Contents

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

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ACS 0003 *Supplementary codes for chronic conditions*

Documentation states patient has a history of NSTEMI with cardiac stents. Can we assign Supplementary Code U82.1 *Ischaemic Heart Disease* on this documentation alone (no IHD or CAD documented)?

Response

No. ACS 0003 *Supplementary codes for chronic conditions* states:
"Note: The specific terms listed in the Alphabetic Index must be followed to inform code assignment. Except where otherwise indicated, only assign codes from this section for unspecified/NEC/NOS conditions (eg hypertension NOS) – see Alphabetic Index: Supplementary/codes for chronic conditions."

A similar question was asked and responded to in the NZ MOH Eleventh Edition questions, see below.

NZ Ministry of Health Eleventh Edition FAQs

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*

Patient came in for TURBT for Bladder TCC. On the operation report it was stated that a TURBT was performed but a diagnostic ureteroscopy could not be done due to a tight ureter. Do we code Z53.3 *Procedure abandoned after initiation,* in this case

Response

No. As per ACS 0019 this scenario would not be considered a procedure abandoned as the intended procedure (TURBT) was completed.
Section 'Failed interventions' states:
"Clinical coders should be cautious when an intervention is documented as 'failed'. It could mean that certain components of the intervention may not be carried out successfully but the expected outcome may have been achieved. In these circumstances, do not assign Z53.3 Procedure abandoned after initiation, but assign an ACHI code for the intervention performed."

ACS 0019 *Intervention abandoned, interrupted or not completed*

A patient has three hernia (bilateral inguinal, plus the paraumbilical hernia), he was supposed to undergo repairs for all three hernias, however when the White Island emergency happened only the R) inguinal repair had been completed. Do we assign the Z53.3 *Procedure abandoned after initiation* for an abandoned procedure or do we consider that it was three separate repairs one of which was completed?... and if we do code the Z53.3 *Procedure abandoned after initiation* will we be funded for the repair of the inguinal hernia that was completed?

Response

As per ACS 0019 *Intervention abandoned, interrupted or not completed* the code Z53.3 *Procedure abandoned after initiation* is assigned when the intervention was abandoned, interrupted or not completed due to unanticipated circumstances. This should be interpreted as an unanticipated problem with the patient, not due to external factors.

In regard to your last question, code Z53.3 *Procedure abandoned after initiation* back maps to Eighth Edition code Z53.8 *Procedure not carried out for other reasons* and as per the WIES cancelled op exclusion rule the event described would not be excluded as the first procedure would not be blank.

ACS 0052 *Same-day endoscopy – surveillance*

Patient presents for follow up colonoscopy (same day) for history of polyps (removed previously). The colonoscopy finds further colonic polyps which are removed. If we follow the pathway in the 3M Codefinder a follow up code is assigned, Z09.0 *Follow-up examination after surgery for other conditions.* However, in ACS 0052 *Same-day Endoscopy Surveillance,* example 11, the follow-up code (Z09.0) is not assigned. Should we be assigning Z09.0 in this case?

Response

No. ACS 0052 *Same-day endoscopy – surveillance,* classification section – principal diagnosis bullet point two states to assign as principal diagnosis “the condition under surveillance (follow-up/screening) if detected at screening (see examples 6 and 10)."

Then in classification section – additional diagnoses it states *"codes from categories Z08 or Z09 Follow-up examination after treatment for… or Z11, Z12 and Z13 Special screening examination for… as appropriate. That is, these codes may be assigned to reflect 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 Example 14).*

There was a Tenth Edition FAQ Part 3 as part of the education material that touched on not assigning the Z codes as an additional diagnosis.

ACS 0110 *SIRS, sepsis, severe sepsis and septic shock*

What code do we assign for post procedural sepsis in Eleventh Edition?

In Eighth Edition we had the code T81.42 *Sepsis following a procedure* but we don’t have this code in Eleventh Edition. So what code is to be assigned when the patient has sepsis following a procedure that is not wound sepsis T81.89 *Other complications following a procedure, not elsewhere classified*?

T81.42 *Sepsis following a procedure*
Fever due to infection postprocedural
Sepsis postprocedural

Response

ACS 0110 *SIRS, sepsis, severe sepsis and septic shock* and ACS 1904 *Procedural complications* have been revised, including the ICD-10-AM Alphabetic Index.
Postprocedural sepsis where applicable is to be coded as a complication of a device, infusion or wound.
In cases where the postprocedural sepsis is documented but cannot be classified as a complication of a device, infusion or wound, it is to be coded as sepsis only – assign a Chapter 1 *Certain infectious and parasitic diseases* (A00-B99), P36 *Bacterial sepsis of newborn* or P37 *Other congenital infectious and parasitic diseases* as per ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses.* See ACS 0110 *SIRS, sepsis, severe sepsis and septic* – sepsis section and ACS 1904 *Procedural complications* – postprocedural wound infection.

ACS 1904 *Procedural complications*

As we are brushing up with Eleventh Edition and in the document ACS 1904 *Procedural complications* I have some concerns on the use of 'additional codes for procedural complications'.

I still think some complications would need an additional chapter code, to give more specificity to the procedural complication (as in the examples below). My concern is that we may be missing out on the exact context of the complication if the chapter codes are totally not used.
For some scenarios, they do give a better picture of the procedural complication, especially when the complication code itself is a 'generic' one e.g T81.0 *Haemorrhage and haematoma complicating a procedure, not elsewhere classified.* I think it would be good to assign a chapter code than to just text edit the complication code.

- Example 10 (Q3368) – unnecessary to assign N64.8 *Other specified disorders of breast*
- Example 11 (Q3368) – unnecessary to assign S06.5 *Traumatic subdural haemorrhage*
- Example 14 (Q3350) – unnecessary to assign S64.4 *Injury of digital nerve of other finger* or S64.3 *Injury of digital nerve of thumb*

Response

Yes, all publsihed coding rules applicable to Eleventh Edition are to be applied.

In regard to your concerns about no longer adding additional codes, in the document at section 'Procedural complications the assignment of additional codes to add specificity' it states:
"The instruction in the ACS regarding 'an additional code from Chapters 1 to 19 may be assigned where it provides further specificity', is intended to provide further specificity of the condition, not an anatomical site."
As we have the ability to add and report free text in the code description field the site can be captured using this function.

ACS 2115 *Admission for allergen challenge*

Can you please advise – should we continue to assign procedure codes for patients admitted for allergy/allergen testing?

Response

In Eighth Edition diagnostic skin and sensitisation testing would have been coded to Z01.5 *Diagnostic skin and sensitisation tests* (includes allergy tests, skin test etc) and the skin testing procedure codes.
If you look at code Z01.5 in Eleventh Edition there are now excludes for:

challenge:
allergen NOS Z41.89
drug Z41.81
food Z41.82
desensitisation to allergens Z51.6-

Therefore, anyone admitted for an allergy challenge (testing) should be coded as per ACS 2115 *Admission for allergen challenge.* In ACS 2115 the classification section states 'It is not necessary to assign a procedure code for the challenge'

ACS 2115 *Admission for allergen challenge*

When a patient has an allergen challenge with a negative response, are we just coding a Z code? In the past we always coded external cause codes but has it changed for us for Eleventh Edition?

We don't have a coding rule with regards to this now, so are we following how Australia applies ACS 2115? There are no examples in the standard for a negative response but we did have a question during the coding exercises we did during the education where only the Z code was used. Please advise.

Response

Yes. When there is no reaction assign the Z code - Z41.8- *Other procedures for purposes other than remedying health state* and any history of allergy.

The reason why external cause codes were added in Eighth Edition was because the code Z03.6 *Observation for suspected toxic effect from ingested substance* was assigned, and as per the NMDS reporting requirements external cause codes are required to be reported with Z03.6. However, in Eleventh Edition there are now specific allergy codes (Z41.8-) and a specific coding standard.

ACS 2115 *Admission for allergen challenge*

A question on how we code anaphylaxis due to bee sting. Following the pathway in 3M Codefinder I have come up with codes:

T63.4 *Venom of other arthropods*
T78.2 *Anaphylaxis and anaphylactic shock, unspecified*
X23.30 *Contact with unspecified bees*
Y92.01 *Place of occurrence, outdoor areas*
U72 *Leisure activity, not elsewhere classified*

In Eleventh Edition T78.2 is asking us to use an additional external cause code (Y37.- *Exposure to or contact with allergens*) to identify allergen, if known. With the situation given, we know that the allergen is bee sting, so I've coded Y37.61 *Allergy to bees.*

Will it be over coding if I have X23.30 *Contact with unspecified bees* and Y37.61 *Allergy to bees* together?

Response

At the category T63 *Toxic effect of contact with venomous animals* there is an instructional note 'use additional code if applicable, to identify reaction, such as: anaphylaxis and anaphylactic shock T78.2' (which was present in Eighth Edition).

Then, at T78.2 *Anaphylaxis and anaphylactic shock, unspecified* there is a new instructional note 'use additional external cause code (Y37.-) to identify allergen, if known', that is why Codefinder is prompting for the assignment of Y37.-.

At the external cause category X20-X29 *Contact with venomous animals and plants* there is a new excludes note for: allergen, allergic reaction (Y37.6-).

So based on the instructional and excludes notes it would appear that only Y37.6- should be assigned. It seems odd to only assign Y37.6- in these cases and I don't think the intention was to assign both external codes when the changes were made in Eleventh Edition. Therefore, I have raised a coding query with IHPA in regard to the instructional and excludes note and asked for clarification about the changes made in Eleventh Edition. In the meantime, I would not assign the Y37.- in addition to T78.2 and X23.30. You will get the warning message in Codefinder but I would just ignore it.

In regard to the case you probably have already coded, if you have assigned both external cause codes, just leave it as is and keep note of the NHI. Then once we get clarification from IHPA you can then update the event record.

Coronary angiogram

We want to confirm whether we should be coding coronary angiography with angioplasty in Eleventh Edition as there is no longer a 'code also when performed' as there was in Eighth Edition. We landed on if the coronary angiography is part of the angioplasty then it should not be coded. This is a change from Eighth Edition. Can you please confirm?

Eleventh Edition

671 Transluminal coronary angioplasty with stenting

Transluminal balloon angioplasty

Includes:
balloon dilation of artery

that with drug eluting stent(s)

transcatheter infusion of thrombolytic or other agent

Code also when performed:

- coronary angioplasty with:
  - aspiration thrombectomy (90218-00, 90218-01 **[669]**)
  - embolic protection device (90218-02, 90218-03 **[669]**)

Excludes:
with atherectomy of coronary artery (see block **[669]**)

Eighth Edition

671 Transluminal coronary angioplasty with stenting

Transluminal balloon angioplasty

Includes:
balloon dilation of artery
that with drug eluting stent(s)

Code also when performed:

- coronary angiography (38215-00, 38218 **[668]**)
- coronary angioplasty with:
  - aspiration thrombectomy (90218-00, 90218-01 **[669]**)
  - embolic protection device (90218-02, 90218-03 **[669]**)

Excludes:
with atherectomy of coronary artery (see block **[669]**)

Response

The code also instruction was deleted in the development of Ninth Edition, see below the information from the Ninth Edition changes document. Where a diagnostic coronary angiography is performed with a catheter based intervention the coronary angiography is to be coded.

A number of other Instructional and includes notes have also been revised in Chapter 6 - *Procedures on cardiovascular system.*

Cardiac catheterisation has been added as an *includes note* to a number of percutaneous cardiac procedures highlighting that catheter access in percutaneous procedures of the heart is inherent.

The *code also when performed* instruction for coronary angiography has also been deleted from a number of percutaneous cardiac procedures to avoid confusion with catheter access for percutaneous procedures, which should not be assigned a separate code.

If a coronary angiography (classified to block [668]) is performed in conjunction with these procedures, as a diagnostic procedure, then an additional code from block [668] is assigned and an instructional note is unnecessary.

The following amendments were made to ACHI Ninth Edition:

- Creation of code 96222-00 *Percutaneous mitral valvuloplasty* using closure device at block [626] *Repair of mitral valve*
- Addition of inclusion term for *percutaneous balloon valvotomy* at 38270-01 [622], 38270-02 [626] and *percutaneous balloon valvuloplasty* at 38270-03 [637]
- Addition of a note to specify *includes: cardiac catheterisation* at 38488-08 [623], 38488-09 [628], 38488-10 [634] and 38488-11 [637] *Percutaneous replacement of heart valves with bioprosthesis*
- Deletion of instructional note for *code also when performed coronary angiography (38218 [668])* at 38488-08 [623], 38488-09 [628], 38488-10 [634] and 38488-11 [637] *Percutaneous replacement of heart valves with bioprosthesis*
- Deletion of *code also when performed coronary angiography (38215-00, 38218 [668])* at blocks [669], [670] and [671]
- Deletion of instructional note *code also when performed valve annuloplasty (38275, 38477 [622], [627] and [633])* at 38270-01 [622] *Percutaneous balloon aortic valvuloplasty* and 38270-02 [626] *Percutaneous balloon mitral valvuloplasty*
- Amendments to the Alphabetic Index to support the above changes.

Diabetes with CKD and hypertension

Could you please clarify how diabetes with CKD and hypertension is coded in Eleventh Edition where CKD and hypertension do not meet ACS 0002 *Additional diagnoses.*

Should we use (as in Eighth Edition):

N18 *Chronic kidney disease*
I10 *Essential (primary) hypertension*

or should we use:

U87.1 *Chronic kidney disease, stage 3 to 5*
U82.3 *Hypertension*

Could you please clarify how diabetes with CKD and hypertension is coded in Eleventh Edition?

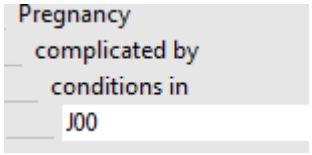
Response

In Eighth Edition at category N18 there was an instructional note 'use additional code to identify presence of hypertension', which has been deleted in Eleventh Edition. This means hypertension is no longer 'automatically' coded when present in CKD. As per ACS 0401 *Diabetes Mellitus* rule 4b you would only code complications/conditions associated with DM when they meet ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses.* Therefore, where hypertension and/or CKD stage 3-5 does not meet ACS 0001 or ACS 0002 assign the supplementary codes for the chronic conditions.

Obstetrics

Patient has a spontaneous vaginal delivery with manual removal of placenta in third stage of labour.

1. Do we need to assign the procedure code as assisted delivery?
2. What if the manual removal of placenta is done for the retained fragments after a delivery procedure is completed? [3M is also giving edit warning for this scenario]
3. How do we code a medical condition which is not a puerperal complication with another puerperal condition? [Do we still use O99 *Other maternal diseases classifiable elsewhere in pregnancy, childbirth and the puerperium* codes for the medical condition in this situation?]. For example, a patient was treated for asthma and mastitis after two weeks of delivery. One is a postpartum condition and another one is a non-obstetric condition in postpartum. We have not assigned O99.5 *Diseases of the respiratory system in pregnancy, childbirth and the puerperium* in this event as the asthma is not a complication in the postpartum episode of care, is this correct? J00–J99 O99.5



Response

1. Yes. Spontaneous vaginal delivery with manual removal of placenta should be assigned the codes 9047701 [1343] *Assisted vertex delivery* and 9048200 [1345] *Manual removal of placenta.*
   As per ACS 1505 *Delivery and assisted delivery codes,* delivery is not complete until after expulsion of the placenta (excluding portions placenta), therefore because the patient required manual removal of placenta the delivery is no longer spontaneous.
2. As per ACS 1505 *Delivery and assisted delivery codes,* retained portions of placenta are excluded from delivery, therefore the case would be coded as O80 *Single spontaneous delivery* with O73.1 *Retained portions of placenta and membranes,* and 90467-00 [1336] *Spontaneous vertex delivery* with 90482-00 [1345] Manual removal of placenta – if you get an error in edit engine ignore it. I will raise this will Jennie at 3M.
3. Yes, agree not to assign O99.5 *Diseases of the respiratory system in pregnancy, childbirth and the puerperium* and to only assign the J459 *Asthma, unspecified.* This is as per bullet point four in ACS 1548 Puerperal/postpartum condition or complication.

Peripheral Angiogram

Do we code peripheral angiography when an angioplasty is also performed?

Response

Peripheral angiography is classified to ACHI Chapter 20 *Imaging Services,* therefore, as per ACS 0042 *Procedures normally not coded* point 11 *Imaging services (blocks [1940] to [2015])* it is not coded.
However, peripheral angiography may be coded if it meets any one of the three classification criteria (below) in ACS 0042 *Procedures normally not coded*.

- a cerebral anaesthesia (GA or sedation) is required in order for the procedure to be performed
- it is the principal reason for admission in a same-day episode of care
- another specialty standard directs it should be coded.