IHPA

National coding rules (Effective 1 October 2020)

Contents

Ref No: Q3553 | Published On: Sep-2020 | Status: Current

Admission for correction of stretched earlobe(s)

Q:

What code is assigned for admission for correction of stretched earlobe(s)?

A:

The stretching of an earlobe due to body piercing (plugs) is an acquired deformity (ie a change in normal size or shape of the body part). Where stretched earlobe is documented as the indication for surgical repair, assign:

H61.1 *Noninfective disorders of pinna*

W45.0 *Body piercing*

Place of occurrence and activity codes

Follow the ICD-10-AM Alphabetic Index Section I:

Deformity
- ear (acquired) H61.1

Follow the ICD-10-AM Alphabetic Index Section II *External causes of injury*:

Piercing
- body (rings) (studs) (voluntary) W45.0

Amendments will be considered for a future edition.

Return to contents page.

Ref No: Q3570 | Published On: Sep-2020 | Status: Current

Airvo™ device for high flow therapy

Q:

What code is assigned when there is documentation of Airvo™ use for high flow therapy?

A:

The Airvo™ system is a device that features a humidifier capable of delivering high flows of air/oxygen mixtures to spontaneously breathing patients via a variety of interfaces (Fisher & Paykel Healthcare n.d.). The device can deliver flows of up to 60 L/minute.

Where documentation states that a high flow therapy device, such as Airvo™, is used for respiratory support and delivered via high flow nasal cannula, assign an appropriate code from block [570] *Noninvasive ventilatory support*.

A code for high flow therapy cannot be assigned based on delivery flow rates alone, due to variability in practice and patient requirements. Documentation must indicate 'high flow therapy' or 'high flow nasal cannula' to access an appropriate lead term, in order to be classified to block [570] *Noninvasive ventilatory support*.

See also coding rule Q2953 High flow therapy.

References:
Fisher & Paykel Healthcare n.d., *Optiflow™ high flow therapy delivery for the entire patient journey: AIRVO™ 2 humidified high flow system*, viewed 18 December 2019, <https://www.fphcare.com/au/hospital/adult-respiratory/optiflow/airvo-2-system/>.

Return to contents page.

Ref No: Q3496 | Published On: Sep-2020 | Status: Current | Supersedes: Q2905 Coding of allergic reactions NOS and anaphylactic reactions and TN1505 Eleventh Edition FAQs Part 1: Allergens and anaphylaxis (See Appendix 2)

Allergens and anaphylaxis

Q:

When assigning codes for anaphylactic reactions, should codes for the symptoms or manifestations of the reaction also be assigned?

A:

Anaphylaxis and anaphylactic shock are part of a continuum. Anaphylaxis is a serious and potentially life-threatening reaction to a trigger such as an allergy. The clinical manifestations of mild anaphylaxis may rapidly progress to a more severe anaphylaxis and lead to upper airway obstruction, respiratory failure, and circulatory shock (that is, anaphylactic shock).

Where a patient is admitted for anaphylaxis or anaphylactic shock, in addition to an appropriate code for the anaphylaxis or anaphylactic shock:

- Assign codes for symptoms of the anaphylactic reaction classified to Chapter 18 *Symptoms signs and abnormal clinical and laboratory findings* in accordance with ACS 0001 *Principal diagnosis/Codes for symptoms, signs and ill-defined conditions* and ACS 0002 *Additional diagnoses/Symptoms, signs and ill-defined conditions* that state:

  > *ACS 0001* Principal diagnosis
  >
  > *Codes for symptoms, signs and ill-defined conditions from Chapter 18* Symptoms signs and abnormal clinical and laboratory findings *are not to be used as principal diagnosis when a related definitive diagnosis has been established.*
  >
  > *ACS 0002* Additional diagnoses
  >
  > *Care should be taken when assigning codes for symptoms, signs and ill-defined conditions from Chapter 18* Symptoms, signs and abnormal clinical and laboratory findings *as additional diagnoses. Clinical coders should ensure they meet the criteria in ACS 0002*

- Assign codes for manifestations of the anaphylactic reaction classified to other chapters (eg bronchospasm) in accordance with ACS 0002 *Additional diagnoses*.

Where documentation is unclear and a clinical coder cannot determine if a symptom is significant in its own right, or a manifestation meets the criteria in ACS 0002, seek clinician advice.

Return to contents page.

Ref No: Q3492 | Published On: Sep-2020 | Status: Current

Anaphylaxis due to bee sting

Q:

What codes are assigned for anaphylaxis due to bee sting?

A:

Where there is documentation of anaphylaxis due to bee sting, assign:

T63.4 *Venom of other arthropods* first, followed by

T78.2 *Anaphylaxis and anaphylactic shock, unspecified*

Y37.61 *Allergy to bees*

Place of occurrence code

Follow the ICD-10-AM Alphabetic Index:

Section I: *Alphabetic Index of Diseases and Nature of Injury*

Bee sting (with allergic or anaphylactic shock) T63.4

Section II: *External causes of injury*

Allergen, allergic reaction
- bees Y37.61

Follow also:

The *Instructional* note at category T63 *Toxic effect of contact with venomous animals*:

> *Use additional code if applicable, to identify reaction such as:*
>
> *…*
>
> - *anaphylaxis and anaphylactic shock (T78.2)*

The *Instructional* note at T78.2:

> *Use additional external cause code (Y37.-) to identify allergen, if known.*

Amendments will be considered for a future edition.

Return to contents page.

Ref No: Q3422 | Published On: Sep-2020 | Status: Current

Catamenial anaphylaxis

Q:

What code is assigned for catamenial anaphylaxis?

A:

Catamenial symptoms are symptoms that occur around the beginning of the menstrual cycle. These symptoms may include cramping, headaches, acne, anxiety or anaphylaxis and may be related to endogenous changes in hormone (eg progesterone) levels (Parker Jones 2016; Mustafa 2018).

Catamenial or cyclic/cyclical anaphylaxis (CA) is an extremely rare condition where the exact cause is complex and unclear, but occurs in the setting of menses. CA results in an allergic reaction with manifestations such as skin rash, abdominal cramping or angioedema (Lin et al. 2018).

Where CA is documented and the cause is not specified, assign N94.8 *Other specified conditions associated with female genital organs and menstrual cycle*.

Follow the ICD-10-AM Alphabetic Index:

Disease, diseased
- pelvis, pelvic
- - female
- - - specified N94.8

Where CA is documented as due to exogenous hormone exposure (eg due to administration of the oral contraceptive pill), assign T88.6 *Anaphylaxis and anaphylactic shock due to adverse effect of correct drug or medicament properly administered*.

Follow the ICD-10-AM Alphabetic Index:

Anaphylaxis
- due to
- - drug or medicament (adverse effect) T88.6

Also assign external cause and place of occurrence codes.

See also Q3496 Eleventh Edition FAQs Part 1: Allergens and anaphylaxis.

Amendments will be considered for a future edition.

References:

Lin, K., Rasheed, A., Lin, S. & Gerolemou, L. 2018, 'Catamenial anaphylaxis: a woman under monthly progesterone curse', *Case Reports*, vol. 2018, viewed 4 November 2019, <http://dx.doi.org/10.1136/bcr-2017-222047>.

Mustafa, S. 2018, *What is catamenial anaphylaxis?*, viewed 4 November 2019, <https://www.medscape.com/answers/135065-52896/what-is-catamenial-anaphylaxis >.

Parker Jones, K. 2016, *Catamenial catastrophes: the worst things that can happen at the start of your period*, University of Utah Health, viewed 4 November 2019, <https://healthcare.utah.edu/the-scope/shows.php?shows=0_30l8vgme >.

Return to contents page.

Ref No: Q3525 | Published On: Sep-2020 | Status: Current

Coding of withdrawal in specialist detoxification units

Q:

Some specialist detoxification units do not assign codes for both dependence and withdrawal, unless the withdrawal is 'clinically significant to require medical support or treatment'. Is this is a correct interpretation of the guidelines in ACS 0503 *Drug, alcohol and tobacco use disorders*?

A:

Withdrawal or detoxification may result after reducing or stopping use of drugs and alcohol or undertaking certain behaviours like gambling (Alcohol and Drug Foundation n.d.; Healthdirect 2020). The process of withdrawal may be attributed to harmful use or dependence and the symptoms can vary in severity (Alcohol and Drug Foundation n.d.; Batra et al. 2016; Healthdirect 2020).

ACS 0503 *Drug, alcohol and tobacco use disorders* states:

> *Cases of dependence (syndrome) with withdrawal should be assigned both a code for the dependence (syndrome) and a code for the withdrawal (syndrome) because withdrawal is not always a feature of dependence (syndrome). Dependence is syndromal (a cluster of phenomena) and withdrawal is only one nonessential criteria for dependence.*

Therefore, where both dependence (syndrome) and withdrawal are documented in an episode of care, assign codes from block F10–F19 *Mental and behavioural disorders due to psychoactive substance use* with four character extensions .2 *dependence syndrome* and .3 *withdrawal state* or .4 *withdrawal state with delirium*.

Sequence codes as per the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*.

References:

Alcohol and Drug Foundation n.d., *Withdrawal*, viewed 26 August 2020, <https://adf.org.au/reducing-risk/withdrawal/>.

Batra, A., Muller, C.A., Mann, K. & Heinz, A. 2016, 'Alcohol dependence and harmful use of alcohol', *Deutsches Arzteblatt International*, vol. 113, no. 17, pp. 301–210, viewed 26 August 2020, <DOI:10.3238/arztebl.2016.0301>.

Healthdirect 2020, *Addiction withdrawal symptoms*, viewed 26 August 2020, <https://www.healthdirect.gov.au/addiction-withdrawal-symptoms>.

Return to contents page.

Ref No: Q3505 | Published On: Sep-2020 | Status: Current

COPD exacerbation and influenza

Q:

What codes are assigned for an exacerbation of chronic obstructive pulmonary disease and influenza?

A:

The *Conventions used in the ICD-10-AM Tabular List* state:

> *In Australia, multiple condition coding (meaning that multiple conditions may be assigned in an episode of care) is used to provide the necessary specificity to fully describe the episode of care. This does not mean multiple codes are assigned to describe a single condition.*

Chronic obstructive pulmonary disease (COPD) with an (infective) exacerbation is a separate clinical entity to influenza although the two conditions may be related.

ACS 0015 *Combination codes* states:

> *Assign only the combination code when that code fully identifies the diagnostic conditions involved and when the Alphabetic Index so directs.*

For COPD exacerbated by influenza assign codes for both conditions to classify both diagnostic conditions. Assign J44.0 *Chronic obstructive pulmonary disease with acute lower respiratory infection* and an appropriate code for influenza (J09–J11), and sequence in accordance with the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*.

Follow the ICD-10-AM Alphabetic Index:

Disease, diseased
- lung
- - obstructive (chronic)
- - - with (acute)
- - - - exacerbation NEC
- - - - - infective J44.0

Influenza
- virus
- - identified (respiratory manifestations) (seasonal) NEC *(see also Influenza/A/H5N1)* J10.1
- - not identified (respiratory manifestations) NEC J11.1

See also coding rules Q3479 Lower respiratory tract infection (LRTI) with presence of chronic obstructive pulmonary disease (COPD) and Q3504 Influenza with lower respiratory infection.

Amendments will be considered for a future edition.

Return to contents page.

Ref No: Q3591 | Published On: Sep-2020 | Status: Current

Drug-induced hepatitis

Q:

What code is assigned for drug-induced hepatitis?

A:

Noninfectious hepatitis (ie noninfectious inflammatory liver disease) is classified in ICD-10 and ICD-10-AM to block K70–K77 *Diseases of liver*.

The term 'toxic hepatitis' is synonymous with 'chemical- or drug-induced' hepatitis.

Chemical- or drug-induced hepatitis (acute, chronic or unspecified) is classified to category K71 *Toxic liver disease*:

K71.2 *Toxic liver disease with acute hepatitis*

K71.3 *Toxic liver disease with chronic persistent hepatitis*

K71.4 *Toxic liver disease with chronic lobular hepatitis*

K71.5 *Toxic liver disease with chronic active hepatitis*

K71.6 *Toxic liver disease with hepatitis, not elsewhere classified*

Assign K71.6 *Toxic liver disease with hepatitis, not elsewhere classified* for drug-induced hepatitis NOS (not otherwise specified).

Follow the ICD-10-AM Alphabetic Index:

Hepatitis
- toxic *(see also Disease/liver/toxic)* K71.6

Assign an external cause code from Chapter 20 to identify the drug, if known. See ICD-10-AM Section III *Table of drugs and chemicals*.

Assign also place of occurrence and activity codes.

Amendments will be considered for a future edition.

Return to contents page.

Ref No: Q3503 | Published On: Sep-2020 | Status: Current | Supersedes: TN1504 Eleventh Edition ACS 1904 *Procedural complications* – due to/related to prosthetic device, implants or grafts (See Appendix 2)

Eleventh Edition ACS 1904 *Procedural complications* – due to/related to prosthetic devices, implants or grafts

This Coding Rule supersedes the published Coding Rule of the same name, implemented 1 July 2019, to correct the following errors:

- Incorrect principal diagnosis assigned in Example 3
- Incorrect code assignment in Example 5

Procedural complications may be classified to either the body system chapters or block T80–T88 *Complications of surgical and medical care, not elsewhere classified.*

Where a complication is related to a prosthetic device, implant or graft, assign an appropriate code from T82–T85 *Complications of prosthetic devices, implants and grafts*, unless otherwise directed by the Alphabetic Index or not supported by an *Includes* note.

Where a condition is not related to a prosthetic device, implant or graft and:

- it is related to a body system, assign an appropriate code from the body system chapter
- the complication is not related to a body system, assign an appropriate code from T80–T81 or T86–T88

ACS 1904 *Procedural complications/Overview/dot point three*, supports the use of codes in T82–T85 for complications specific to prosthetic devices, implants and grafts including mechanical complication, infection, pain, thrombosis, haemorrhage, mesh erosion and so on.

A causal relationship does not need to be documented to assign a procedural complication when a condition is classified to block T82–T85 unless there is a specific Coding Rule or ACS that indicates otherwise (eg complications related to coronary artery bypass graft).

Example 1: Patient with a history of endovascular aneurysm repair (EVAR) of an abdominal aortic aneurysm (AAA) with a bifurcated endoprosthesis, was readmitted due to intermittent abdominal pain and progressive dyspnoea. Computed tomography (CT) angiogram of the aorta confirmed endoleaks following EVAR.

Assign:

T82.3 *Mechanical complication of other vascular grafts*

External cause codes

Follow the ICD-10-AM Alphabetic Index Section I:

Leak, leakage
- device, implant or graft *(see also Complication(s)/by site and type)*
- - arterial graft NEC T82.3

Example 2: Patient was admitted for a ruptured anterior cruciate ligament (ACL) graft for which the patient underwent revision of a left knee ACL reconstruction.

Assign:

T84.4 *Mechanical complication of other internal orthopaedic devices, implants and grafts*

External cause codes

Follow the ICD-10-AM Alphabetic Index Section I:

Complication(s) (from) (of)
- orthopaedic
- - device, implant or graft *(see also Complication(s)/by site and type)* T84.9
- - - mechanical NEC T84.4

Example 3: A 59-year-old woman was admitted with loss of mobility, and pain in her left leg stump. She had a below knee amputation (BKA) of her left lower limb in 2010. She only intermittently wore her prosthesis over the amputated site, because of persistent touch-evoked pain. Physical examination revealed erythema on the stump with cellulitis. She was diagnosed with cellulitis of the amputation stump due to an ill-fitting prosthetic limb.

Assign:

T88.8 *Other specified complications of surgical and medical care, not elsewhere classified*

L03.13 *Cellulitis of lower limb*

Y84.8 *Other medical procedures*

Place of occurrence code

Z89.5 *Acquired absence of leg at or below knee*

Follow the ICD-10-AM Alphabetic Index Section I:

Complication(s)
- orthopaedic
- - external device or appliance T88.8

Cellulitis (diffuse) (with lymphangitis)
- limb
- - lower L03.13

Absence
- extremity (acquired)
- - lower
- - - below knee (unilateral) Z89.5

Follow the ICD-10-AM Alphabetic Index Section II *External causes of injury*:

Complication(s) (delayed) (medical or surgical procedure) (of or following)
- procedures other than surgical operation NEC *(see also Complication(s)/by type of procedure)*
- - specified Y84.8

Example 4: Urethral trauma/injury sustained from displacement of an indwelling catheter.

Assign:

T83.0 *Mechanical complication of urinary (indwelling) catheter*

External cause codes

Follow the ICD-10-AM Alphabetic Index Section I:

Displacement, displaced
- device, implant or graft (see also Complication(s)/by site and type/mechanical)
- - catheter NEC
- - - urinary (indwelling) T83.0

It is not necessary to assign an additional code from Chapter 19 (eg S37.3- *Injury of urethra*) to indicate the site of the post-operative complication. The purpose of S codes in Chapter 19 *Injury, poisoning and certain other consequences of external causes* is to classify injures due to trauma (ie an injury not related to an intervention).

If urethral trauma/injury occurs during removal (accidental or intentional) of an indwelling catheter (IDC) by a patient, ACS 1904 is not applicable as the trauma/injury is not a complication of the device (catheter).

Where the urethral trauma/injury meets the criteria in ACS 0002 *Additional diagnoses*, assign:

S37.3- *Injury of urethra*

X58 *Exposure to other specified factors*

Place of occurrence and activity codes

Follow the ICD-10-AM Alphabetic Index Section I:

Injury
- urethra (sphincter) S37.30
- - membranous S37.31
- - penile S37.32
- - prostatic S37.33
- - specified part NEC S37.38

Follow the ICD-10-AM Alphabetic Index Section II *External causes of injury*:

Exposure (to)
- factor(s)
- - specified NEC X58

Example 5: Ureteral stricture due to a procedure.

Ureteral stricture occurring after insertion of prosthetic devices, implants or grafts is classified as a complication of prosthetic devices, implants or grafts.

Assign:

T83.84 *Stenosis following insertion of genitourinary prosthetic devices, implants and grafts*

External cause codes

Follow the ICD-10-AM Alphabetic Index Section I:

Complication(s) (from) (of)
- genitourinary NEC (see also Complication(s)/by site and type)
- - device, implant or graft
- - - stricture (stenosis) T83.84

Ureteral stricture due to a procedure with no involvement of prosthetic devices, implants or grafts is classified to an appropriate code from the end of body system chapter.

Assign:

N99.89 *Other intraoperative and postprocedural disorder of genitourinary system*

N13.5 *Kinking and stricture of ureter without hydronephrosis*

External cause codes

Follow the ICD-10-AM Alphabetic Index Section I:

Complication(s) (from) (of)
- genitourinary NEC *(see also Complication(s)/by site and type)*
- - intraoperative or postprocedural
- - - specified NEC N99.89

Stricture
- ureter (postprocedural) N13.5

N13.5 is assigned as an additional diagnosis to provide further specificity of the condition (ie ureteral stricture).

Example 6: Lymphocele following cannulation of the femoral vein.

Assign:

T82.89 *Other specified complications of cardiac and vascular prosthetic devices, implants and grafts*

I97.83 *Postprocedural lymphocele, lymphoedema and chylothorax*

External cause codes

Follow the ICD-10-AM Alphabetic Index Section I:

Complication(s) (from) (of)
- vascular
- - device, implant or graft *(see also Complication(s)/by site and type)*
- - - infusion catheter
- - - - specified NEC T82.89

Lymphocele I89.8
- postprocedural I97.83

I97.83 is assigned to provide further specificity of the condition (ie postprocedural lymphocele) (Note: there are no *Excludes* notes to prevent assignment of T82.89 and I97.83 together). However, it is not necessary to assign I89.8 *Other specified noninfective disorders of lymphatic vessels and lymph nodes* as it does not provide further specificity of the condition.

This content has been adapted and disaggregated from the Clarification on the application of ACS 1904 *Procedural complications* issued 28 June 2019 for implementation 1 July 2019 (updated for 1 October 2020)

Return to contents page.

Ref No: Q3573 | Published On: Sep-2020 | Status: Current

Excision of mesh following vaginal or urethral erosion

Q:

What codes are assigned for excision of mesh following vaginal or urethral erosion?

A:

Assign the following codes for excision of mesh due to vaginal erosion:

35557-00 [1282] *Excision of lesion of vagina*

92116-00 [1900] *Removal of other device from genital tract*

Follow the ACHI Alphabetic Index:

Excision — *see also Removal*
- lesion(s)
- - vagina 35557-00 [1282]

Removal — *see also Excision*
- device
- - genitourinary tract NEC 92116-00 [1900]

Mesh erosion involving the urethra is a more serious complication and may require corrective surgery depending on the extent of the erosion. Therefore, assign ACHI codes in accordance with the procedure(s) performed and documented.

Amendments will be considered for a future edition.

Return to contents page.

Ref No: Q3558 | Published On: Sep-2020 | Status: Current

Haemorrhoid procedure **using LigaSure™ device**

Q:

What code is assigned for haemorrhoid procedure using LigaSure™ device?

A:

The LigaSure™ device is a bipolar electrothermal sealing device that uses a combination of pressure and energy (ie radiofrequency ablation) to permanently fuse (seal) blood vessels (Medtronic 2020; Nienhuijs et al. 2010).

Where the LigaSure™ device is used for haemorrhoids, assign 32135-01 [941] *Destruction of haemorrhoids*.

Follow the ACHI Alphabetic Index:

Destruction (ablation) (cauterisation) (coagulation) (cryotherapy) (diathermy) (HIFUS) (irreversible electroporation) (laser) (microwave) (radiofrequency) (thermotherapy)
- haemorrhoids (cauterisation) (cryotherapy) (infrared therapy) 32135-01 [941]

Amendments will be considered for a future edition.

References:

Medtronic 2020, *LigaSure™ technology*, viewed 22 June 2020, <https://www.medtronic.com/covidien/en-us/products/vessel-sealing/ligasure-technology.html>.

Nienhuijs, S.W. & de Hingh, I.H.J.T. 2010, 'Pain after conventional versus Ligasure haemorrhoidectomy. A meta-analysis', *International Journal of Surgery*, vol. 8, issue 4, pp. 269–273, viewed 22 June 2020, <https://doi.org/10.1016/j.ijsu.2010.04.001>.

Return to contents page.

Ref No: Q3504 | Published On: Sep-2020 | Status: Current

Influenza with lower respiratory tract infection (LRTI)

Q:

What codes are assigned for influenza with LRTI?

A:

The *Conventions used in the ICD-10-AM Tabular List* state:

> *In Australia, multiple condition coding (meaning that multiple conditions may be assigned in an episode of care) is used to provide the necessary specificity to fully describe the episode of care. This does not mean multiple codes are assigned to describe a single condition.*

Influenzal means pertaining to influenza (ie 'with' influenza), therefore, where the respiratory condition or associated manifestation is linked to influenza not otherwise specified (NOS) it classifies to category J11 *Influenza, virus not identified*.

Where there is documentation of lower respiratory tract infection with influenza NOS, assign J11.1 *Influenza with other respiratory manifestations, virus not identified*.

Follow the ICD-10-AM Alphabetic Index:

Infection, infected
- respiratory (tract)
- - influenzal *(see also Influenza)* J11.1

See also coding rules Q3479 Lower respiratory tract infection (LRTI) with presence of chronic obstructive pulmonary disease (COPD) and Q3505 COPD exacerbation and influenza.

Amendments will be considered for a future edition.

Return to contents page.

Ref No: Q3479 | Published On: Sep-2020 | Status: Current

Lower respiratory tract infection (LRTI) with presence of chronic obstructive pulmonary disease (COPD)

Q:

What code is assigned for LRTI in a patient with COPD, where the presence of COPD does not meet the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*?

A:

For patients admitted with a lower respiratory tract infection (LRTI) in the presence of chronic obstructive pulmonary disease (COPD) that does not meet the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*, assign J44.0 *Chronic obstructive pulmonary disease with acute lower respiratory infection*.

Follow the ICD-10-AM Alphabetic Index:

Infection, infected (opportunistic)
- respiratory (tract) NEC
- - lower (acute) J22

Follow the *Excludes* note at block J20–J22 *Other acute lower respiratory infections*:

Excludes: chronic obstructive pulmonary disease with acute:

…

- lower respiratory infection (J44.0)

Return to contents page.

Ref No: Q3547 | Published On: Sep-2020 | Status: Current

Newborn of a diabetic mother

Q:

Is P70.0 *Syndrome of infant of mother with gestational diabetes* or P70.1 *Syndrome of infant of a diabetic mother* assigned for a newborn of a diabetic mother, where the infant has blood glucose monitoring but does not have hypoglycaemia documented in the clinical record?

A:

Syndrome of infant of a diabetic mother describes a range of effects on an infant born to a mother with diabetes mellitus (eg type I, type II or gestational). Hypoglycaemia is a common manifestation of the syndrome (WHO 2019a; WHO 2019b).

In the absence of documentation specifying 'syndrome of infant of a diabetic mother':

- Where a newborn has a mother with diabetes mellitus, assign P70.0 *Syndrome of infant of mother with gestational diabetes* or P70.1 *Syndrome of infant of a diabetic mother* only if the infant is documented with a manifestation (ie effect) of the syndrome (eg hypoglycaemia) in accordance with ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*.

  Follow the ICD-10-AM Alphabetic Index:

  Diabetes, diabetic (controlled) (mellitus) (without complication)
  - in pregnancy, childbirth or puerperium
  - - affecting fetus or newborn P70.1
  - - arising in pregnancy
  - - - affecting fetus or newborn P70.0
  - - gestational
  - - - affecting fetus or newborn P70.0

- Where a newborn with a diabetic mother is suspected and observed but does not manifest any signs of the syndrome (ie there is no effect on the infant), assign Z03.79 *Observation of newborn for other suspected condition*.

  Follow the ICD-10-AM Alphabetic Index:

  Observation (for)
  - newborn
  - - for suspected condition
  - - - specified condition NEC Z03.79

See also ACS 0010 *Clinical documentation and general abstraction guidelines / Test results and medication charts* and coding rule Q3146 Neonatal hypoglycaemia in infant of diabetic mother.

Amendments will be considered for a future edition.

References:

World Health Organization (WHO) 2019a, *ICD-11 Mortality and Morbidity Statistics (MMS) April 2019*, United Nations, viewed 20 April 2020, Foundation Id: <http://id.who.int/icd/entity/1010481205>.

World Health Organization (WHO) 2019b, *ICD-11 Mortality and Morbidity Statistics (MMS) April 2019*, United Nations, viewed 20 April 2020, Foundation Id: <http://id.who.int/icd/entity/1500607905>.

Return to contents page.

Ref No: Q3548 | Published On: Sep-2020 | Status: Current

Open wound with artery, nerve and/or tendon injury

Q:

What is the principal diagnosis in scenarios where the principal diagnosis is documented as 'open wound' or 'laceration' in the discharge summary and the operation report further describes repair of underlying structures of tendon, artery or nerve?

A:

ACS1908 *Open wound with artery, nerve and/or tendon damage* provides guidelines about how to capture the severity of a laceration where surgery may be required. Injury details such as the type, depth and underlying structures damaged or repaired is often found in the operation report.

ACS0010 *Clinical documentation and general abstraction guidelines* states:

> *Before classifying any documented clinical concept, the clinical coder must verify information on the front sheet and/or the discharge summary (or equivalent) by reviewing pertinent documents/data within the body of the current episode of care.*

The discharge summary and the body of the clinical notes should be used together to identify the specificity or severity of the laceration and inform code assignment. Classification decisions are not based solely on the discharge summary.

Return to contents page.

Ref No: Q3555 | Published On: Sep-2020 | Status: Current

Operculectomy

Q:

What code is assigned for operculectomy?

A:

Operculectomy is the surgical excision of excess gum mucosa (operculum) that covers a unenrupted or partially erupted tooth (American Dental Association n.d.; Rao et al. 2016).

Where operculectomy is performed assign 97377-00 [460] *Dental treatment involving removal or repair of soft tissue, not elsewhere classified*.

Follow the ACHI Alphabetic Index:

Removal — *see also Excision*
- operculum, dental procedure 97377-00 [460]

Amendments will be considered for a future edition.

References:

American Dental Association n.d., *Operculectomy*, American Dental Association, viewed 27 July 2020, <https://www.ada.org/en/publications/cdt/glossary-of-dental-clinical-and-administrative-terms>.

Rao, B.H.S., Rai, B.G. & Sinha, S.S. 2016, 'Comparison of healing process of operculectomy with laser and surgical knife – a clinical study', *International Journal of Current Research*, vol. 8, issue 1, pp. 25368–25373, viewed 29 July 2020, <http://www.journalcra.com/sites/default/files/issue-pdf/12146.pdf?_ga=2.166512377.658322849.1595994854-1287072610.1595994854>.

Return to contents page.

Ref No: Q3566 | Published On: Sep-2020 | Status: Current

Phantom limb pain

Q:

What code is assigned for phantom limb pain?

A:

Phantom limb syndrome is described as the perception of sensations in a limb that has been amputated or a body part that has been removed (Healthdirect n.d.; Woodhouse 2005). These sensations may include a specific position, shape, or movement of the phantom, feelings of warmth or cold, itching, tingling, or electric sensations, and other paraesthesias (WHO 2019).

Phantom limb pain (phantom pain following amputation of a limb) is synonymous with phantom limb syndrome with (perception of) pain; assign G54.6 *Phantom limb syndrome with pain*.

Follow the ICD-10-AM Alphabetic Index:

Phantom limb syndrome (without pain) G54.7
- with pain G54.6

Amendments will be considered for a future edition.

References:
Healthdirect n.d., *Amputation*, Healthdirect, viewed 29 July 2020, <https://www.healthdirect.gov.au/amputation>.

Woodhouse, A. 2005, 'Phantom limb sensation', *Clinical and Experimental Pharmacology and Physiology*, vol. 32, issue 1–2, pp. 132–34, viewed 29 July 2020, <https://doi.org/10.1111/j.1440-1681.2005.04142.x>.

World Health Organization (WHO) 2019, *8E43.00 Phantom limb syndrome*, ICD-11 Mortality and Morbidity Statistics (MMS) April 2019, viewed 22 June 2020, <https://icd.who.int/ct11/icd11_mms/en/release>.

Return to contents page.

Ref No: Q3524 | Published On: Sep-2020 | Status: Current

Radionecrosis of the brain

Q:

What codes are assigned for radionecrosis of the brain?

A:

Radionecrosis of the brain occurs when brain tissue dies due to an adverse effect of radiotherapy.

Assign:

I67.8 *Other specified cerebrovascular diseases*

Y84.2 *Radiological procedure and radiotherapy*

Place of occurrence code.

Follow the ICD-10-AM Alphabetic Index Section I:

Necrosis, necrotic, necrotising (ischaemic)
- brain I67.8
- radiation — *see Necrosis/by site*

ICD-10-AM Alphabetic Index Section II *External cause of injury*:

Complication(s) (delayed) (medical or surgical procedure) (of or following)
- radiological procedure or therapy Y84.2

Amendments will be considered for a future edition.

Return to contents page.

Ref No: Q3489 | Published On: Sep-2020 | Status: Current

Spinal cord compression secondary to neoplasm

Q:

What codes are assigned for spinal cord compression secondary to a neoplasm?

A:

Spinal cord compression is a type of myelopathy, that is, functional disturbance or pathological change in the spinal cord. Myelopathy is an injury to the spinal cord due to compression that may result from trauma, stenosis or degenerative disease (Johns Hopkins Medicine n.d.). Neoplastic myelopathy is commonly caused by direct intraparenchymal involvement or external compression on the spinal cord (Nagpal & Clarke 2012).

Where spinal cord compression is documented as due to a neoplasm, assign:

A code for the neoplasm from Chapter 2 *Neoplasms* (C00–D48) with appropriate morphology code

G99.2* *Myelopathy in diseases classified elsewhere*

G95.2 *Cord compression, unspecified*

Sequence codes in accordance with the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*.

Follow the ICD-10-AM Alphabetic Index:

Myelopathy
- in (due to)
- - neoplastic disease NEC (M8000/1) (*see also Neoplasm*) D48.9† G99.2*

Compression
- spinal (cord) G95.2

References:
Johns Hopkins Medicine n.d., *Spinal cord compression*, Johns Hopkins Medicine, viewed 12 March 2020, <https://www.hopkinsmedicine.org/health/conditions-and-diseases/spinal-cord-compression>.

Nagpal, S. & Clarke, J.L. 2012, 'Neoplastic myelopathy', *Seminars in Neurology*, vol. 32, no. 2, pp. 137–145, viewed 12 March 2020, <https://www.ncbi.nlm.nih.gov/pubmed/22961188>.

Return to contents page.

Ref No: Q3528 | Published On: Sep-2020 | Status: Current

Subcapital neck of femur fracture (NOF) with total hip joint replacement (THJR)

Q:

What intervention code is assigned for a subcapital NOF fracture with THJR?

A:

The Conventions used in the Alphabetic Index of Interventions state:

> *Wherever a preposition from the list below immediately follows a lead term or subterm, it takes precedence over symbols, numbers and the alphabetic sequence of subterms:*
>
> - *as*
> - *by*
> - *for*
> - *with*
> - *without*

Where there is documentation of total hip joint replacement (THJR), the ACHI Alphabetic Index at *Replacement/joint/hip/with/fracture of subcapital femur* is misleading if the convention regarding prepositional terms is applied strictly and in isolation.

Replacement
- joint (total) 50127-00 [1571]
- - hip
- - - with
- - - - fracture of subcapital femur (hemiarthroplasty) 47522-00 [1489]
- - - - insertion of cement spacer 49312-00 [1489]
- - - - removal of prosthesis 49312-00 [1489]
- - - excision 49312-00 [1489]
- - - partial 49315-00 [1489]
- - - revision — *see Revision/joint replacement/hip*
- - - total (unilateral) (with bone graft) 49318-00 [1489]
- - - - bilateral 49319-00 [1489]
- - - - Birmingham (metal) (unilateral) (with bone graft) 90607-00 [1489]
- - - - - bilateral 90607-01 [1489]

For documentation of THJR for unilateral fractured subcapital neck of femur, assign 49318-00 [1489] *Total arthroplasty of hip, unilateral*.

Follow the ACHI Alphabetic Index:

Replacement
- joint (total) 50127-00 [1571]
- - hip
- - - total (unilateral) (with bone graft) 49318-00 [1489]

Amendments will be considered for a future edition.

Return to contents page.

Ref No: Q3615 | Published On: Sep-2020 | Status: Current

Tight perineum as indication for episiotomy

Q:

What code is assigned for tight perineum, when documented as the indication for episiotomy?

A:

The perineum stretches during vaginal delivery to accommodate passage of the fetus. A perineum that is rigid (tight) does not stretch easily (Thomas 2019) and an episiotomy may be performed to facilitate delivery (Kilgore 2015).

Where tight perineum is documented as an indication for episiotomy, assign O65.5 *Labour and delivery affected by abnormality of maternal pelvic organs*.

Follow the ICD-10-AM Alphabetic Index:

Rigid, rigidity
- perineum or vulva
- - affecting
- - - labour or delivery O65.5

Amendments will be considered for a future edition.

References:
Kilgore, R. 2015 *To episiotomy or not to episiotomy?,* blog, Herman & Wallace Pelvic Rehabilitation Institute, viewed 21 July 2020, <https://hermanwallace.com/blog/to-episiotomy-or-not-to-episiotomy>.

Thomas, L. 2019, *Perineal tear*, News-Medical.Net, viewed 21 July 2020, <https://www.news-medical.net/health/Perineal-Tear.aspx>.

Return to contents page.

Ref No: Q3457 | Published On: Sep-2020 | Status: Current

Transoral endoscopic (hemi)thyroidectomy vestibular approach

Q:

What is the correct code assignment for transoral endoscopic (hemi)thyroidectomy vestibular approach?

A:

Transoral endoscopic thyroidectomy is an emerging technique that uses natural orifice transluminal endoscopic surgery to access the thyroid gland via the mouth. In transoral endoscopic thyroidectomy vestibular approach (TOEVA), incisions are made in the region between the lips and cheek mucosa and the teeth (the oral vestibule) to allow placement of three endoscopic ports and to create space below the platysma, using carbon dioxide insufflation. This technique offers a scarless operation while retaining the advantages of minimally invasive surgery (Camenzuli et al. 2018).

As ACHI does not include a code for transoral endoscopy using vestibular approach, assign an ACHI code according to the type of thyroidectomy performed using this technique, for example:

- 30306-01 [114] *Total thyroid lobectomy*, unilateral alone for transoral endoscopic hemithyroidectomy vestibular approach
- 30296-01 [114] *Total thyroidectomy* alone for transoral endoscopic thyroidectomy vestibular approach.

Follow the ACHI Alphabetic Index:

Hemithyroidectomy (complete or total excision of 1 lobe) 30306-01 [114]

Thyroidectomy
- bilateral (complete or total excision of both lobes) 3029601 [114]

Amendments will be considered in a future edition.

References:
Camenzuli, C., Schembri Wismayer, P. & Calleja Agius, J. 2018, 'Transoral endoscopic thyroidectomy: a systematic review of the practice so far', *Journal of the Society of Laparoendoscopic Surgeons*, vol. 22, no. 3, viewed 9 January 2020, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6158973/>.

Return to contents page.

Ref No: Q3614 | Published On: Sep-2020 | Status: Current

Venous hypertension

Q:

What code is assigned for peripheral venous hypertension?

A:

Peripheral venous hypertension is described as increased pressure in the veins of the lower legs, caused by venous reflux due to dysfunction of venous valves or venous obstruction (eg deep vein thrombosis, thrombophlebitis), or a combination of both. Chronic peripheral venous hypertension may lead to redirection of blood flow from deep to superficial vessels, producing local tissue inflammation, fibrosis or ulceration (Alguire et al. 2019; Goldman 2015; Raju et al. 2019).

Assign I87.8 *Other specified disorders of veins* for peripheral venous hypertension.

Follow the ICD-10-AM Alphabetic Index:

Increase, increased
- venous pressure I87.8

Amendments will be considered for a future edition.

References:
Alguire, P. & Mathes, B.M. 2019, *Pathophysiology of chronic venous disease,* UpToDate, viewed 20 July 2020, <https://www.uptodate.com/contents/pathophysiology-of-chronic-venous-disease>.

Goldman, M. 2015 'Adverse sequelae and complications of venous hypertension', *Sclerotherapy*, viewed 20 July 2020, <DOI:10.1016/B978-0-323-37726-3.00002-2>.

Raju, S., Knight, A., Lamanilao, L., Pace, N. & Jones, T. 2019, 'Peripheral venous hypertension in chronic venous disease', *Journal of Vascular Surgery: Venous and Lymphatic Disorders,* vol. 7, issue 5, pp 706–714, viewed 20 July 2020, <https://doi.org/10.1016/j.jvsv.2019.03.006>.

Return to contents page.

Appendix 1—Updated coding rules

Ref No: TN1504 | Published On: 28-Jun-2019 | Status: Updated | Updated On: Sep-2020

Eleventh Edition ACS 1904 *Procedural complications* – additional code to add specificity

Note: The scenario in Example 12 of this coding rule has been amended to specify a causal relationship between the intervention and the postprocedural pain, and how care for the pain was beyond routine postoperative pain.

…

Example 12: Patient admitted with an old medial meniscal tear of the left knee and underwent arthroscopic meniscal debridement under general anaesthetic (GA). In the postoperative period, the patient complained of extreme left knee pain, confirmed by the clinician as secondary to the arthroscopic debridement. The pain management team was requested to review the patient, and an increase in pain medication dosage was prescribed and administered. Discharge home was delayed due to ongoing knee pain. Discharged home on day 4 postoperatively once the pain was well controlled and patient was able to mobilise.

Assign:

M23.23 *Derangement of meniscus due to old tear or injury, medial collateral ligament or other and unspecified medial meniscus*

T81.83 *Pain following a procedure, not elsewhere classified*

with appropriate external cause codes.

Follow the Alphabetic Index:

Complication(s) (from) (of)
- postprocedural
- - pain NEC T81.83

It is unnecessary to assign M25.56 *Pain in joint, lower leg* to capture the site of the pain.

If the pain being assessed/treated is not at the site of the operation, such as shoulder pain following laparoscopic cholecystectomy and the clinician confirms that the shoulder pain is due to laparoscopy, and it meets ACS 0002 *Additional diagnoses*, an additional code for the shoulder pain (M25.51) can be added to provide further specificity.

Return to contents page.

Ref No: Q2712 | Published On: 15-Jun-2012 | Status: Updated | Updated On: Sep-2020

Ultrasound guided compression repair of pseudoaneurysm

Note: This coding rule has been amended for consistency with the guidelines in ACS 0042 *Procedures normally not coded* and ACS 0016 *General procedure guidelines*.

Q:

Can you please clarify how to code ultrasound guided compression repair of a pseudoaneurysm?

A:

Ultrasound guided compression repair of a pseudoaneurysm meets the definition of a procedure as per ACS 0016 *Procedure guidelines*, as it:

- carries a procedural risk
- may carry and anaesthetic (sedation risk)
- requires specialised training

The correct code to assign for repair of cubital fossa pseudoaneurysm using ultrasound guided compression is 92205-00 [1908] *Noninvasive therapeutic intervention, not elsewhere classified*, following the pathway:

Procedure
- therapeutic NEC 92205-00 [1908]

Do not assign an ACHI code for the ultrasound component, in accordance with the guidelines in ACS 0042 *Procedures normally not coded* and ACS 0016 *General procedure guidelines*, as it is inherent in the compression procedure.

See also coding rules Q3130 CT guided core biopsy of the lung and Q3378 Hookwire localisation of extramammary lesions.

Appendix 2—Superseded coding rules

Ref No: Q2905 | Published On: 15-Sep-2015 | Status: Superseded | Superseded On: Sep-2020 | Superseded By: Q3496 Allergens and anaphylaxis

Coding of allergic reactions NOS and anaphylactic reactions

Q:

How should allergic reactions not otherwise specified (NOS) and anaphylactic reactions be coded? Should symptom codes be assigned for allergic reactions?

A:

The correct code assignment for allergic reactions NOS and anaphylactic reactions are outlined below.

Allergic reaction NOS:

T78.4 *Allergy, unspecified* following the Alphabetic Index:

Allergy, allergic (reaction) T78.4

Allergic reaction NOS to food:

T78.1 *Other adverse food reactions, not elsewhere classified* following the Alphabetic Index:

Allergy, allergic (reaction)
- food (any) (ingested) NECT78.1

Anaphylaxis/anaphylactic shock due to food:

T78.0 *Anaphylaxis and anaphylactic shock due to adverse food reaction* following the Alphabetic Index:

Anaphylaxis
- due to
- - food reaction T78.0

When assigning a code classified to category T63 *Toxic effect of contact with venomous animals* additional codes should be assigned for any associated allergic reaction as per the instructional note at this category.

Symptoms such as wheeze, urticaria and swelling should not be coded when a diagnosis of allergic reaction or anaphylaxis has been established unless the symptom is significant in its own right and treated independently of the allergic reaction (see also *Note* at the beginning of Chapter 18 *Symptoms, signs and abnormal clinical findings, not elsewhere classified*).

Assign external cause codes from Y37 *Exposure to or contact with allergens* as appropriate.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM / ACHI / ACS.

Return to contents page.

Ref No: TN1504 | Published On: 28-Jun-2019 | Status: Superseded | Superseded On: Sep-2020 | Superseded By: Q3503 Eleventh Edition ACS 1904 *Procedural complications* – due to/related to prosthetic devices, implants or grafts

Eleventh Edition ACS 1904 *Procedural complications* – due to/related to prosthetic devices, implants or grafts

Procedural complications may be classified to either the body system chapters or block *Complications of surgical and medical care, not elsewhere classified* (T80–T88), and the following rules apply:

- Where a complication is related to a prosthetic device, implant or graft, assign T82–T85 *Complications of prosthetic devices, implants and grafts*, except where directed by an *Includes* note or the Alphabetic Index
- Where a condition is not related to a prosthetic device, implant or graft and:
    - it is related to a body system, assign an appropriate code from the body system chapter
    - the complication is not related to a body system, assign an appropriate code from T80–T81 or T86–T88

As per ACS 1904 *Procedural complications/Overview/dot point three*, codes in categories T82–T85 are generally intended to be used for complications specific to prosthetic devices, implants and grafts such as mechanical complication, infection, pain, thrombosis, haemorrhage, mesh erosion and so on.

Therefore, unless there is a specific coding rule or ACS that indicates otherwise (eg complications related to coronary artery bypass graft), a causal relationship does not need to be documented to assign a procedural complication when the condition is classified to categories T82–T85.

Example 1: Patient with a history of endovascular aneurysm repair (EVAR) of an abdominal aortic aneurysm (AAA) with a bifurcated endoprosthesis, was readmitted due to intermittent abdominal pain and progressive dyspnoea. Computed tomography (CT) angiogram of the aorta confirmed endoleaks following EVAR.

Assign:

T82.3 *Mechanical complication of other vascular grafts*

with appropriate external cause codes

Follow the Alphabetic Index:

Leak, leakage
- device, implant or graft *(see also Complication(s)/by site and type)*
- - arterial graft NEC T82.3

Example 2: Patient was admitted for a ruptured anterior cruciate ligament (ACL) graft for which the patient underwent revision of a left knee ACL reconstruction

Assign:

T84.4 *Mechanical complication of other internal orthopaedic devices, implants and grafts*

with appropriate external cause codes

Follow the Alphabetic Index:

Complication(s) (from) (of)
- orthopaedic
- - device, implant or graft *(see also Complication(s)/by site and type)* T84.9
- - - mechanical NEC T84.4

Example 3: A 59-year-old woman was admitted with complaints of pain and loss of mobility of the stump of her left leg. She had a below knee amputation (BKA) of her left lower limb in 2010. She did not wear her prosthesis over the amputated side, because of persistent touch-evoked pain. Physical examination revealed erythema on the stump with cellulitis. She was diagnosed with cellulitis of the amputation stump due to an ill-fitting prosthetic limb.

Assign:

T84.7 *Infection and inflammatory reaction due to other internal orthopaedic prosthetic devices, implants and grafts*

L03.13 *Cellulitis of lower limb*

Z89.5 *Acquired absence of leg at or below knee*

with appropriate external cause codes

Follow the Alphabetic Index:

Complication(s)
- orthopaedic
- - device, implant or graft
- - - infection or inflammation NEC T84.7

Cellulitis (diffuse) (with lymphangitis)
- limb L03.19
- - lower L03.13

Absence
- extremity (acquired) Z89.9
- - lower (above knee) (unilateral) Z89.6
- - - with upper extremity (any level) Z89.8
- - - below knee (unilateral) Z89.5

Example 4: Urethral trauma/injury sustained from displacement of an indwelling catheter

Assign:

T83.0 *Mechanical complication of urinary (indwelling) catheter*

with appropriate external cause codes

Follow the Alphabetic Index:

Displacement, displaced
- device, implant or graft (see also Complication(s)/by site and type/mechanical)
- - catheter NEC
- - - urinary (indwelling) T83.0

It is unnecessary to assign an additional code from Chapter 19 (eg S37.3- *Injury of urethra*) to indicate the site of the post-operative complication. The purpose of S codes in Chapter 19 *Injury, poisoning and certain other consequences of external causes* is to classify injures due to trauma (ie an injury not related to an intervention).

If urethral trauma/injury occurs during removal (accidental or intentional) of an indwelling catheter (IDC) by a patient, ACS 1904 is not applicable as the trauma/injury is not a complication of the device (catheter). Where the urethral trauma/injury meets the criteria in ACS 0002 *Additional diagnoses*, assign:

S37.3- *Injury of urethra*

X58 *Exposure to other specified factors*

with place of occurrence and activity codes as appropriate.

Follow the Alphabetic Index of diseases and nature of injury (Section I):

Injury
- urethra (sphincter) S37.30
- - membranous S37.31
- - penile S37.32
- - prostatic S37.33
- - specified part NEC S37.38

Follow the Alphabetic Index of external causes of injury (Section II):

Exposure (to)
- factor(s)
- - specified NEC X58

Example 5: Ureteral stricture due to a procedure

Ureteral stricture occurring after insertion of prosthetic devices, implants or grafts is classified as a complication of prosthetic devices, implants or grafts:

Assign:

T83.89 *Other specified complications of genitourinary devices, implants and grafts*

N13.5 *Kinking and stricture of ureter without hydronephrosis*

with appropriate external cause codes.

Follow the Alphabetic Index:

Complication(s) (from) (of)
- genitourinary NEC *(see also Complication(s)/by site and type)*
- - device, implant or graft
- - - specified NEC T83.89

Ureteral stricture due to a procedure with no involvement of prosthetic devices, implants or grafts, is classified to an appropriate code from the end of body system chapter.

Assign:

N99.89 *Other intraoperative and postprocedural disorder of genitourinary system*

N13.5 *Kinking and stricture of ureter without hydronephrosis*

with appropriate external cause codes.

Follow the Alphabetic Index:

Complication(s) (from) (of)
- genitourinary NEC *(see also Complication(s)/by site and type)*
- - intraoperative or postprocedural
- - - specified NEC N99.89

Stricture
- ureter (postprocedural) N13.5

N13.5 is assigned as an additional diagnosis to provide further specificity of the condition (ie ureteral stricture).

Example 6: Lymphocele following cannulation of the femoral vein

Assign:

T82.89 *Other specified complications of cardiac and vascular prosthetic devices, implants and grafts*

I97.83 *Postprocedural lymphocele, lymphoedema and chylothorax*

with appropriate external cause codes.

Follow the Alphabetic Index:

Complication(s) (from) (of)
- vascular
- - device, implant or graft *(see also Complication(s)/by site and type)*
- - - infusion catheter
- - - - specified NEC T82.89

Lymphocele I89.8
- postprocedural I97.83

I97.83 is assigned to provide further specificity of the condition (ie postprocedural lymphocele) (Note: there are no *Excludes* notes to prevent assignment of T82.89 and I97.83 together). However, it is unnecessary to assign I89.8 *Other specified noninfective disorders of lymphatic vessels and lymph nodes* as it does not provide further specificity of the condition.

This content has been adapted and disaggregated from the Clarification on the application of ACS 1904 *Procedural complications* issued 28 June 2019 for implementation 1 July 2019 (updated for 1 October 2019)

Return to contents page.

Ref No: TN1505 | Published On: 28-Jun-2019 | Status: Superseded | Superseded On: Sep-2020 | Superseded By: Q3496 Allergens and anaphylaxis

Eleventh Edition FAQs Part 1: Allergens and anaphylaxis

Q:

When assigning codes for anaphylactic reactions, should codes for the individual components of the reaction also be assigned?

A:

Research indicates that anaphylaxis and anaphylactic shock are part of a continuum. Anaphylaxis is a serious and potentially life-threatening reaction to a trigger such as an allergy. The clinical manifestations of mild anaphylaxis may rapidly progress to a more severe anaphylaxis and lead to upper airway obstruction, respiratory failure, and circulatory shock (that is, anaphylactic shock).

ACS 0001 *Principal diagnosis/Codes for symptoms, signs and ill-defined conditions* states:

> *Codes for symptoms, signs and ill-defined conditions from Chapter 18* Symptoms signs and abnormal clinical and laboratory findings *are not to be used as principal diagnosis when a related definitive diagnosis has been established.*

Therefore, the individual components of the anaphylactic reaction (ie bronchospasm) would not be classified in addition to the anaphylaxis.

This content has been adapted and disaggregated from the Eleventh Edition Frequently Asked Questions – Amended, issued 28 June 2019 for implementation 1 July 2019 (updated for 1 October 2019).

Return to contents page.

Appendix 3—List of coding rules retired or superseded since 1 July 2019

Subject	Reference number	Status	Date
ACS 0002/ACS 0010 Revision – Definition of 'clinical significance' or 'transient' in relation to ACS 0002 *Additional diagnoses*	TN1505	Retired	30 September 2019
Cardiac pacemaker and implanted defibrillator	Q3013	Retired	31 December 2019
Musculoskeletal injury of specified site	Q3084	Retired	31 December 2019
Coding of allergic reactions NOS and anaphylactic reactions	Q2905	Superseded	September 2020
Eleventh Edition FAQs Part 1: Allergens and anaphylaxis	TN1505	Superseded	September 2020

Return to contents page.