ICD-10-AM/ACHI/ACS 8th edition summary of main changes

Dagger and asterisk convention

The dagger and asterisk convention in ACS 0001 *Principal diagnosis* has changed with relaxing of the sequencing principle. Dagger and asterisk codes are now sequenced according to the principal diagnosis definition, rather than automatically sequencing the dagger code first in the combination.

The PAS data reporting method for a dagger and asterisk codes remains unchanged i.e. when a dagger and asterisk code combination is the principal diagnosis, the second code must be recorded as a co-diagnosis ('Code Also' or 'CA' in TOPAS).

ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia*

These changes were implemented last year on 1 July 2012. See summary of changes on Coding Education Team website: http://www.clinicalcoding.health.wa.gov.au/docs/changes-to-diabetes.pdf

ACS 1911 *Burns*

There are new guidelines in ACS 1911 regarding sunburn, which now requires multiple diagnosis codes to fully describe the injury.

1. Code first the appropriate code from L55.- *Sunburn*
2. Assign a code to indicate the site of sunburn from blocks T20-T25, T29-T30
3. Assign the appropriate code from T31.- *Burns classified according to extent of body surface area involved* to indicate the sunburn body surface area percentage
4. Assign the appropriate external cause code e.g. X32 *Exposure to sunlight*, W89 *Exposure to man-made visible and ultraviolet light*
5. Assign the appropriate place of occurrence and activity codes

ACS 0104 *Viral hepatitis*

Advances in antiviral therapy have resulted in the ability to successfully treat hepatitis C which was previously an incurable infection. Once cleared, there is no ongoing infection risk.

Hepatitis C may be documented as:

- 'Cured/cleared' hep C
- 'Cleared' with 'SVR' (sustained virological response)
- PCR –ve (polymerase chain reaction)

Classification

- Hepatitis should be coded whenever documented, **except** when hepatitis C is documented as 'cured', 'cleared' etc where the following guidelines apply:
    - **Cured hepatitis C with manifestation** that meets ACS 0002:
      Code the manifestation(s) followed by B94.2 *Sequelae of viral hepatitis*
    - **Cured hepatitis C without manifestation**, or manifestation does not meet ACS 0002:
      Assign Z86.18 *Personal history of other infectious and parasitic disease* only if the history is directly relevant to the episode of care as per ACS 2112 *Personal history*
- Past history of hepatitis A or E should be assigned Z86.18 *Personal history of other infectious and parasitic disease* only if the history is directly relevant to the episode of care as per ACS 2112 *Personal history*
- When documentation is unclear or ambiguous, such as 'hep C positive', clarification should be sought from the clinician. If this is not possible, it should be coded as chronic viral hepatitis.
- The concept of carrier is outdated and Z22.5- *Carrier of viral hepatitis* should **never** be assigned.

ACS 2114 *Prophylactic surgery*

There have been two key changes:

- The prophylactic mastectomy section of ACS 1204 *Plastic surgery* has been deleted, along with the statement:
  "When the reason for the prophylactic mastectomy can be assigned a code, this should be sequenced as principal diagnosis, even if all evident disease was previously resected."
- ACS 2114 *Prophylactic surgery* has been created which instructs coders that an appropriate code from Z40 *Prophylactic surgery* can be assigned as principal diagnosis, and the risk factor necessitating prophylactic surgery as additional diagnosis. This is a change in sequencing from the previous edition.

Example 1

Patient admitted for mastectomy for ductal carcinoma of left breast, and prophylactic mastectomy of right breast.
Diagnosis code assignment:

C50.9	Malignant neoplasm of breast, unspecified part
M8500/3	Infiltrating duct carcinoma NOS
Z40.00	Prophylactic surgery for risk-factors related to malignant neoplasm, breast

As per ACS 0001 *Principal diagnosis*, the reason chiefly responsible for occasioning this episode is breast cancer which is sequenced as principal diagnosis.

Example 2

Consider again example 1, however the planned prophylactic right mastectomy is not performed at the same time as the left mastectomy. Instead it is scheduled for 6 weeks later (staged surgery).

Diagnosis code assignment:

Z40.00	Prophylactic surgery for risk-factors related to malignant neoplasm, breast
C50.9	Malignant neoplasm of breast, unspecified part
M8500/3	Infiltrating duct carcinoma NOS

As per ACS 0001 *Principal diagnosis*, the reason chiefly responsible for occasioning this episode is prophylactic surgery, therefore Z40.00 is sequenced as principal diagnosis. We then refer to ACS 0236 *Neoplasm coding and sequencing* to determine whether the cancer should be coded as a current condition. As per ACS 0236, because the episode is for staged prophylactic surgery, the cancer is coded as a current condition irrespective of whether it is considered 'cured' or is receiving current treatment.

ACS 2114 *Prophylactic surgery (cont.)*

Example 3

Patient previously underwent a left mastectomy for breast cancer, followed by chemotherapy. Follow-up investigations confirmed the cancer was cured and no further treatment was required. Due to patient's anxiety regarding possible cancer recurrence, the patient decides to have a prophylactic right mastectomy.

Diagnosis code assignment:

Z40.00	Prophylactic surgery for risk-factors related to malignant neoplasm, breast
Z85.3	Personal history of malignant neoplasm of breast

Prophylactic surgery was not part of the initial treatment plan and is therefore not considered staged, so the 'staged prophylactic surgery' criteria in ACS 0236 do not apply in this instance and cancer is not automatically coded as a current condition. None of the other criteria in ACS 0236 are met either - the cancer has been cured and is not receiving any current management so it is coded as personal history.

Example 4

Treatment plan decided for newly diagnosed breast cancer patient: mastectomy followed by prophylactic oopherectomy 6 months later. Patient admitted for prophylactic bilateral oopherectomy.

Diagnosis code assignment:

Z40.01	Prophylactic surgery for risk-factors related to malignant neoplasm, ovary
C50.9	Malignant neoplasm of breast, unspecified part
M8000/3	Neoplasm, unspecified

As per ACS 0001 *Principal diagnosis*, the reason chiefly responsible for occasioning this episode is prophylactic surgery, therefore Z40.01 is sequenced as principal diagnosis. We then refer to ACS 0236 *Neoplasm coding and sequencing* to determine whether the cancer should be coded as a current condition. As per ACS 0236, because the episode is for staged prophylactic surgery, the cancer is coded as a current condition irrespective of whether it is considered 'cured' or is receiving current treatment.

Hints

- There is no ICD-10-AM code for gene mutation. If this is the only risk factor for which prophylactic surgery is being performed, code the appropriate code from Z40 *Prophylactic surgery* alone.
- When selecting the appropriate code from Z40 *Prophylactic surgery,* select the code that corresponds with the healthy organ being removed this episode (see example 4 above).

ACS 1551 *Obstetric perineal lacerations/grazes*

There is a new instruction in ACS 1551 advising:

Perineal grazes and lacerations that are not sutured are not coded, with the exception of perineal lacerations/grazes where repair is clinically warranted but is not carried out, for example, where the patient chooses not to have their tear repaired. In this scenario assign the appropriate code for the laceration/graze with the addition of a code from Z53 *Persons encountering health services for specific procedures, not carried out*.

This instruction only applies to ACS 1551 and should not be interpreted for use with every instance of a procedure not performed due to patient decision.

ACS 0020 *Bilateral/multiple procedures*

The guidelines for multiple skin lesion removal, excision or biopsy have changed. The new guidelines in ACS 0020:

> **For multiple excisions or biopsies or removals performed on:**
>
> - **separate skin lesions: assign relevant code(s) as many times as it is performed**
> - **same lesion: assign relevant code once.**
>
> **For excision or biopsy or removal of skin lesions repeated during the episode of care at different visits to theatre – see point 1.**

Example 1

Excision of two separate lesions from forearm during the same visit to theatre
Assign a code as many times as it is performed:
31205-00 [1620] *Excision of lesion(s) of skin and subcutaneous tissue of other sites*
31205-00 [1620] *Excision of lesion(s) of skin and subcutaneous tissue of other sites*

N.B. the code description still states 'lesion(s)' as there was inadequate time prior to 8th edition publication for this to be amended. The (s) will be removed in the next edition of ACHI.

Example 2

Biopsy x2 of same lesion nose
Assign code once only for multiple biopsies of the same lesion during the same visit to theatre:
30071-00 [1618] *Biopsy of skin and subcutaneous tissue*

ACS 0048 *Condition onset flag*

The COF flags and intentions remain unchanged. However the definitions have been re-worded and several new examples added to provide further clarification about the types of inclusions under COF 1 and 2.

There are also new guidelines for neonates, combination codes, dagger/asterisk combinations and some Z codes.

Clarification of inclusions in COF 1

- Misadventure
- Abnormal reactions and complications of surgical/medical care
- Obstetric and postpartum complications arising after admission e.g. postpartum haemorrhage
- Conditions arising during HITH and authorised leave

Clarification of inclusions in COF 2

- Conditions not documented at time of admission, but clearly did not/could not develop during episode e.g. malignancy
- A previously existing condition that is exacerbated during the current episode e.g. acute exacerbation of COPD.
  Please note this does not include combination codes – these are described below in the 'New COF rules' section.
- Obstetric complications arising prior to admission e.g. maternal disproportion
- Z37 *Outcome of delivery* and Z38 *Liveborn infant* codes should always be COF 2

New COF guidelines

Neonate birth episode

There is now one exception to the rule 'principal diagnosis code is always assigned COF 2'. The exception is neonates in their admitted **birth episode** may be assigned COF 1 for principal diagnosis if appropriate. This includes a condition in the birth episode determined to have arisen **during** the labour and delivery process and already present at time of birth. Examples:

- Neonate sustains scalp laceration during caesarean delivery (laceration requires review by Paediatrician)
- Meconium aspiration syndrome

New COF guidelines (continued)

Combination code (single code describing multiple conditions)

Where a diagnosis within a combination code meets the criteria of COF 1, and is not represented by another code with a COF 1 value, then assign COF 1 to the combination code. Examples of combination codes:

- Type 2 diabetic develops lactic acidosis during admission, E11.13 *Type 2 diabetes mellitus with lactic acidosis* is assigned COF 1
- Type 2 diabetic develops hypoglycaemia during admission E11.64 *Type 2 diabetes mellitus with hypoglycaemia* is assigned COF 1

Multiple codes to describe multiple conditions

Where multiple codes are assigned to describe multiple conditions, only the condition that arose during the admission is assigned COF 1. Examples:

- Type 2 diabetic develops acute kidney failure during admission
  COF 1: N17.9 *Acute kidney failure, unspecified*
  COF 2: E11.29 *Type 2 diabetes mellitus with other specified kidney complication*
  N.B. this is taken from Example 11 in ACS 0048 which originally had COF 1 assigned for E11.29. This was amended to COF 2 in Errata 1, June 2013.
- Type 2 diabetic develops postural hypotension during admission
  COF 1: I95.1 *Orthostatic hypotension*
  COF 2: E11.43 *Type 2 diabetes with diabetic autonomic neuropathy*

Dagger & asterisk code combinations

The COF value for dagger and asterisk codes should be appropriate to each condition, therefore the dagger and asterisk codes may be assigned different COF values

New COF guidelines (continued)

Z codes

- Z53 *Procedure not carried* out may be assigned a COF value 1 if Z53.- is an **additional diagnosis**. Examples:
    - ACS 1551 *Obstetric perineal lacerations/grazes* instructs to code the laceration/graze followed by Z53.- for cases where repair is clinically warranted but patient chooses not to have the tear repaired.
    - Cases of booked admissions where procedure is cancelled or abandoned once patient is already in theatre, and Z53.- is assigned as an additional diagnosis (see Coding Tip in Coding Education Newsletter, Issue 3, April 2013).

  When Z53.- is principal diagnosis the default COF value is always 2.
- Z06 *Resistance to antimicrobial drugs* and Z29.0 *Isolation* may be assigned COF value 1 to match a corresponding COF 1 infection code.
- All other Z codes are generally assigned COF value 2, in keeping with the intent of COF reporting being to inform prevention strategies relating to complications of medical care.

ACS 0402 Cystic fibrosis

Coding guidelines for cystic fibrosis have been clarified with revision of ACS 0402 and additional clarification in Errata 1 June 2013. There is also published national advice (June 2013 NCCC Coding Q&A). A summary of these guidelines:

- Follow ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses* to determine whether cystic fibrosis should be coded (cystic fibrosis itself, or at least one manifestation, should meet ACS 0001 or 0002)
- If it is to be coded, assign the appropriate code(s) from E84.- *Cystic fibrosis* followed by code(s) for any specified manifestation(s). The E84.- is always sequenced **before** the corresponding manifestation(s) code.
- ALL specified manifestations should be coded to reflect the severity of the patient's cystic fibrosis, irrespective of whether the manifestation(s) meet ACS 0002. More than one code from E84.- *Cystic fibrosis* may be needed.
- The reason we can now assign multiple E84.- codes in 8th edition is because the inclusion term "Cystic fibrosis with combined manifestations" has been deleted from code E84.8 *Cystic fibrosis with other manifestations*
- There must be documentation in the clinical record that states a problem is a manifestation of cystic fibrosis in order for it to be coded as one. If there is uncertainty as to whether a condition is a manifestation of cystic fibrosis, then the relationship between the condition and cystic fibrosis should be verified with the clinician.

Respiratory failure

New fifth character subdivisions have been added at code J96 *Respiratory failure, not elsewhere classified* to further classify respiratory failure as either type I (hypoxic), type II (hypercapnic), or unspecified.

Resistance to antimicrobial & antineoplastic drugs

Due to the increasing problem of drug resistance, the classification has been revised to better capture this information. New codes have been created and resistance is now classified into the following four categories:

- Beta-lactam antibiotics e.g. penicillin, methicillin
- Other antibiotics e.g. vancomycin, quinolones
- Antimicrobials e.g. antiparasitic, antifungal, antiviral, tuberculostatic
- Antineoplastic drugs

Hints

- Drug resistance must be documented by a clinician i.e. it should not be coded from a laboratory report result.
- Z06.67 *Resistance to multiple antibiotics* and Z06.77 *Resistance to multiple antimicrobial drugs* are intended for use only when the drug types are not specified. Where multiple drug types are resistant, code each documented type separately.

Duration of pregnancy

The code title at O09.5 has been amended from **34 - 36 weeks** to **34 - <37 weeks** which is a more accurate description.

Hints

- Full term = 37 completed weeks = 36 weeks + 7 days
- Premature = 36 weeks + 6 days, and earlier

ACS 1530 Premature delivery

ACS 1530 *Premature delivery* has been deleted in 8th edition as the content was considered superfluous – its guidelines are in the Tabular list at codes O42 *Premature rupture of membrane*s and O60 *Preterm labour and delivery*.

ACS 1615 *Specific interventions for the sick neonate*

New guidelines have been added (see bolded text below) and the standard has been re-organised into two sections:

Interventions that are coded only when the criteria in ACS 1615 are met

- Enteral infusion
- Maternal illness/incapacity to care
- Oxygen therapy
- Parenteral antibiotics/anti-infectives
- **Phototherapy**
  Previous Coding Matters advice about neonates readmitted with jaundice is now incorporated in ACS 1615
- **Ventilatory support (new guideline about combined invasive/noninvasive ventilatory support)**

Interventions that are coded whenever performed

- Administration of blood and blood products
- **Catheterisation in a neonate (new guidelines)**
- **Nitric oxide therapy (new guidelines)**
- **Parenteral fluid therapy**
  Errata 1 June 2013 has clarified that parenteral fluid therapy e.g. TPN ,IV Dextrose is to be coded whenever performed, with the sentence '...should be assigned when used for management of carbohydrate, hydration or electrolyte disorders' deleted from ACS 1615
- **Therapeutic hyperthermia (new guidelines)**

New ICD-10-AM & ACHI codes

A list of the main diagnoses & procedures with new codes/index pathways in 8th edition:

- Atrial fibrillation
- Haemorrhoids
- Hernia
- Pancreatic tumour of unknown or uncertain behaviour
- Resistance to antimicrobial and antineoplastic drugs
- Respiratory failure
- Sunburn
- Neonates
    - Cerebral leukomalacia
    - Hypoxic ischaemic encephalopathy
    - Peri/intraventricular haemorrhage
    - Sudden infant death syndrome
    - Posthaemorrhagic hydrocephalus
- Endoluminal fundoplication
- Insertion of seeds/fiducial markers into prostate
- Minimally invasive procedure proceeding to open procedure
- Laparoscopic colectomy and ileocolic resection
- Procedures for obesity
- Single event multilevel surgery
- Irreversible electroporation
- High intensity focused ultrasound
- Percutaneous heart valve replacement
- Aspiration thrombectomy of coronary artery
- Transcatheter thrombectomy of intracranial arteries
- Peritonectomy/cytoreduction surgery
- Sacral nerve stimulation
- Sentinel lymph node biopsy