ACCD Update

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ACCD Update

This presentation will encompass the following topics:

- ACCD activities
- NCCH activities
- ICD-10-AM/ACHI/ACS Eleventh Edition
- Tenth Edition FAQs discussion
- *Standards for ethical conduct in clinical coding* clarification

ACCD activities

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ACCD Activities

- In a 'typical' two year work cycle ACCD undertakes:
  - Management of incoming queries and public submissions regarding ICD/ACHI/ACS/AR-DRGs.
  - Coordination of the ICD Technical Group (ITG).
  - A public consultation process to ensure the public are aware of major ICD-10-AM/ACHI/ACS changes as proposals are finalised through ITG.
  - Participation on the AR-DRG Technical Group (DTG) and the Classifications Clinical Advisory Group (CCAG), both now managed by IHPA

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ACCD Activities

- Production of the electronic code lists for ICD and ACHI, and mapping files between ICD-10-AM and ICD-10.
- Production of the Chronicle and Reference to Changes Document.
- Production of the education for Eleventh Edition
- Ongoing development of the IT infrastructure to support ICD-10-AM/ACHI/ACS development.

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ACCD Activities

- Ongoing development of a strategic plan for ICD-10-AM/ACHI/ACS.
- Liaise with IHPA in regards to DRG impact of proposed ICD/ACHI/ACS amendments, and in DRG development.

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Common ACCD questions

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Who is the ACCD?

- The ACCD is a consortium between the University of Sydney (USYD) and Western Sydney University (WSU).

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Who is the ACCD?

- USYD (NCCH) is now responsible for providing leadership in the revision and maintenance of ICD-10-AM/ACHI/ACS Eleventh Edition, communication with stakeholders, education & publishing

- WSU is responsible for systems maintenance & development, user interfaces for submissions and queries, IT platform to manage processing of proposals.

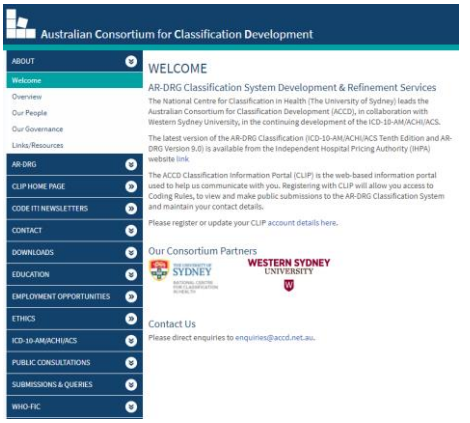
ACCD Activities

- **How can a coder submit a coding query to the ACCD?**

- The ICD-10-AM/ACHI/ACS coding query process provides clinical coders, through their jurisdictions with an avenue to resolve coding queries to facilitate correct, relevant and nationally consistent assignment of ICD-10-AM and ACHI codes to episodes of care.

How can a coder submit a coding query to the ACCD?

- https://www.accd.net.au/Submissions.aspx?page=4



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How can a coder submit a coding query to the ACCD?

Individual Queries

Before sending a query to your State/Territory Coding Advisory Committee (CAC) you should:

- Review the current edition of ICD-10-AM, ACHI and ACS including any errata and current national published advice (Coding Rules).
- Reference texts; perform a web search (if available).
- Seek advice from peers/local coding group/clinicians.

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How can a coder submit a coding query to the ACCD?

State/Territory Coding Advisory Committee (CAC) Queries

- The coding advisory committees (CAC) act as reference groups in each state/territory for clinical coders who request assistance on coding issues.
- These committees are responsible for responding to coders queries. The CACs may then decide to forward a query to the ACCD, however it **must** be of a significantly complex/difficult nature that cannot be resolved at a local (state) level.

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How can a coder submit a coding query to the ACCD?

The state CACs must follow these steps before considering to submit a query to the ACCD:

- Review the current edition of ICD-10-AM, ACHI and ACS including any errata and current national published advice (Coding Rules).

- Review and discuss the query using the documentation and any references or clinical advice supplied and decide if a state/territory decision can be made.

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How can a coder submit a coding query to the ACCD?

- Determine if the query is significantly complex or of a difficult nature before forwarding to ACCD. Query submissions need to include supporting documents, references and clinical advice.
- Provide an interim jurisdictional response, where possible, and forward to ACCD with the query.

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How can a coder submit a coding query to the ACCD?

Do you know who your CAC representative is?

Coding Leadership Association ACT
Diana Erika
National Capital Private Hospital
Cnr Gilmore Crescent & Hospital Road
Garran ACT 2605
diana.erika@healthscope.com.au

NSW Clinical Coding Leadership Group
Amelia Chee
Clinical Information Specialist
Data Quality Unit
Health System Information & Performance Reporting Branch
NSW Health Department
Level 5, 73 Miller Street
North Sydney NSW 2060
achee@doh.health.nsw.gov.au

SA Coding Advisory Group
Medical Record Advisory Unit
System Performance
Department for Health and Ageing SA
PO Box 287 Rundle Mall
Adelaide SA 5000
medicalrecords@health.sa.gov.au

Victorian ICD Coding Committee
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50 Lonsdale Street
Melbourne VIC 3000
carla.read@health.vic.gov.au
Please submit queries online at
http://forms.health.vic.gov.au/TakeSurveycss.asp?SurveyID=33J4845238821

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How can a coder submit a coding query to the ACCD?

The ACCD coding query response process includes:

- Reviewing the current edition of ICD-10-AM, ACHI and ACS, including any errata and current classification advice (Coding Rules)
- Referencing other classifications
- Research the clinical concept
- Seek clinical and classification advisor input
- The ACCD team will then prepare a final response based upon all this input

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How can a coder submit a coding query to the ACCD?

Once a final response is developed:

- The ACCD responds to the enquirer and publishes the query as part of Coding Rules in CLIP (where applicable).
- Coding Rules in CLIP, are generally published quarterly (15 March, 15 June, 15 September, 15 December).
- Coding Rules should be implemented for separations from the first day of the following month. For example, Coding Rules published on 15 June take effect for separations from 1 July.

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ACCD Activities

Who can send in a public submission?

Anyone !

https://www.accd.net.au/Submissions.aspx?page=2

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Who can send in a public submission?

There are a number of reasons to consider modification of the disease and intervention classification:

- Existing ICD-10-AM/ACHI code is too general or lacks specificity.
- Existing ICD-10-AM/ACHI code is outdated due to advances in medical knowledge, and the disease, related health problem or intervention is currently not classified in ICD-10-AM/ACHI.

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What to consider when completing a public submission

To lodge or track an ICD-10-AM/ACHI/ACS Public Submission go to the ACCD Classification Information Portal (CLIP).

You will then be able to prepare your submission at your convenience and save your work until you have completed it (Save Draft).

Once your submission is complete, you can then submit it. All documentation in support of and/or relevant to your submission should be attached.

ACCD Activities

What is ITG?

- The purpose of the ICD Technical Group (ITG) is to provide technical input and expert advice to the ACCD with respect to development and refinement of ICD-10-AM/ACHI/ACS.

- The ICD Technical Group (known as the ITG) generally meets quarterly and considers all proposals that require changes to ICD-10-AM/ACHI/ACS.

What is ITG?

Membership

- One representative from:
- Australian Commission on Safety and Quality in Healthcare (the Commission)
- Australian Institute of Health and Welfare (AIHW)
- Australian Private Hospitals Association (APHA)
- Catholic Health Australia (CHA)
- Classifications Clinical Advisory Group (CCAG)
- Commonwealth Department of Health (DoH)
- Health Information Management Association of Australia (HIMAA)
- Independent Hospital Pricing Authority (IHPA)
- New Zealand Ministry of Health
- National Health Information Standards and Statistics Committee (NHISSC)
- Private Healthcare Australia (PHA)
- State and territory health authorities

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ICD-10-AM/ACHI/ACS development update

NCCH activities

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NCCH Activities

- The NCCH (National Centre for Classification in Health) also has activities outside of the ACCD responsibilities.
  - Liaise with other countries using ICD-10-AM/ACHI/ACS and AR-DRGs
  - Participate as part of the Australian Collaborating Centre in the development of the WHOs ICD-10 and ICD-11.

NCCH Activities

- NCCH has been leading the WHO development of the International Classification of Health Interventions (ICHI) since 2007.
- Mapping - NCCH has had extensive experience in the mapping processes, which enables data users to interpret old and new data across different classifications.

NCCH Activities

- Conferences: NCCH collaborates with HIMAA to present the annual national HIMAA and NCCH conference.

- NCCH team members regularly present at a variety of health information and classification forums in Australia and internationally.

NCCH Activities

- Fundamentals of Morbidity Coding

With each new edition of ICD-10-AM/ACHI/ACS the NCCH updates and publishes the Fundamentals of Morbidity Coding

NCCH and ICD-11

- NCCH team members have been playing an important role in the international effort to develop ICD-11.
  - WHO ICD-11 MMS Joint Task Force
  - Chapter Reviews
  - Education Material
  - Participation in field trials
  - Transition Guide

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NCCH and ICD-11

The implications and opportunities for Australia and other countries as a result of ICD-11 have been kept under close attention by NCCH, and we are well placed to provide expert advice on ICD-11 and its application for various purposes in the health care setting.

The NCCH is well placed to assist in the transition to ICD-11 by Australia and other countries if and when this is decided.

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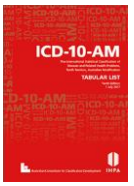
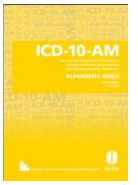
ICD-10-AM/ACHI/ACS Eleventh Edition





ICD-10-AM/ACHI/ACS Eleventh Edition

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ICD-10-AM/ACHI/ACS Eleventh Edition

Factors that are considered when determining the ICD-10-AM/ACHI/ACS work plan:

- need to reflect updates to underpinning classifications, WHO ICD-10, Medicare Benefits Schedule (MBS), and Australian Dental Association (ADA)
- requests initiated by the Independent Hospital Pricing Authority (IHPA)
- need to consider updates in the context of other public submissions and queries
- need to review ICD-10-AM/ACHI/ACS for clinical currency

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ICD-10-AM/ACHI/ACS Eleventh Edition

- need to correct anomalies in the structure of the classification(s)
- impact on National Health Priority Areas (NHPAs)
- impact on Safety & Quality in Health Care
- impact on clinical coder burden

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ICD-10-AM/ACHI/ACS Eleventh Edition

- The topics identified for revision in Eleventh Edition are:
  - Chronic conditions
  - Ophthalmology (ACHI)
  - Obstetrics / Abortion (ICD/ACHI/ACS)
  - *Excludes* note review
  - WHO updates
  - MBS Updates & ADA Updates

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ICD-10-AM/ACHI/ACS Eleventh Edition

- The topics identified for revision cont:
  - Syndromes/ Congenital/ Neonatal conditions and interventions
  - Wound Management
  - Neoplasms
  - FESS and ENMT (ICD/ACHI/ACS)

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ICD-10-AM/ACHI/ACS Eleventh Edition

Chronic conditions

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Chronic Conditions

- In 2014 work commenced on the issue of chronic conditions and in particular ACS 0002 *Additional diagnoses*, which resulted in the creation of the '*U Codes'* U78-U88 *Supplementary codes for chronic conditions* and ACS 0003 *Supplementary codes for chronic conditions* which were implemented 1 July 2015.
- To date there has been no systematic measurement of the cost variation in treating patients with/without a pre-existing chronic disease.
- Also, the collection of chronic disease information has become increasingly important in recent years

Chronic Conditions

- The major focus of this phase of the project is to analyse the data generated from application of the supplementary U codes and the Australian Coding Standards to gain better understanding of the impact of chronic diseases on overall case complexity.

- The outcome of this analysis will inform the changes that may be required to the Australian Coding Standards in regard to chronic diseases.

Chronic Conditions

- The Australian Coding Standards (ACS) provide inconsistent coding guidelines when instructing coders to code particular chronic diseases.

- Some chronic diseases such as diabetes mellitus, viral hepatitis and HIV were identified previously as conditions that are always significant comorbidities and should always be coded regardless of whether they meet the criteria in ACS 0002 *Additional diagnoses*

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Chronic Conditions

- While other chronic diseases such as cerebral palsy, hypertension, Parkinson's disease that co-exist are coded only when they meet the criteria in ACS 0002 *Additional diagnoses*.

- Based upon the analysis of the data to establish a systematic measurement of the cost variation in treating patients with/without a pre-existing chronic disease, it is expected that some ACS standards will be revised (including but not limited to ACS 0002 *Additional diagnoses*).

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Ophthalmology

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Ophthalmology

- This is a continuation of a review initiated in Tenth Edition.

- A review of all codes in blocks **[221]** to **[256]** will be undertaken.
- Amendments in the MBS item numbers will be incorporated where applicable.
- Smaller tasks originating from queries and public submissions will also be incorporated.

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Obstetrics / Abortion

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Obstetrics / Abortion

- This is a continuation of a review initiated in Tenth Edition of ICD/ACHI/ACS in regards to Obstetrics/Abortion.
- This task will continue with refinements in regards to obstetric and abortion diagnoses and interventions.
- Amendments in the MBS items will be incorporated where applicable.
- Smaller tasks originating from queries and public submissions will also be incorporated.

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Excludes note review

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Excludes note review

- This is a continuation of a review initiated in Tenth Edition.
- This task will continue with review and revision of *Excludes* notes at category and code level across ICD-10-AM.

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WHO updates

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WHO Updates

- As a National Modification (NM) of the WHOs ICD-10, ICD-10-AM maintains close links to amendments to ICD-10 to ensure that international compatibility is maintained.
- This task will encompass approved updates to ICD-10 by WHO in 2015 and 2016, where the clinical concept is not already classified/amended in ICD-10-AM.

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MBS Updates & ADA Updates

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MBS Updates & ADA Updates

- ACHI was originally developed using the Commonwealth Medicare Benefits Schedule (MBS) as a basis
- Interventions not represented in MBS (including the dental ADA schedule) were (are) allocated a code number from the 90000 series.

- This task will encompass consideration of :
  - MBS item updates between August 2015 and May 2017
  - ADA Eleventh (2015) and Twelfth (2016) editions

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Syndromes/ Congenital/ Neonatal conditions and interventions

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- This ICD task encompasses multiple smaller tasks that include multiple concepts primarily congenital/perinatal in origin, which originated from queries and public submissions.
- Creation of a ‘syndrome’ flag code is being considered (for both congenital and acquired syndromes) to capture syndromic conditions.

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Wound Management

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Wound Management

- This task is primarily based on wound management interventions including (but not limited to) debridement and grafting procedures. Both ACHI and ACS will be reviewed and revised where appropriate.
- This review will also incorporate other smaller existing tasks regarding skin interventions.

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Neoplasms

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- These tasks are for review of ICD/ACHI/ACS neoplasm related content including:
  - Chemotherapy
  - Brachytherapy / radiotherapy
  - Classification of specific neoplasms
- Lymph node interventions are also being reviewed.

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ENMT Interventions

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ENMT Interventions

- These tasks are primarily based on a variety of ENMT interventions (including FESS).
- One option under consideration is a ‘flag code’ for FESS.
- ICD based tasks in ENMT may be undertaken if time permits within this work cycle.

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Other amendments

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- ACCD also undertake non-developmental (administrative) tasks in regard to ICD-10-AM/ ACHI/ACS.
- Other content tasks (based on queries, public submissions or ACCD initiatives) may also be undertaken if time permits within this work cycle.

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Tenth Edition
ICD-10-AM/ACHI/ACS
FAQs

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- September 15 2017
  - *Excludes* Notes
  - Multiple Coding Convention
  - Use of definitional information
  - ACS mutual exclusivity
  - ACS deleted for Tenth Edition
  - Application of ACS 0001 and ACS 0002 in conjunction with specialty standards

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FAQs

- Difficult Intubation
- Abnormal coagulation profile due to anticoagulants
- Chronic Pain
- Administration of agents
- Mental Health Interventions
- Adoption
- Deep Venous Thrombosis
- Passive Smoking
- Fractional Flow Reserve (FFR)
- Obesity and BMI

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FAQs

- September 22 2017
  - Procedural complications
  - Obstetrics
  - Same-day endoscopy
- September 29 2017
  - Obstetrics
  - Same-day endoscopy

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FAQs

Excludes Notes

The structure of ICD-10-AM has not changed.
Some *Excludes* notes have been removed due to redundancy, but chapter structure has not changed.

Excludes Notes

As per the Reference to Changes document, a high level review at chapter level was undertaken to remove redundancy.

Australia (ICD-10-AM) utilises the multiple condition coding convention to identify both the underlying cause and manifestation(s), and as such a number of *Excludes* notes were determined to be redundant.

Excludes Notes

As a result, *Excludes* notes (at the chapter level) identified as redundant for ICD-10-AM purposes were removed for Tenth Edition.

The review of *Excludes* notes at the category and code level will continue for Eleventh Edition.

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Excludes Notes

Problems and Underlying conditions

The ICD-10-AM *Conventions used in the Tabular List of diseases/Multiple condition coding* state:

In classifying a condition with an underlying cause, if the Alphabetic Index (see Example 2) or *Excludes* note (see Example 18) results in a code for one of the clinical concepts not being assigned, follow the guidelines in ACS 0001 *Principal diagnosis/Problems and underlying conditions* and assign codes for both the condition and the underlying cause.

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Excludes Notes

Scenario:
Neurogenic bladder due to cauda equina syndrome

N31.9 *Neuromuscular dysfunction of bladder, unspecified*

G83.4 *Cauda equina syndrome*

Note: The ICD-10-AM *Conventions used in the Tabular List of diseases/Multiple condition coding* 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 in the Tabular List or an Australian Coding Standard.

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FAQs

Multiple Coding Convention

The concept of 'translate medical statement into code' in the classification and coding standards has been revised to 'classify the clinical concept' in line with the purpose of ICD-10 as a classification.

Do not assign an additional code to further classify a condition unless directed by an *Instructional* note in the Tabular List or an Australian Coding Standard.

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Multiple Coding Convention

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

FAQs

Use of definitional information

A clinical coder **cannot** use definitional information contained in any ACS for classification purposes.

This information is provided for coder education only.

ACS mutual exclusivity

Mutual exclusivity does not apply to coding standards; however, multiple standards may apply to a particular case.

Apply first the general standards for diseases and interventions.

Apply the guidelines in the specialty standards on a case by case basis.

Note: There may be a *See* instruction within an ACS to indicate that there may be applicable guidelines in another ACS.

ACS deleted for Tenth Edition

When a coding standard is deleted from the ACS, the content is relocated to either another standard or incorporated into the Tabular List and/or Alphabetic Index, as applicable.

In some instances, a specialty standard is considered redundant if the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses* (or other general/specialty standards) are applicable to the topic.

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For example, ACS 1436 *Admission for trial of void* was deleted for Tenth Edition as the following principles apply:

- Follow the Alphabetic Index: *Trial of void/admission for*
- Assign a code for urinary retention when it meets the criteria in ACS 0002
- Assign codes for intervention(s) as per the guidelines in ACS 0042 *Procedures normally not coded/Classification/Dot point 2*)

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ACS deleted for Tenth Edition

Information regarding ACS deletion is documented in the *Chronicle* available on the ACCD website (https://www.accd.net.au/Downloads.aspx).

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FAQs

Application of ACS 0001 and ACS 0002 in conjunction with specialty standards

ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses* are general standards applicable to ICD-10-AM. Unless specifically indicated, the general classification principals in ACS 0001 and ACS 0002 apply to all conditions listed in the specialty standards.

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Therefore, after selecting the principal diagnosis, all other conditions documented in an episode of care must meet the criteria in ACS 0002, unless there are specific guidelines in a specialty standard indicating otherwise (eg (condition) “should always be coded”).

Difficult Intubation

What codes (including external cause codes) are assigned for difficult intubation?

T88.42 *Difficult intubation*

Y84.8 *Other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of unintentional events at the time of the procedure*

Y92.24 *Health service area, this facility*

Abnormal coagulation profile due to anticoagulants

Z92.1 *Personal history of long term (current) use of anticoagulants*

R79.83 *Abnormal coagulation profile* and

D68.3 *Haemorrhagic disorder due to circulating anticoagulants*

are mutually exclusive

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R79.83 Abnormal coagulation profile

▽ 0303

Nontherapeutic coagulation assay due to anticoagulants
Abnormal or prolonged:
- bleeding time
- coagulation time
- international normalised ratio (INR)
- partial thromboplastin time (PTT)
- prothrombin time (PT)

Overwarfarinisation
Supratherapeutic/subtherapeutic INR (due to anticoagulants)
Underwarfarinisation
Unstable INR

Use additional external cause code (Chapter 20) to identify any administered anticoagulant.

Excludes: haemorrhagic disorder due to circulating anticoagulants (D68.3)
long term use of anticoagulants without haemorrhagic disorder (Z92.1)

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Abnormal coagulation profile due to anticoagulants

Does INR monitoring need to be documented to assign Z92.1 and R79.83?

INR/anticoagulant level monitoring is required to assign Z92.1 *Personal history of long term (current) use of anticoagulants* and R79.83 *Abnormal coagulation profile*, as per the guidelines in ACS 0303 *Abnormal coagulation profile due to anticoagulants/Classification* which states:

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Abnormal coagulation profile due to anticoagulants

CLASSIFICATION

- If patients on long term anticoagulants require anticoagulant level monitoring during an episode of care and the INR level is within the target therapeutic range (ie no supratherapeutic or subtherapeutic INR is documented), assign Z92.1 *Personal history of long term (current) use of anticoagulants* as an additional diagnosis
- If the INR value is outside the patient's normal/usual therapeutic range (eg supratherapeutic or subtherapeutic INR is documented) but no bleeding occurs, assign R79.83 *Abnormal coagulation profile* together with appropriate external cause codes to indicate that the abnormal coagulation profile is related to the administration of an anticoagulant.

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FAQs

Chronic Pain

Will there be amendments to chronic pain in Errata 2?

Errata 2 incorporates amendments to ICD-10-AM code R52.2 *Chronic pain* and ACS 1807 *Acute and chronic pain* with regard to the classification of chronic pain.

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Chronic Pain

What codes are assigned for chronic pain with underlying conditions?

The ICD-10-AM Conventions used in the *Tabular List of diseases/Multiple condition coding* state:

In classifying a condition with an underlying cause, if the Alphabetic Index (see Example 2) or *Excludes* note (see Example 18) results in a code for one of the clinical concepts not being assigned, follow the guidelines in ACS 0001 *Principal diagnosis/Problems and underlying conditions* and assign codes for both the condition and the underlying cause.

ACS 1807 Acute and chronic pain states:

CLASSIFICATION:

To classify chronic pain with a documented underlying cause and/or site:

- code first the underlying cause and/or site and,
- assign R52.2 *Chronic pain* as an additional diagnosis

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Chronic Pain

Scenario:

Chronic low back pain due to bone metastases

Assign:

C79.5 *Secondary malignant neoplasm of bone and bone marrow*

M54.5 *Low back pain*

R52.2 *Chronic pain*

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Chronic Pain

What documented terminology for chronic pain may be used for code assignment?

To assign R52.2 *Chronic pain*, documentation within the clinical record must state any of the following terms:

- neoplastic (or cancer) pain
- neuropathic pain
- nociceptive pain
- chronic pain

Note: 'Nerve pain' is not synonymous with 'neuropathic pain'

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Chronic Pain

Scenario:

Pain due to osteoarthritis of the hip.

M16.1 *Other primary coxarthrosis*

Note: * R52.2 *Chronic pain* is not assigned as there is no documentation of 'chronic pain' or 'nociceptive pain'

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Chronic Pain

What codes are assigned for chronic pain with external causes?

Where chronic pain is the sequelae of an external cause, follow the guidelines in ACS 0008 *Sequelae* or ACS 1912 *Sequelae of injuries, poisoning, toxic effects and other external causes* as appropriate to the case.

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Administration of agents

Is there a hierarchy at the lead term Administration for the subterms indication, specified site and type of agent?

There is no hierarchy for Administration/indication, Administration/specified site and Administration/type of agent.

Cross-references are included to direct clinical coders to other subterms, as appropriate.

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For example, to classify steroid injection into a joint (NOS), assign 50124-01 **[1552]** *Administration of agent into joint or other synovial cavity, not elsewhere classified*, follow the Alphabetic Index:

Administration
- specified site
- - joint NEC 50124-01 **[1552]**

…

- type of agent
- - steroid NEC — code to block **[1920]** with extension -03

(see also Administration/specified site)

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Mental Health Interventions

Are mental health intervention codes mandatory?

ACS 0534 *Specific interventions related to mental health care services* states:

For admitted episodes of care it is not mandatory to assign code(s) for mental health care interventions with the exception of electroconvulsive therapy. However their use is encouraged in specialist mental health care facilities and units to better represent care provided to these patients. It should also be noted that these interventions are not exclusive to mental health and may be assigned outside of this context.

Adoption

Is Z76.22 *Health supervision and care of other infant/child NEC* assigned for babies/infants when a Family and Community Services (FACS) evaluation is undertaken?

Assign Z76.22 *Health supervision and care of other infant/child NEC* for infants receiving care or assessment for the purposes of adoption, foster placement, or family supervision.

FAQs

Deep Venous Thrombosis

What code is assigned when there is documentation of DVT at multiple levels? For example, DVT extending inferiorly into the popliteal and posterior tibial veins.

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Deep Venous Thrombosis

There is nothing to preclude assignment of multiple codes from category I80 Phlebitis and thrombophlebitis, as there is no hierarchy within the category. Therefore, where the site of a DVT is documented as 'extending inferiorly into the popliteal and posterior tibial veins', assign:

I80.22 *Phlebitis and thrombophlebitis of popliteal vein*
and
I80.23 *Phlebitis and thrombophlebitis of tibial vein*

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Passive Smoking

Does passive smoking need to meet the criteria in ACS 0002 *Additional diagnoses*, or is it assigned whenever documented similar to Z72.0 *Tobacco use, current*?

ACS 2118 *Exposure to tobacco smoke* states:

CLASSIFICATION

Assign Z58.7 *Exposure to tobacco smoke* when exposure to secondhand tobacco smoke is documented by a clinician, except if the patient is a current or ex-smoker.

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Fractional Flow Reserve (FFR)

Is Fractional flow reserve (FFR) assigned with a cardiac catheterisation with angiogram code OR coronary angiogram only (ie no catheterisation) code?

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Fractional Flow Reserve (FFR)

The *code also* instruction at 38241-00 **[668]** states:

Code also when performed:
- coronary:
  - angiography (38215-00, 38218-00, 38218-01, 38218-02 **[668]**)
  - angioplasty (see blocks **[669]**, **[670]** and **[671]**)

Therefore, assign 38241-00 **[668]** *Coronary artery blood flow measurement* (for FFR) in addition to any other procedures listed in the *code also* instruction, as appropriate to the documented case.

ACCD

FAQs

Obesity and BMI

What code is assigned for obesity without a BMI documented?

For obesity NOS, assign E66.90 *Obesity, not elsewhere classified, body mass index [BMI] not elsewhere classified.*

ACCD

Obesity and BMI

Follow the Alphabetic Index:

Obesity (morbid) (simple) E66.9-

Assign a fifth character by referring to the Tabular List:

Fifth characters 1, 2 and 3 are assigned for patients 18 years of age and above.

For patients under 18 years of age, assign fifth character 0.

0 body mass index [BMI] not elsewhere classified

1 body mass index [BMI] ≥ 30 kg/m^2 to ≤ 34.99 kg/m^2
Obese class I

2 body mass index [BMI] ≥ 35 kg/m^2 to ≤ 39.99 kg/m^2
Obese class II

3 body mass index [BMI] ≥ 40 kg/m^2
Clinically severe obesity
Extreme obesity
Obese class III

ACCD

Obesity and BMI

Can a code from category E66 *Obesity and overweight* be assigned for a patient with a documented body mass index of 28, but no documentation of 'obese' or 'overweight'?

As per the ICD-10-AM Alphabetic index:

BMI (body mass index)

- ≥ 25 kg/m^2 to ≤ 29.99 kg/m^2 E66.3
- ≥ 30 kg/m^2 — *see Obesity*

ACCD

Obesity and BMI

Can coders use documentation of a patient's height and weight to calculate BMI when there is documentation such as "increased BMI"?

There are no index entries for increased BMI:

BMI (body mass index)

- ≥ 25 kg/m^2 to ≤ 29.99 kg/m^2 E66.3
- ≥ 30 kg/m^2 — *see Obesity*

ACCD

FAQs

Procedural complications

Which complication code is assigned when a postprocedural complication is not classified to T82-T85 *Complications of prosthetic devices, implants and grafts* but the complication is documented as due to a prosthetic device, graft or implant?

ACCD

Procedural complications

Codes in the categories of T82-T85 are generally intended to be used for complications specific to prosthetic devices, grafts and implants such as mechanical complication, infection, pain, thrombosis, haemorrhage, mesh erosion and so on.

Other conditions may occur when a prosthetic device, graft or implant is present but they are more general complications non-specific to the procedure itself (eg implantation of a prosthetic device).

ACCD

Procedural complications

Scenario:

Lymphocele following radical prostatectomy

I97.83 *Postprocedural lymphocele, lymphoedema and chylothorax*
External cause codes as appropriate

ACCD

Procedural complications

Scenario:

Lymphocele due to cannulation of the femoral vein

T82.89 *Other specified complications of cardiac and vascular prosthetic devices, implants and grafts*
I97.83 *Postprocedural lymphocele, lymphoedema and chylothorax*
External cause codes as appropriate

ACCD

Procedural complications

What code is assigned for peritonitis in a peritoneal dialysis patient when there is no documentation that the complication is due to the device?

Peritonitis is a medical condition that may occur in the postoperative period. It may or may not be related to the procedure performed. Peritonitis is not classified as a procedural complication unless the causal relationship is clearly documented.

ACCD

Procedural complications

Therefore, for peritonitis in a peritoneal dialysis patient without further specification assign:

T85.71 *Infection and inflammatory reaction due to peritoneal dialysis catheter*
K65.- *Peritonitis*
Y84.1 *Kidney dialysis*

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

ACCD

Procedural complications

Where another cause of the peritonitis is specified, such as perforated diverticulum, assign codes following the guidelines in ACS 0001 *Principal diagnosis/Problems and underlying conditions*, and ACS 0002 *Additional diagnoses*.

Note: The above advice defaults to the classification of **peritonitis** in PD patients. It should not be applied to other medical conditions occurring postoperatively.

ACCD

Procedural complications

What code is assigned for postoperative pain following insertion of prosthetic devices, grafts or implants?

A code for postoperative pain is only assigned when there is no underlying cause of the pain specified in the clinical record, and it meets the criteria in ACS 0001 *Principal diagnosis/Problems and underlying conditions* or ACS 0002 *Additional diagnoses*.

If the cause of pain is specified in the clinical record, an appropriate code for the underlying cause is assigned, not postoperative pain.

ACCD

Procedural complications

Scenario:

A patient readmitted with persisting pain after a recent left hip replacement. Extensive investigations, including CT of the hip were conducted, but did not reveal the cause of the pain.

T84.83 *Pain following insertion of internal orthopaedic prosthetic devices, implants and grafts*
External cause codes as appropriate

ACCD

Procedural complications

Scenario:

A patient admitted with chronic hip pain 12 months after a left hip replacement. A radiograph showed loosening of the prosthesis at the bone–cement interface and a revision of hip replacement was carried out.

T84.0 *Mechanical complication of internal joint prosthesis*
M25.55 *Pain in joint, pelvic region and thigh*
R52. 2 *Chronic pain*
External cause codes as appropriate

ACCD

Procedural complications

Could postoperative anaemia be assumed as posthaemorrhagic anaemia in the absence of any documented cause?

The overall concept of procedural complications has been reviewed for ICD-10-AM Tenth Edition. This clarifies that conditions that arise during a procedure, or in the postoperative period are not considered as procedural complications unless a causal relationship is documented in the clinical record.

ACCD

Procedural complications

However, for certain conditions, the causal relationship is assumed, i.e. a cause and effect relationship does not have to be documented to assign a procedural complication code. These include:

- Certain conditions where the relationship is inherent in the diagnosis (eg. acute blood loss anaemia during a procedure or from a surgical wound)

ACCD

Procedural complications

- Conditions classified to T82–T85 for complications related to prosthetic devices, implants or grafts
- Conditions that are a direct consequence of a procedure, resulting in an unintended event
- These conditions may or may not be documented as ‘secondary to’ or ‘due to’ the procedure performed, however they are classified as procedural complications.

ACCD

Procedural complications

For example: a haemorrhage associated with a device

Haemorrhage
- due to or associated with
- - device, implant or graft NEC (*see also Complication(s)/by site and type*) T85.83

ACCD

Procedural complications

Scenario:

A tracheoesophageal fistula formed following tracheostomy

J95.04 *Tracheo-oesophageal fistula following tracheostomy*
External cause codes as appropriate

ACCD

Procedural complications

Scenario:

Acute blood loss anaemia post ORIF for femoral fracture, without further specification as to cause of the anaemia.

T84.81 *Haemorrhage and haematoma following insertion of internal orthopaedic prosthetic devices, implants and grafts*
D62 *Acute posthaemorrhagic anaemia*
External cause codes as appropriate

ACCD

Procedural complications

What is the correct place of occurrence code to assign when the patient is registered in the hospital system, but care is delivered by a private provider on behalf of the hospital?

The note at Y92.23 *Health service area, not specified as this facility* and Y92.24 *Health service area, this facility* states*:*

Note: 'This facility' includes satellite units managed and staffed by the same health care provider. These units may be located on the hospital campus or off the hospital campus and treat movements of patients between sites as ward transfers.

ACCD

Procedural complications

Scenario:

Patient admitted for chest pain and transferred to the radiology department (privately owned, contracting to the facility) for a coronary angiogram. A haematoma at the arterial puncture site was identified the next day while the patient was still admitted at the hospital.

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

ACCD

Procedural complications

Scenario:

Patient admitted to Hospital A for treatment of sepsis. During the admission, he slipped on the hospital floor and suffered a fracture of neck of femur (NOF). This was surgically treated and eventually he was transferred to Hospital B for rehabilitation of the fracture and deconditioning. During his stay at Hospital B he developed pneumonia and was transferred back to Hospital A where he continued physiotherapy for the fractured NOF.

ACCD

Procedural complications

Hospital A: Y92.24 *Place of occurrence, health service area, this facility* (with COF=1)

Hospital B: Y92.23 *Place of occurrence, health service area, not specified as this facility* (with COF=2)

Hospital A: *Y92.24 Place of occurrence, health service area, this facility* (with COF=2)

ACCD

FAQs

Obstetrics

Should ACS 1505 *Delivery and assisted delivery codes* refer to 'ACHI code(s)'?

ACS 1505 *Delivery and assisted delivery codes* states:

Where a patient delivers during an episode of care, assign:

- a code from O80–O84 *Delivery* **and**
- an ACHI code from **[1336]**–**[1340]** *Delivery procedures* or other procedure(s) to assist delivery

ACCD

Obstetrics

Is it correct that 90467-00 **[1336]** *Spontaneous vertex delivery* is assigned once only for a twin delivery where both infants are delivered by spontaneous vertex delivery?

- ACS 1505 *Delivery and assisted delivery codes* states:

In a multiple delivery, if the babies are delivered by different methods, ACHI codes for all of the delivery methods must be assigned (except for any deliveries that occurred prior to the admitted episode of care, noting that delivery is not complete until after expulsion of the placenta).

ACCD

Obstetrics

That is:

O84.0 *Multiple delivery, all spontaneous* – assign one spontaneous delivery code if all infants delivered by the same method

O84.1 *Multiple delivery, all by forceps and vacuum extractor* – assign one forceps or vacuum code if all infants are delivered by the same method

O84.2 Multiple delivery, all by caesarean section – assign one caesarean section code if all infants are delivered by the same method

ACCD

Obstetrics

Scenario:

Healthy twins both delivered by spontaneous vertex delivery.

O84.0 *Multiple delivery, all spontaneous*
O30.0 *Twin pregnancy*
Z37.2 *Twins, both liveborn*
90467-00 **[1336]** *Spontaneous vertex delivery*
Anaesthesia code if applicable

ACCD

Obstetrics

What codes are assigned for spontaneous vertex delivery with McRoberts manoeuvre?

As per the table in ACS 1505 *Delivery and assisted delivery codes*, codes for spontaneous delivery (90467-00 **[1336]** *Spontaneous vertex delivery* and 90470-00 **[1339]** *Spontaneous breech delivery*) are only assigned with O80 *Single spontaneous delivery* or O84.0 *Multiple delivery, all spontaneous.*

Note that for classification purposes, once a delivery is 'assisted' it is no longer 'spontaneous'.

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Obstetrics

Scenario:

Single delivery; McRoberts manoeuvre performed, followed by vertex delivery of healthy infant.

O83 *Other assisted delivery*
Z37.0 *Single live birth*
90477-00 **[1343]** *Other procedures to assist delivery*

ACCD

Obstetrics

What codes are assigned for fetal death in utero (FDIU)/missed abortion before fetal viability, with induction of labour?

ACS 1511 *Termination of pregnancy* states:

For delivery episodes of care following **fetal death in utero** (intrauterine death) (not induced), follow the Alphabetic Index at *Death/fetus, fetal* and the guidelines in ACS 1500 *Diagnosis sequencing in delivery episodes of care.*

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Obstetrics

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Termination of pregnancy may be performed by:

- extraction (eg dilation and curettage/evacuation (D&C/D&E) or suction curettage). Assign an appropriate code from **[1265]** *Curettage and evacuation of uterus.*
- induction of labour. Assign a code from block **[1334]** *Medical or surgical induction of labour* regardless of the duration of pregnancy and outcome
- other methods (eg insertion of prostaglandin suppository). Code specific procedure(s) performed (see ACHI Alphabetic Index).

ACCD

Obstetrics

Scenario:

FDIU/missed abortion before fetal viability (14/40).
Patient induced with prostaglandin suppository.
Documentation: "IOL – Misoprostol 400mg inserted PV".

O02.1 *Missed abortion*
O09.2 *14–19 completed weeks*
90465-01 [1334] *Medical induction of labour, prostaglandin*

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Obstetrics

Follow the Alphabetic Index:

Death
- fetus, fetal (cause not stated) (intrauterine)
- - before fetal viability, with retention (< 20 completed weeks (140 days) gestation and/or fetal weight < 400g) O02.1

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Obstetrics

and

Induction
- labour
- - medical (administration of pharmacological agent)
- - - prostaglandin 90465-01 [1334]

Note: that an ACHI code for induced abortion is not assigned as the fetus is already deceased.

ACCD

Obstetrics

Is the assignment of codes from categories E09-E14 with codes from category O24 Diabetes mellitus in pregnancy contradictory to ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia/General classification rules/Rule 6*?

ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia/Specific classification principles for DM and IH/DM and IH in pregnancy, childbirth and the puerperium* states:

Assign codes for DM or IH (E09–E14) as per the *Instructional* notes (*code also*) at O24.-.

ACCD

Obstetrics

Scenario:

Pregnant patient with type 2 diabetes mellitus; diabetes diagnosed two years ago. Patient does not have any diabetes complications; diabetes managed by diet.

O24.14 *Pre-existing diabetes mellitus, Type 2, in pregnancy, other*
E11.9 *Type 2 diabetes mellitus without complication*

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Obstetrics

Are the guidelines in ACS 0104 *Viral hepatitis* and ACS 0505 *Mental illness in pregnancy, childbirth and the puerperium* sequencing directives?

ACS 0104 *Viral hepatitis/Classification point 2. Viral hepatitis in pregnancy, childbirth and the puerperium* states:

Where viral hepatitis is documented in pregnancy, childbirth or the puerperium, assign:

- a code for the specific type of viral hepatitis (B15–B19)
- O98.4 *Viral hepatitis in pregnancy, childbirth and the puerperium*

ACCD

Obstetrics

ACS 0505 *Mental illness in pregnancy, childbirth and the puerperium* states:

Where a mental disorder is documented in pregnancy, childbirth or the puerperium, assign:

- a code from Chapter 5 *Mental and behavioural disorders* for the specific type of mental illness
- O99.3 *Mental disorders and diseases of the nervous system in pregnancy, childbirth and the puerperium.*

The previous two guidelines are not sequencing directives. Both ACS 0104 and ACS 0505 contain cross references to standards where sequencing guidelines are provided for conditions/complications in pregnancy and the puerperium.

See ACS 1521 *Conditions and injuries in pregnancy* and ACS 1548 *Puerperal/postpartum condition or complication.*

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Obstetrics

Does “including delivery of placenta” as a definition of delivery mean whole placenta? If there are retained portions of placenta, is the delivery considered incomplete?

- ACS 1548 *Puerperal/postpartum condition or complication* states:

The puerperium is defined as the period of 42 days following delivery (including delivery of placenta).

Delivery of placenta means expulsion of the whole placenta, excluding any retained portions that are expelled or require removal post delivery (see also ACS 1548 Example 7).

ACCD

Obstetrics

Scenario:

Patient delivered (baby and placenta) at home (planned home birth). She is admitted to hospital four hours later due to postpartum haemorrhage, and is taken to theatre for removal of retained portions of placenta by dilation and curettage (D&C).

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Obstetrics

O72.2 *Delayed and secondary postpartum haemorrhage*
Z39.02 *Postpartum care after planned, out of hospital delivery*
16564-00 **[1345]** *Postpartum evacuation of uterus by dilation and curettage*
Anaesthesia code, if applicable

ACCD

Obstetrics

What code is assigned for a patient admitted five months post delivery with low milk supply?

Where a patient has a condition relating to lactation, assign a code from category O91 *Infections of breast associated with childbirth* or O92 *Other disorders of breast and lactation associated with childbirth*, regardless of whether the condition occurs in the delivery episode, within the puerperium or beyond the puerperium.

ACCD

Obstetrics

Scenario:

Breastfeeding patient admitted 5 months post delivery with a nonobstetric condition. Patient commenced on Domperidone for low milk supply. No attachment difficulties documented.

PDx for the nonobstetric condition as per the criteria in ACS 0001 *Principal diagnosis*

O92.40 *Hypogalactia, without mention of attachment difficulty* as an additional diagnosis

ACCD

FAQs

Same-day endoscopy

Where an endoscopy incorporates both diagnostic and surveillance components or where a diagnostic endoscopy and a surveillance endoscopy are performed in the same episode, should the diagnostic findings be sequenced before the surveillance diagnoses?

There is no hierarchy for assignment of the principal diagnosis in the above scenario.

ACCD

Same-day endoscopy

Follow the guidelines in ACS 0051 *Same-day endoscopy – diagnostic* and ACS 0052 *Same-day endoscopy – surveillance* where there are both diagnostic and surveillance endoscopies in the one episode.

Then, apply the general principles in ACS 0001 *Principal diagnosis* to determine the principal diagnosis.

This has always been the case in these scenarios and has not changed with Tenth Edition.

ACCD

Same-day endoscopy

Why does ACS 0052 *Same-day endoscopy – surveillance* instruct that Z codes for follow-up or screening are not assigned as an additional diagnosis? Where a second endoscopic procedure is performed in the same episode for screening and nothing is found, this instruction means a diagnosis code for that particular endoscopy is unable to be assigned.

ACCD

Same-day endoscopy

This instruction was added into the standard due to the fact that there is inconsistent use of the terminology ‘follow-up’ and ‘screening’, and therefore the addition of these codes provides little value in the data.

However, this has been reconsidered in the context of multiple endoscopies performed in the one operative episode, and is amended in Tenth Edition Addenda to Errata 2, for implementation 1 October 2017, to allow assignment of these codes as additional diagnoses, as appropriate.

Same-day endoscopy

Why is the code for liver cirrhosis sequenced as principal diagnosis in ACS 0052 *Surveillance* Example 13?

Example 13 has been reviewed and is amended in Tenth Edition Addenda to Errata 2, for implementation 1 October 2017, to sequence the varices as the principal diagnosis. It’s acknowledged that in that scenario there would be no surveillance of the liver cirrhosis (chronic incurable condition).

Same-day endoscopy

Why has a personal history code been assigned in ACS 0052 *Surveillance* Example 11?

The assignment of the personal history code in this scenario was seen as relevant to the episode. However, upon review it is acknowledged that it is not consistent with the guidelines in ACS 2112 *Personal history* which states:

These codes would only be assigned as additional diagnoses where the condition is completely resolved yet the history is directly relevant to the current episode of care.

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ICD-10-AM/ACHI/ACS development update

Clarification on the application of the *"Standards for ethical conduct in clinical coding"*

ACCD

Australian Consortium for Classification Development

Thank you

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