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Source of ICD-10-AM/ACHI/ACS information contained within this document

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ACS 0003 *Supplementary codes for chronic conditions*

When assigning U82.1 *Ischaemic heart disease* is this code only used for coronary artery disease (CAD) or is it used for other forms of ischaemic heart disease such as cardiomyopathy for example. When reviewing the standard ACS 0940 *Ischaemic Heart Disease* (IHD), it tells us that IHD is classified to I20-I25, so do we then use U82.1 when a patient has any form of IHD?

Response

No. Coders need to refer to the lead term 'Supplementary' in the ICD-10-AM Alphabetic Index to correctly classify chronic conditions.

Supplementary
- disease
- - artery, coronary (CAD) (conditions in I25.1-) U82.1
- - - chronic
- - - - heart, congestive U82.2
- - - ischaemic heart (IHD) U82.1

ACS 0019 *Intervention abandoned, interrupted or not completed*

Is the code Z53.3 *Procedure abandoned after initiation* to be used in all circumstances or just for inpatient (IP) events where the patient has been specifically admitted for the procedure (like the cancelled procedures)? ie: can it be used on an acute admission where the procedure was abandoned?

Response

The intervention abandoned code Z53.3 is assigned irrespective of event type or event length of stay. Therefore, Z53.3 *Procedure abandoned after initiation* can be used in all cases where the intervention was initiated/commenced but then abandoned.

ACS 0052 *Same-day endoscopy – surveillance*

I am about to start on the current coding and would like to understand the same day endoscopy coding changes. I'm fine with diagnostic but can you steer me in the right direction for Z codes.

1. Has there been a change in applying Z12.1 *Special screening examination for neoplasm of intestinal tract* & Z80.0 *Family history of malignant neoplasm of digestive organs* where it is screening for family history?
2. Then Z08.0 & Z85.0 *Personal history of malignant neoplasm of digestive organs* for follow up after surgery
3. Lastly Z09.0 *Follow-up examination after surgery for other conditions* & Z87.12 *Personal history of colonic polyps* for follow up after previous polyps.
4. If polyps are found we code the findings do we also assign the Z09.0

Response

1. No change

Disease/disorder not detected- assign Z12.1 as PDx + F/H – see ACS example 3
Disease/disorder detected – code disease/disorder + F/H – see ACS example 6

2. & 3 No change

If disease/disorder not detected – assign Z08 *Follow-up examination after treatment for malignant neoplasms* or Z09 *Follow-up examination after treatment for conditions other than malignant neoplasms* as PDx + P/H – see ACS examples 1 & 2

4. No, not in a single endoscopy, see below.

Minor change if disease/disorder detected - code only the disease/disorder – see examples

8th Edition

EXAMPLE 4:
Carcinoma of bladder found at check cystoscopy.

Codes:	C67.9	*Malignant neoplasm of bladder, unspecified*
	M8010/3	*Carcinoma NOS*
	Z08.9	*Follow-up examination after unspecified treatment for malignant neoplasm*

11th Edition

Example 10:
Patient with history of transitional cell cancer of the bladder treated with radiotherapy five years ago, admitted for follow-up cystoscopy. Recurrence of the malignancy was treated with diathermy.

Codes:	C67.9	*Malignant neoplasm of bladder, unspecified*
	M8120/3	*Transitional cell carcinoma NOS*

Example 11:
Follow-up colonoscopy for hyperplastic polyps of the colon, removed surgically one year ago. Polyp found in the descending colon and removed. Histology revealed tubulovillous adenoma.

Codes:	D12.4	*Benign neoplasm of descending colon*
	M8263/0	*Tubulovillous adenoma NOS*

In this example the polyp (tubulovillous adenoma) found at endoscopy is the principal diagnosis even though it is a different topography/morphology to the polyps previously removed.

As per the third bullet point under Classification section 'Assign as additional diagnosis' codes Z08 or Z09 *Follow-up examination after treatment for…* or Z11, Z12 and Z13 *Special screening examination for…* can be assigned as an additional diagnosis where a patient undergoes multiple endoscopies for different purposes within the same episode of care and no condition is detected for one of the endoscopies, see ACS example 14.

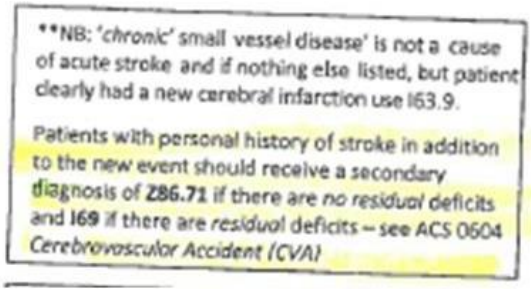
Example 14:
Patient admitted for oesophagogastroduodenoscopy and biopsy for known coeliac disease, and for colonoscopy due to family history of colorectal cancer. Pathology report detected evidence of coeliac disease in the biopsied tissue. No neoplasm was identified in colon or rectum.

Codes:	K90.0	*Coeliac disease*
	Z12.1	*Special screening examination for neoplasm of intestinal tract*
	Z80.0	*Family history of malignant neoplasm of digestive organs*

Note: Sequence codes as per the guidelines in ACS 0001 *Principal diagnosis.*

ACS 0604 *Cerebrovascular accident (CVA)*

Am I reading this correctly – we are to code a history of CVA with an acute CVA/stroke…. Isn't that kind of like coding I25.2 *Old myocardial infarction* with I21.4 *Acute subendocardial myocardial infarction* or a history of CA with a new primary of a different site?


**NB: 'chronic' small vessel disease' is not a cause of acute stroke and if nothing else listed, but patient clearly had a new cerebral infarction use I63.9.

Patients with personal history of stroke in addition to the new event should receive a secondary diagnosis of **Z86.71** if there are *no residual deficits* and **I69** if there are *residual deficits* – see ACS 0604 *Cerebrovascular Accident (CVA)*

This came up when a coder asked "how do you tell if it is a residual from a previous stroke/CVA or due to a new stroke/CVA" ie: hemiplegia – noted to be present before, but also noted as part of the new episode…. confusing!!

Response

In Eighth Edition ACS 0604 *Stroke – Old CVA* stated:

Old CVA – care should be taken when coding this inappropriate and misleading diagnostic statement which might mean either:

1. *the patient has a history of stroke with no neurological deficits now present, or*
2. *a history of stroke with neurological deficits still present*

But there was no classification for history of stroke with no deficits, this is why a code has been created at Z86.71 *Personal history of cerebrovascular disease.*
With the treatment these days if a patient can get treatment eg, thrombolysis within the required time frame stroke deficits can completely resolve, so it will be good to be able to now capture the history.

You can only code what's documented and/or may need consult the clinician as per ACS 0010 *Clinical documentation and general abstraction.*

ACS 0941 *Arterial disease*

Can you please let us know if we code coronary artery disease (C.A.D) if it's less than 50%. It was in the old standards not to code, but doesn't appear in the new standards

Response

Yes, you do code CAD less than 50% in Eleventh Edition.
The less than 50% was removed from ACS 0941 *Arterial disease* in Ninth Edition, as clinical advice was that stenosis of coronary artery less than 50% is regarded as clinically significant and often requires medical management.

ACS 1438 *Chronic kidney disease* – kidney transplant

We've just found a mismatch between the rubric at Z94.0 and ACS 1438 *Chronic kidney disease* (CKD).
There is a *code also* instruction at Z94.0 for the stage of CKD.

However, ACS 1438 section Kidney Replacement Therapy, third bullet point under Classification states:
"For patients who have received a kidney transplant, assign Z94.0 Kidney transplant status together with N18.3 Chronic kidney disease, stage 3 or higher, as indicated by an eGFR/GFR level where CKD meets the criteria for code assignment (see ACS 0001 Principal diagnosis and ACS 0002 Additional diagnoses)."

If the status of kidney transplant meets ACS 0002 and the CKD doesn't, then we have conflicting instructions. (3M Edit Engine is reflecting the *code also* instruction.)

Response

The code also instruction in the Tabular list at Z94.0 is correct as per ACS 1438 *Chronic kidney disease* (CKD).

As per the coding standard it states:
For patients who have received a kidney transplant, assign Z94.0 Kidney transplant status together with N18.3 Chronic kidney disease, stage 3 or higher, as indicated by an eGFR/GFR level where CKD meets the criteria for code assignment (see ACS 0001 Principal diagnosis and ACS 0002 Additional diagnoses).

The standard is saying where the CKD meets the criteria for code assignment as per ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses* and they have received a kidney transplant, then you can assign both the CKD stage 3 or higher plus the Z94.0.

If the CKD does not meet ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses* you assign a supplementary code only.

Z94.0 should never be assigned with U87.1 *Chronic kidney disease, stage 3–5.*

Alcohol Involvement

Is it mandatory to capture the involvement of alcohol now and report it to the Ministry of Health for National Minimum Dataset (NMDS) data as per the new substance addiction bill?

Response

Clinical coders will continue to code hospitalisations as per the coding standards.

Alcohol involvement has been collected for all Emergency Department presentations since 1 July 2015. From 1 July 2017 it became a mandatory requirement for all DHBs to report this to the National Non-Admitted Patient Collection (NNPAC). The question is: "Is alcohol associated with this presentation"

National Non-admitted Patient Collection Alcohol Involved Field Guidelines **Version 1.0**

3 Guidelines

3.1 Usage Guidelines

There are four valid responses to the question

"Is Alcohol Associated with this Presentation?"

Response	Description of the response
Y	Yes - it has been determined that alcohol consumption is directly associated with this presentation
N	No - it has been determined that alcohol consumption is not directly associated with this presentation
U	Not known (unknown) - it is not known, or could not be determined, whether or not alcohol consumption is directly associated with this presentation. PLEASE NOTE: where possible it is preferable that a Y or N be assigned to this field rather than a U
S	Secondary (this presentation is as a consequence of others' alcohol consumption – family violence, hit by drunk driver, sexual offence etc.)

Bronchoscopy with washings

How do we code Bronchoscopy with washings without mention of biopsy?

Tabular List:

543 Examination procedures on bronchus

Excludes: that with:
- argon plasma coagulation (lesion)(tissue):
  - bronchus (96217-01 [547])
  - lung (90181-01 [558])
- biopsy (washings for specimen collection):
  - bronchus (41898-04 [544])
  - lung (38418-06 [550])
- destruction (lesion)(tissue):
  - bronchus (96217-01 [547])
  - lung (90181-01 [558])
- dilation (41904-00 [546])
- excision of lesion:
  - bronchus (90163-01 [545])
  - lung (96218-00 [554])
- insertion of bronchial device (stent) (valve) (41905-06 [546])
- removal of:
  - bronchial device (stent) (valve) (41905-08 [546])
  - foreign body (41895-02 [544])
- replacement of bronchial device (stent) (valve) (41905-07 [546])

Response

As per the ACHI Index you would assign the code 41898-04 *Endoscopic [needle] biopsy of bronchus* from block [544].
I have highlighted below in red text the new sections in the Eleventh Edition ACHI Index.

Washing(s) - see also Lavage AND Irrigation
- for specimen collection (diagnostic) - see Biopsy

Bronchoscopy (electromagnetic navigation) (with bronchial lavage) (with fluoroscopic guidance) 41889-05 [543]
- with
- - biopsy (brush) (needle) (with brushing(s)) (with washing(s) for specimen collection) - see Biopsy, by site

Biopsy (brush) (with brushing(s)) (with washing(s) for specimen collection)
- bronchus (closed) (endoscopic) (needle) 41898-04 **[544]**

Delivery – Born Before Arrival (BBA)

If a mother gives birth in an ambulance but delivers the placenta in the hospital – the place of delivery is in a hospital. And here is my question…. But what about the baby – is this still BBA
The place of birth won't match the mothers?

Response

On the mothers record the diagnosis codes will indicate delivery of the baby, but the procedure will show it was only the placenta delivered in hospital. See example 3 from ACS 1505 *Delivery and assisted delivery codes.*

EXAMPLE 3:
Patient delivered baby (spontaneous vertex) in the ambulance on route to hospital. Placenta delivered spontaneously after admission to hospital.

Codes:	O80	*Single spontaneous delivery*
	Z37.0	*Outcome of delivery, single live birth*
	90467-01 **[1336]**	*Spontaneous delivery of placenta, not elsewhere classified*

In this example, delivery codes are assigned, as the delivery was completed (ie delivery of the placenta) during the admitted episode of care.

For the baby, yes you are correct. The newborn record will be born outside of hospital. See example 2 from ACS 1607 *Newborn/neonate.*

EXAMPLE 2:
Single infant born on the way to hospital. Transferred by ambulance to hospital with mother; newborn completely well.

Codes:	Z38.1	*Singleton, born outside hospital*

Place of occurrence – health service area

A quick question about procedural complications and free text
Free text changes for the new place of occurrence code for "this" health care facility – will we need to overtype this code description as the facility code is submitted to the MoH?
Is this specifically "this" hospital or "this" DHB? as we have two hospital sites….

Response

'This facility' refers to the facility not DHB.
With regards to free text I would definitely add additional information on the code Y92.23 *Place of occurrence, health service area, not specified as this facility* to specify the other facility.

Ventilation 1

With the changes to the ventilation ACS 1006 *Ventilatory support,* do you think the National Minimum Dataset (NMDS) will change as well for reporting ventilation hours? The ACS has changed from cumulative to non-cumulative, so this is a change to how we code but do we change how we report ventilation hours? See the scenario 13.6 in the workbook.

Response

There are no changes to the calculation of total hours on mechanical ventilation or non-invasive ventilation when reporting to the NMDS.
ACS 1006 *Ventilatory support* in Eleventh Edition is the same as Eighth Edition apart from the clarification about ventilation less than 1 hour. Below is bullet point c from Eleventh Edition

c. For the purpose of calculating the duration of ventilatory support:
- hours of ventilatory support should be interpreted as **completed cumulative hours**. If a patient is intubated and ventilated for < 1 hour the intubation and ventilation are not coded. This includes patients who die or are discharged or transferred.
- a period of ≤ 1 hour between cessation and then restarting ventilatory support should be accounted for in the duration, ie continue counting the duration.
- removal and immediate replacement of airway devices (tubes, masks) should be accounted for in the duration, ie continue counting the duration.

Bullet point f below, the highlighted section is the new wording in Eleventh Edition, but the guidelines are still the same as they were in Eighth Edition

f. The ventilatory support that is provided to a patient **during surgery** is associated with anaesthesia and is considered an integral part of the surgical procedure. The patient may remain on ventilatory support for some hours while recovering following surgery. Ventilation of ≤ **24 hours post surgery** should not be coded in these cases. Ventilatory support should be coded when:

- it is initially performed for **respiratory support** prior to surgery and is then **continued during surgery andpost surgery** (even if ≤ 24 hours post surgery).
- it is **initiated during surgery** and **continues** after surgery (in recovery, ICU, ward or for further surgery) for > **24 hours post** (initial) **surgery**.

The duration of ventilatory support should be counted from the time of intubation (see *Calculating the duration of CVS*). In cases where ventilatory support has been initiated **during** surgery and has met the above criteria for coding then the duration begins from the time of (initial) intraoperative intubation.

Where a patient has multiple visits to theatre requiring ventilation, each period of ventilation should be considered individually. If the period of ventilation post surgery is ≤ 24 hours, a code for ventilation is not assigned and not used cumulatively with other periods of ventilation in the episode of care.

In the workbook scenario 13.6 (below) you wouldn't add the hours together because they are separate episodes of ventilation. This is how the coders should be calculating it in Eighth Edition, see Coding Rule below.

13.6 A patient is admitted to the intensive care unit (ICU) and is intubated and ventilated via an endotracheal tube (ETT) then extubated 20 hours later. Two days later, the patient is taken to the operating theatre and returns to ICU still ventilated. The patient is extubated 16 hours later. Three days later, the patient is transferred to theatre again. This time, the patient returns to ICU still ventilated for a further 8 hours. Which of the following codes would be assigned?

a) 13882-00 [569] *Management of continuous ventilatory support, ≤ 24 hours*
b) 13882-01 [569] *Management of continuous ventilatory support, > 24 and < 96 hours*
c) 13882-02 [569] *Management of continuous ventilatory support, ≥ 96 hours*

Ref No: TN202 | Published On: 15-Dec-2008 | Status: Current

Ventilation (2 of 2)

Q:
If a patient, during one episode of care, has three theatre episodes with periods of post ventilation all of which are 24 hours, should the ventilation be coded as per the first dot point at point C in ACS 1006 *Ventilatory support Classification section*?

A:
No, point F in the classification section of ACS 1006 *Ventilatory support* should be followed. Each visit to theatre, where the patient is intubated and extubated, needs to be looked at individually and if the period of ventilation post surgery is <=24 hours a code for ventilation is not assigned and not used cumulatively with other periods of ventilation in the episode of care.

Whereas, the Coding Rule below is where the ventilation is continuous so is added together.

Ref No: TN203 | Published On: 15-Sep-2008 | Status: Updated | Updated On: 30-Jun-2013

Ventilation

Q:
If a patient is ventilated for surgery for 6 hrs - ICU 10 hrs - back to theatre 6 hrs - ICU 15 hrs and is then finally extubated, how is this type of scenario coded?

A:
As per ACS 1006 *Ventilatory support* point 1 *f,* even though the ventilation was originally initiated for surgery, if it continues for >24 hours post surgery (including subsequent surgical episodes) then it should be coded with the duration beginning from the time of the first intraoperative intubation. Minor errata changes will be made to this section of the standard. In the scenario cited, CVS continued for 31 hours (10+6+15=31) post the original surgery; therefore, count the number of hours of CVS from the time of initial intubation = 37 hours ventilation, assign 13882-01 **[569]** *Management of continuous ventilatory support, > 24 and < 96 hours.*

Ventilation 2

If we don't code ventilation < 1 hour (and here comes the question) do we have to report that hour to the MoH?

Response

Yes. 1 hour is to be reported to the National Minimum Dataset (NMDS) in the total hours on mechanical ventilation field.
This has always been the reporting requirement, see below the information from the NMDS Data Dictionary

When reporting the total hours on mechanical ventilation an incomplete hour is rounded up to the next hour; e.g., if the time ventilated is 98 hours 10 minutes, then the total hours on mechanical ventilation reported will be '00099'. The minimum number of 'total hours on mechanical ventilation' reported is 1.

3. For ICD procedure coding the minimum number of completed hours is 1.

Ventilation 3

There has been recent discussion on the coding of non-invasive ventilation (NIV) hours and on the rounding up or down.
Can you please confirm if we *only* round up for NIV and MV hours less than 1 hour?
There is an understanding that if we are coding anything greater than 1 hour that we round down as it is completed hours.

Australian Consortium for Classification Development ACCD Classification Information Portal
Coding Rules - Current as at 14-Dec-2018 11:28
Coding Rule is effective for event records with an event end date on or after 1 January 2019
Ref No: Q3386 | Published On: 15-Dec-2018 | Status: Current

Noninvasive ventilation (NIV) provided for less than 1 hour
Q:
Is a code assigned when noninvasive ventilation (NIV) is provided for less than 1 hour?
A:
ACS 1006 *Ventilatory support* states:
CLASSIFICATION
1. Code first the ventilatory support
…
c. For the purpose of calculating the duration of ventilatory support:
o hours of ventilatory support should be interpreted as **completed cumulative hours.** If a patient is intubated and ventilated for < 1 hour the intubation and ventilation are not coded. This includes patients who die or are discharged or transferred.

Although the above highlighted text relates specifically to continuous ventilatory support, the same logic is applicable to noninvasive ventilatory (NIV) support.
Therefore, if a patient receives NIV for less than one hour, do not assign 92209-00 **[570]** *Management of noninvasive ventilatory support, < 24 hours.*
Ministry of Health comment:
As per the NMDS reporting requirements, total hours on noninvasive (NIV) and mechanical ventilation (MV) are to be rounded up. Therefore, where ventilation is provided less than 1 hour the reported value in the total hours on NIV or MV will be 1.
Amendments may be considered for a future edition.
Published 15 December 2018, for implementation 01 January 2019.

Response

Rounding up for reporting total hours is for all hours on NIV and MV. This has always been the reporting requirement, see below the information from the NMDS Data Dictionary

Reporting hours – always round up incomplete NIV and MV hours when reporting the total hours in the separate field
Procedure code assignment – always round down incomplete NIV or MV hours when determining the procedure code assignment

The published coding rule is addressing the question about coding (assigning a procedure code) if the NIV or MV is less than 1 hour. In these cases where NIV or MV is less than 1 hour, 1 should be reported in the separate field and no procedure code is assigned.

When reporting the total hours on mechanical ventilation an incomplete hour is rounded up to the next hour; e.g., if the time ventilated is 98 hours 10 minutes, then the total hours on mechanical ventilation reported will be '00099'. The minimum number of 'total hours on mechanical ventilation' reported is 1.

CLINICAL CODING
All hours on mechanical ventilation in the Emergency Department (ED) should be coded, whether the patient is intubated in ED or in the ambulance. If ventilation is commenced in the ambulance, it will be counted only from the time of hospitalisation.

Hours on continuous ventilatory support (CVS) (mechanical ventilation) should be interpreted as completed cumulative hours.

1. If more than one period of CVS (mechanical ventilation) occurs during the same hospitalisation when used for treatment (not weaning) should be added together. For example, if a patient is on CVS for the first day of their admission, then on CVS again on the fourth day of their admission, the CVS hours should be added together to arrive at the correct CVS procedure code.

2. ICD procedure coding includes all time spent ventilated from time of arrival to hospital (or time of intubation).

3. For ICD procedure coding the minimum number of completed hours is 1.

4. Partially completed hours are not counted when allocating a procedure code, ie, they are rounded down for ICD procedure coding.

WORKED EXAMPLE
Patient brought in by ambulance at 10.32am. Patient goes into acute respiratory failure and was intubated and commenced ventilation in ED at 10.50am. Once the patient was stabilised he was admitted to ICUat 11.43am (day one). The next day (day two) the patient was transferred to theatre for surgery. Total time in theatre was 4 hours. The patient returned to ICU and remained ventilated until the next day (day three) when mechanical ventilation ceased and the patient was extubated at 12.32pm.

On day one patient commenced ventilation in ED at 10.50am and was extubated 12.32pm on day three. Total mechanical ventilation hours:
(Day 1) 13hrs 10mins + (Day 2) 24hrs + (Day 3) 12.32hrs
Total hours on mechanical ventilation = 49 hours 42 minutes

Reporting total hours on mechanical ventilation:
49.42 hours minus 4 hours in theatre = 45.42 hours (rounded up) = 46 hours.
46 hours is to be reported in the total hours on mechanical ventilation field.

Procedure code assignment:
13882-01 [569] *Management of continuous ventilatory support, > 24 and < 96 hours*
As per the coding guidelines the total hours used in order to assign the correct procedure code would be 49 hours.