Delivering a Healthy WA

Government of Western Australia
Department of Health

ICD-10-AM 7th edition summary of changes

Coding Education Team
Performance, Activity & Quality Division
Department of Health WA

ACS 0042 Procedures normally not coded

There has been expansion of the list of procedures normally not coded:

Do not routinely code (unless performed with anaesthetic, or is the principal reason for admission in a same-day episode):

- Imaging Services (all codes in chapter 20) including CT scans, MRI scans, angiograms, DSA, VQ scan, CTPA, nuclear medicine imaging, WBBS, RGP, intraoperative ultrasound
- PICC / CVC / arterial lines
- Bladder washout via indwelling catheter
- Doppler recordings

Continue to code:

- Coronary angiograms
- Intraoperative cholangiogram
- Cardiac catheterisation
- Transoesophageal echocardiogram (TOE)

D63 Anaemia in chronic diseases

D63.0 Anaemia in neoplastic disease* and *D63.8* Anaemia in other chronic diseases classified elsewhere* are no longer valid codes. The dagger and asterisk pathway has been removed for anaemia; instead follow ACS 0001 and 0002 in determining sequencing of anaemia codes in presence of neoplastic disease or chronic kidney disease.

Delivering a Healthy WA

Obstetrics

New codes O83 and O84 have been created. Every delivery in 7th edition must have a code from O80-O84 to indicate the mode of delivery - follow guidelines in ACS 0001 to determine whether O80-O84 is assigned as principal or additional diagnosis.

Summary of ACS 0001 obstetrics guidelines:

- Patient admitted in labour, for induction, or for caesarean section: O80-O84 is principal diagnosis. Reason(s) for induction or planned caesarean are additional diagnoses.
- Patient admitted for management of an antepartum condition and proceeds to delivery: antepartum condition (e.g. pre-eclampsia, PROM) is sequenced as principal diagnosis and O80-O84 as additional diagnosis.

Diabetes

Double coding

Coders are no longer forced to code 'diabetes with' E10-E14 (i.e. double coding) when diabetes does not meet *ACS 0001* or *ACS 0002*.

However, if a condition is documented as 'diabetic', 'due to diabetes', 'secondary to diabetes' etc then a code from E10-E14 is appropriate along with a code from another chapter if required to fully explain the condition. As per usual, there is no need to use codes from other chapters in conjunction with the E10-E14 code if the description of the condition is inherent in the "E" code title.

If diabetes itself meets ACS 0001 or 0002 i.e. assignment of a code from E10-E14, do not use codes from other chapters to specify the type of complication unless that particular condition itself meets ACS 0001 or 0002. For example *I10 Essential hypertension* would only be coded with *E11.72 Type 2 diabetes mellitus with features of insulin resistance* if hypertension met *ACS 0001* or *0002*.

Remember to follow "code also" notes. For example, diabetic patient admitted for treatment of end stage renal failure, has hypertension which is not being treated. "Code also" note at *N18.5 Chronic Kidney Disease, stage 5* instructs to code also hypertension if present. Therefore, assign *I10 Essential hypertension*, even though it does not meet ACS 0002. In this case *E11.72 Type 2 diabetes with features of insulin resistance* would not be assigned as diabetes did not meet ACS 0002.

When should diabetes be coded?

If a patient meets criteria in the *Diabetic foot* section – follow the classification guidelines provided in that section of *ACS 0401*.

For all other cases - once diabetes (or a condition documented as 'diabetic') meets ACS 0001 or 0002, code out ALL diabetic complications (E10-E14 codes). However, do not use codes from other chapters to specify the type of complication unless that particular condition itself meets ACS 0001 or 0002. If the patient meets criteria for *Multiple microvascular and other specified nonvascular complications* follow the classification guidelines as additional codes may be required.

Diabetes (continued)

Diabetes with multiple microvascular and other specified nonvascular complications

Diabetes itself, or a condition documented as 'diabetic', must first meet ACS 0001 or 0002 before deciding whether patient meets criteria for *E1x.71 Diabetes with multiple microvascular and other specified non-vascular complications.*

Codes from other chapters should be assigned only if they meet *ACS 0001* or *0002*.

Diabetic Foot

Patient with a condition(s) classified in category 1 along with one or more conditions in category 2 to 5 meet criteria for *E1x.73 Diabetes mellitus with foot ulcer due to multiple causes.* Additional codes should be assigned from other chapters to fully describe the complications.

Once *E1x.73 Diabetes mellitus with foot ulcer due to multiple causes* is assigned, diabetes itself is considered to have met criteria for coding, therefore all other diabetic complications from codes E10-E14 (not captured in *Diabetic Foot* categories 2-4) should be assigned to reflect the severity of the diabetes.

Potential error – diabetic foot classification guidelines

Confusion currently exists because the category 1 list does not include 'Foot ulcer L97' (only 'Diabetes with foot ulcer E1x.69'). This seems to indicate an ulcer alone is insufficient and that diabetes must meet ACS 0001 or 0002.

For example, patient with diabetes (which does not meet ACS 0002) admitted for amputation of toe due to ulcer with presence of PVD. According to the category 1 list, this case does not meet criteria to assign E1x.73. This is obviously incorrect as a toe ulcer in a diabetic with PVD should meet criteria for diabetic foot.

To resolve the problem the category 1 list needs to be amended to include 'Foot ulcer L97'. This issue will be raised with the NCCC.

Eradicated conditions in diabetes

The *Eradicated conditions* component of *ACS 0401 Diabetes mellitus and impaired glucose regulation* has been removed in 7th edition.

Delivering a Healthy WA

Sepsis

Sepsis is defined as the body's systemic reaction to an infection. In 7th edition, sepsis is classified as part of a continuum:

1. localised or generalised infection
2. SIRS
3. sepsis
4. severe sepsis
5. septic shock

New codes have been created to capture:

- Systemic inflammatory response syndrome (SIRS) =R65.x
- Severe sepsis = R65.1
- Septic shock = R57.2

These new 'R' codes are for use only as an additional diagnosis to capture the progress/stage of the body's reaction according to the above continuum. Interestingly, a new 'R' code was not created for sepsis. The codes for sepsis remain the same as 6th edition (A40.x and A41.x).

What do we mean by *localised* and *generalised*?

Localised infection = infection such as pneumonia, UTI, wound infection
Generalised infection = systemic infection; documentation of "sepsis" i.e. A40.x or A41.x

Classification guidelines

Systemic inflammatory response syndrome (SIRS)

Assign first a code for the aetiology (e.g. localised infection and/or generalised infection, trauma, pancreatitis, ischaemia etc), followed by the appropriate code from R65.x

Sepsis/septicaemia

Assign a code for the localised infection and/or generalised infection, following *ACS 0001* and *ACS 0002* to determine sequencing and whether both infections require coding. Generalised infection alone is A40.x or A41.x

Severe sepsis

Assign first a code for the localised infection and/or generalised infection, followed by *R65.1 Systemic inflammatory response syndrome of infectious origin with acute organ failure*, followed by code(s) to identify organ failure.

Septic shock

Assign first a code for the localised and/or generalised infection, followed by *R57.2 Septic shock,* followed by code(s) to identify organ failure.

ACS 0001 Principal Diagnosis and *ACS 0002 Additional Diagnoses* should be followed to determine sequencing of localised and generalised infection, and whether both infections require coding.

Healthcare associated Staphylococcus aureus bacteraemia (SAB)

A new code *U90.0 Healthcare associated Staphylococcus bacteraemia* has been created. "Health care associated", "hospital acquired", "nosocomial" SAB etc must be documented by a clinician before U90.0 can be assigned.
U90.0 is an additional diagnosis code intended as a supplementary code and should be sequenced directly after the staphylococcus infection code, or after activity code (U73.8) if SAB is a complication and external cause codes are required.