and grafts*. Assign an additional code to provide specificity of the condition.

Assign:

- T82.74 *Infection and inflammatory reaction due to central vascular catheter* for thrombophlebitis due to central vein catheter (CVC) OR
- T82.75 *Infection and inflammatory reaction due to peripheral vascular catheter* for thrombophlebitis due to (peripheral) intravenous catheter (IVC)
- a code from category I80 *Phlebitis and thrombophlebitis* to provide specificity regarding the inflammatory reaction
- Y84.8 *Other medical procedures*
- Y92.23 *Health service area, not specified as this facility* OR Y92.24 *Health service area, this facility*

Follow the ICD-10-AM Alphabetic Index:

Section I Alphabetic Index of Diseases and Nature of Injury:

Complication(s) (from) (of)
- vascular
- - device, implant or graft
- - - infusion catheter
- - - - infection or inflammation
- - - - - central vascular (infusion port) (PICC) (Port-A-Cath) T82.74
- - - - - peripheral vascular T82.75

See lead term *Thrombophlebitis / by site,* for example:

Thrombophlebitis
- specified site NEC I80.8
- upper extremity NEC I80.40
- - antecubital I80.41

Section II External causes of injury:

Complication(s) (delayed) (medical or surgical procedure) (of or following)
- catheterisation Y84.8

Place of occurrence of external cause
- health service area (not specified as this facility) NEC Y92.23
- - this facility Y92.24

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Ref No: Q3610 | Published On: Dec-2020 | Status: Current

Vena cava thrombus or pulmonary embolism due to central or peripheral vascular catheter

Q:

What codes are assigned for vena cava thrombus or pulmonary embolism due to central or peripheral vascular catheter?

A:

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 the Alphabetic Index. Assign an additional code to provide specificity of the condition, not the anatomical site.

Assign T82.82 *Embolism and thrombosis following insertion of cardiac and vascular prosthetic devices, implants and grafts* for vena cava thrombus or pulmonary embolism clearly documented as due to central or peripheral vascular catheter.

Follow the ICD-10-AM Alphabetic Index:

Complication(s) (from) (of)
- vascular
- - device, implant or graft
- - - embolism T82.82
- - - thrombosis T82.82

Also assign external cause codes.

T82.82 contains sufficient specificity regarding the complicating condition (ie embolism or thrombosis). Do not assign an additional code from Chapter 9 *Diseases of the circulatory system* to specify the site of the embolism or thrombosis.

Note, however, that embolism or thrombosis following a procedure (eg insertion of a device) are medical conditions that commonly occur postoperatively. Where there is no causal link documented between these conditions and insertion of a device, do not assign T82.82. Follow the guidelines in ACS 1904 *Procedural complications/Intraoperative/postoperative medical conditions*.

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Post COVID-19 conditions—Additional emergency use codes

Ref No: TN1545 | Published On: Dec-2020 | Status Current

Classification of post COVID-19 conditions

The long term health outcomes of the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection and coronavirus disease 2019 (COVID-19) are uncertain and unfolding.

The World Health Organization has activated two additional emergency use codes to identify episodes of care where documentation indicates a post COVID-19 condition, resulting from either a previous COVID-19 diagnosis or SARS-CoV-2 infection.

These emergency use codes are not for the classification of current infections of SARS-CoV-2 and are never assigned as a principal diagnosis.

In Australia, the post COVID-19 emergency use codes will be implemented as follows:

- assign U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* as an additional diagnosis where clinical documentation indicates that the patient has previously confirmed COVID-19 that is no longer current.
- assign U07.4 *Emergency use of U07.4 [Post COVID-19 condition]* as an additional diagnosis where clinical documentation indicates a current condition is causally related to previous COVID-19.

  Do not assign B94.8 *Sequelae of other specified and infectious and parasitic diseases* as this concept is identified by the assignment of U07.4.

  Where clinical documentation indicates previous COVID-19 but it is not clearly linked to a current condition, seek clarification from the treating clinician before assigning U07.4. Where a causal relationship is not established, assign U07.3 *Emergency use of U07.3 [Personal history of COVID-19]*.

U07.3 and U07.4 are only assigned when COVID-19 is documented as no longer current. This includes where clinical documentation indicates that a patient does not have COVID-19, despite a positive laboratory test result for SARS-CoV-2. This scenario may occur where antibodies remain in the system even though an acute infection is no longer present (World Health Organization 2020). See also Coding Rule Coronavirus disease 2019 (COVID-19) when COVID-19 is documented as current.

Example 1: A patient is diagnosed with interstitial lung disease associated with previous COVID-19. As the clinical documentation states a causal relationship between the interstitial lung disease and previous history of COVID-19, assign emergency use code U07.4 *Emergency use of U07.4 [Post COVID-19 condition]* as an additional diagnosis.

Codes: J84.9 *Interstitial pulmonary disease, unspecified*

U07.4 *Emergency use of U07.4 [Post COVID-19 condition]*

Example 2: Following a full recovery from viral pneumonia with a SARS-CoV-2 (COVID-19) infection a patient is statistically discharged from an acute admitted episode of care and transferred to rehabilitation. The SARS-CoV-2 infection is no longer active in the rehabilitation episode of care.

In the rehabilitation episode of care, assign U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* as an additional diagnosis NOT U07.1 *Emergency use of U07.1 [COVID-19, virus identified]* as the SARS-CoV-2 infection is no longer current.

Codes: J12.8 *Other viral pneumonia*

Z50.9 *Rehabilitation*

U07.3 *Emergency use of U07.3 [Personal history of COVID-19]*

Example 3: Patient admitted with community acquired pneumonia. Laboratory test identifies SARS-CoV-2 positive, but a review by the infectious diseases team states 'old viral RNA that is not infectious'. As there is clinical documentation of a previous SARS-CoV-2 infection but no causal relationship with a current condition, assign emergency use code U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* as an additional diagnosis.

Codes: J18.9 *Pneumonia, unspecified*

U07.3 *Emergency use of U07.3 [Personal history of COVID-19]*

Example 4: Patient presents with gastro-oesophageal reflux disease. Clinical documentation in the current episode of care notes a recent history of COVID-19. As there is no causal relationship documented between COVID-19 and the current condition, assign emergency use code U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* as an additional diagnosis.

Codes: K21.9 *Gastro-oesophageal reflux disease without oesophagitis*

U07.3 *Emergency use of U07.3 [Personal history of COVID-19]*

Reference:
World Health Organization 2020, *Serology and early investigation protocols*, viewed 2 September 2020, <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/serology-in-the-context-of-covid-19>.

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Multisystem inflammatory syndrome associated with COVID-19

The COVID-19 pandemic has resulted in reports describing patients with COVID-19-associated multisystem inflammatory conditions that appear to develop after the infection rather than during the acute stage of COVID-19. This condition may be synonymously referred to as:

- paediatric inflammatory multisystem syndrome temporally associated with SARS-CoV-2 (PIMS-TS)
- multisystem inflammatory syndrome in children (MIS-C) associated with COVID-19
- multisystem inflammatory syndrome in adults (MIS-A).

While the clinical presentation may vary, signs and symptoms generally include persistent fever, abdominal pain, vomiting, diarrhoea, skin rash, mucocutaneous lesions and, in severe cases, hypotension and shock. Some patients may develop myocarditis, cardiac dysfunction or acute kidney injury (Centres for Disease Control and Prevention 2020a; World Health Organization 2020).

To identify this condition, the World Health Organization has activated an emergency use code that will be implemented in Australia as U07.5 *Emergency use code U07.5 [Multisystem inflammatory syndrome associated with COVID-19].*

U07.5 *Multisystem inflammatory syndrome associated with COVID-19* is assigned in accordance with ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*.

Example 1: A patient is diagnosed with multisystem inflammatory syndrome after recovering from COVID-19. Assign emergency use code U07.5 *Emergency use code U07.5 [Multisystem inflammatory syndrome associated with COVID-19]* in accordance with the guidelines in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*.

Codes: U07.5 *Emergency use code U07.5 [Multisystem inflammatory syndrome associated with COVID-19]*

Example 2: A paediatric patient is diagnosed with Kawasaki-like syndrome. Symptoms include fever, odynophagia, two days of diarrhoea and vomiting, and abdominal pain. Laboratory tests reveal residual antibodies from a previous SARS-CoV-2 infection. Assign emergency use code U07.5 *Emergency use code U07.5 [Multisystem inflammatory syndrome associated with COVID-19]* as principal diagnosis. Do not assign additional diagnosis codes for the symptoms or M30.3 *Mucocutaneous lymph node syndrome [Kawasaki]* in addition to U07.5.

Codes: U07.5 *Emergency use code U07.5 [Multisystem inflammatory syndrome associated with COVID-19]*

References:

Centres for Disease Control and Prevention 2020a, *Information for healthcare providers about multisystem inflammatory syndrome in children (MIS-C)*, United States Department of Health & Human Services, viewed 2 September 2020, <https://www.cdc.gov/mis-c/hcp/>.

Centres for Disease Control and Prevention 2020b, *Multisystem inflammatory syndrome in adults (MIS-A)*, United States Department of Health & Human Services, viewed 2 December 2020, <https://www.cdc.gov/mis-c/mis-a.html>.

Jiang, L., Tang, K., Levin, M., Irfan, O., Morris, S.K., Wilson, K., Klein, J.D., & Bhutta, Z.A. 2020, 'COVID-19 and multisystem inflammatory syndrome in children and adolescents', *Lancet Infectious Diseases: Online First*, viewed 2 September 2020, <https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(20)30651-4/fulltext#:~:text=This%20COVID%2D19%2Dassociated%20multisystem,19%2C%20and%20herein%20is%20referred>.

World Health Organization 2020, *Multisystem inflammatory syndrome in children and adolescents temporally related to COVID-19: Scientific brief*, viewed 2 September 2020, <https://www.who.int/news-room/commentaries/detail/multisystem-inflammatory-syndrome-in-children-and-adolescents-with-covid-19>.