ICD-10-AM/ACHI/ACS 9th edition changes summary

ACS 0003 *Supplementary codes for chronic conditions*

- 29 new supplementary codes for chronic conditions have been created in the range U78-U88 *Supplementary codes for chronic conditions*.
- The Index pathway for U78-U88 codes is:
  - Supplementary/codes for chronic conditions.
- New ACS 0003 contains instructions for assigning U78-U88 codes.
- Certain chronic conditions affecting patient management can now be assigned a code from U78-U88 if they do not meet the criteria for coding, as per:
  - ACS 0002 *Additional diagnoses*
  - other ACS
  - other coding conventions/rules.
- Supplementary U78-U88 codes are assigned for chronic conditions that are:
  - present on admission and documented in the current episode
  - part of the patient's current health status, including conditions documented as 'past history'. Conditions may be assumed to be current unless there is documentation that indicates otherwise.
- Supplementary U78-U88 codes are not assigned:
  - for an acute condition
  - in addition to another chapter code for the same condition
  - for conditions documented in previous episodes/old correspondence, and not documented in the current episode.
  - for conditions only noted on forms completed by the patient (e.g. patient questionnaire), and not documented by a clinician in the current episode
- **Where it is unclear or difficult to determine whether a code from U78-U88 should be assigned, do not assign the code.**
- Where diabetic complications such as chronic kidney disease (CKD stage 3 to 5) and obesity are used to inform the assignment of diabetes codes (E09-E14) but do not themselves meet the criteria for coding as per ACS 0001 *Principal diagnosis* or 0002 *Additional diagnoses*, they can be assigned a supplementary U code.
- Supplementary U78-U88 codes should be sequenced last, after all other ICD-10-AM codes. They are not considered in the grouping process for Diagnosis Related Group (DRG) allocation and are for temporary assignment in Ninth and Tenth Edition ICD-10-AM.

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

- Re-wording of ACS 0110 to clarify clinical concepts and existing classification instructions.
- ACS 0110 now clarifies sepsis as a 'generalised infection' with classification instructions for sepsis as a generalised infection only.
- Documentation of sepsis without qualifying terminology (i.e. wound sepsis, chest sepsis, biliary sepsis) should be clarified with the treating clinician to determine whether it is a case of sepsis.
- Addition of Index entries and Tabular instructions to support ACS 0110.
- The concept and classification of SIRS due to non-infectious aetiology is now clearly distinguished from SIRS due to infectious aetiology (i.e. sepsis, severe sepsis, septic shock).
- **R65.0** *Systemic inflammatory response syndrome of infectious origin without acute organ failure* is now included in ACS 0049 *Disease codes that* ***must never be assigned*** as the concept of SIRS due to infectious aetiology is the same as sepsis.
- Code title for R65.1 updated to *Severe sepsis*.
- Inclusion of previously published advice to ACS 0110 classification instructions for severe sepsis:
    - Do not assume severe sepsis when there is documentation of sepsis and acute organ failure.
    - Severe sepsis must be documented before R65.1 *Severe sepsis* can be assigned.
    - In cases of documented severe sepsis or septic shock, documentation of 'organ dysfunction' can be considered interchangeable with 'organ failure' where it is unexplained by any other cause.
- Combination of T81.41 *Wound infection following a procedure* and T81.42 *Sepsis following a procedure* into the fourth character code T81.4 *Wound infection following a procedure, not elsewhere classified.*
- T81.4 is no longer valid with a fifth character.

ACS 1506 *Fetal presentation, disproportion and abnormality of maternal pelvic organs*

- Re-wording of ACS 1506 in relation to fetal presentations, O34.2 *Maternal care due to uterine scare from previous surgery* and O75.7 *Vaginal delivery following previous caesarean section* to clarify existing classification instructions.

- Updated classification instructions for codes O32-O34 and O64-O66:
    - O32-O34 codes are assigned when care and/or intervention is required **before the onset of labour**
    - O64-O66 codes are assigned when care and/or intervention is required **during labour**, regardless of when the condition is first diagnosed.

ACS 1552 *Premature rupture of membranes, labour delayed by therapy*

- Updated Index and Tabular entries define premature rupture of membranes as spontaneous pre-labour rupture of membranes (PROM) at term or pre-term (PPROM).

- New ACS 1552:
    - instructs the assignment of O42.2 *Premature rupture of membranes, labour delayed by therapy* only when **tocolytics** are administered for **pre-term premature/pre-labour rupture of membranes** (PPROM)
    - allows assignment of O42.2 with O42.0 *Premature rupture of membranes, onset of labour within 24 hours*
    - prevents assignment of O42.2 with O42.11 *Premature rupture of membranes, onset of labour between 1-7 days later* or O42.12 *Premature rupture of membranes, onset of labour more than 7 days later*.

- Inclusion of previously published advice as a *Note* to O42 *Premature rupture of membranes* in the Tabular:
    - A code from O42 should not be assigned based on documentation of the times for the establishment of labour alone.
    - Premature/pre-labour rupture of membranes must be documented to assign a code from O42.

Cystic fibrosis

- There is now one code for cystic fibrosis – E84 *Cystic fibrosis*. Previous four character codes in E84 for cystic fibrosis with manifestations are now invalid.
- Assignment and sequencing of cystic fibrosis and manifestation codes should be determined by the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*.
- ACS 0402 *Cystic fibrosis* has been amended to reflect these changes.

Obesity procedures

- Codes for insertion of gastric band have been revised. Codes are no longer divided into adjustable and non-adjustable.
- New codes have been created for insertion and removal of device into stomach which replace the codes for insertion/removal of gastric balloon and gastric bubble.
- New codes have been created for revision of gastric band which include adjustment, replacement and repositioning of the band (not the reservoir). Old codes containing these concepts have been deleted.
- Codes have been deleted and a new code created for revision of gastric band reservoir. This code includes adjustment, repair, replacement and repositioning of the reservoir.
- Adjustment of the gastric band by addition or removal of fluid from the reservoir has been moved to Chapter 19 *Noninvasive, cognitive and other interventions, NEC*.
- The code 30514-01[889] *Revision procedures for obesity* has been clarified and should only be used for revision of the procedures listed under the code. It is not to be used for revision of a gastric band.

ACS 0909 *Coronary artery bypass grafts*

- New instructions about coding occlusion of a CABG have been added. The occlusion may be coded as atherosclerosis or a complication of the graft.
- Instructions regarding reoperation CABGs have been moved to ACS 0934 *Cardiac and vascular revision/reoperation procedures.*

ACS 0934 *Cardiac and vascular revision/reoperation procedures*

- Title has been changed to indicate that this standard now refers to all cardiac and vascular (including peripheral) reoperation procedures.
- The timeframe of 1 month has now been removed. Coders should now assign codes based on the documentation in each record.
- The code 35202-00 [763] *Reoperation of arteries or veins, NEC* has also been revised to include all arteries and veins not classified elsewhere.

ACS 0940 *Ischaemic heart disease*

- Now includes instructions on coronary artery dissection.
- Instructions on how to code embolism of bypass grafts have now been moved to other standards (0941, 0909).

ACS 0941 *Arterial disease*

- Multiple inconsistent terms have been removed and synonymous terms of stenosis, occlusion, obstruction, CAD, TVD and arterial plaque have been confirmed.
- The instruction to code atherosclerosis only if over 50% obstruction has been documented has been removed.

Failed or difficult intubation

- The concepts of difficult and failed intubation have been split at the fifth character level.

CVA deficit of facial droop

- G83.8 *Other specified paralytic syndromes* is no longer valid at the fourth character level.
- Addition of fifth characters to G83.8, i.e. G83.81 *Facial paralysis due to cerebrovascular accident* and G83.89 *Other specified paralytic syndromes*.
- G83.81 *Facial paralysis due to cerebrovascular accident* and G81.9 *Hemiplegia, unspecified* are not to be assigned together for those CVA patients with documentation of both facial droop and hemiplegia.

Site specific codes for diabetic foot

- Site specific codes have been created for conditions which contribute to diabetic foot.
- Addition of fifth characters to indicate site, for the following conditions:
    - L02.4 *Cutaneous abscess, furuncle and carbuncle of limb*
    - L03.1 *Cellulitis of other parts of limb*
    - L84 *Corns and callosities*
    - L97 *Ulcer of lower limb, not elsewhere classified*

Removal of instructional notes for assigning chronic kidney disease (CKD) and hypertension

- Removal of '*Use additional code to identify presence of chronic kidney disease*' and '*Code also associated chronic kidney disease*' from:
    - E09.2 *Intermediate hyperglycaemia with kidney complication*
    - E1x.21 *Diabetes mellitus with incipient diabetic nephropathy*
    - E1x.22 *Diabetes mellitus with established diabetic nephropathy*
    - I15.0 *Renovascular hypertension*
    - I15.1 *Hypertension secondary to other kidney disorders*
    - N00-N08 *Glomerular diseases*
    - N10-N16 *Renal tubule-interstitial diseases*
- Removal of '*Use additional code to identify the presence of hypertension*' from:
    - I20-I25 *Ischaemic heart diseases*
    - I60-I69 *Cerebrovascular diseases*
    - N18 *Chronic kidney disease*
- Assignment of codes for chronic kidney disease and hypertension must now meet the criteria for coding in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*

Manual removal of placenta

- O83 *Other assisted single delivery* now includes manual removal of placenta.
- O80 *Single spontaneous delivery* now includes controlled cord traction (CCT).

Spinal dural tear

- For traumatic non-procedural tear/laceration of the spinal dura assign T09.3 *Injury of spinal cord, level unspecified*.

W26 *Contact with other sharp object(s)*

- Update of W26 block title to *Contact with other sharp object(s)*.
- Addition of fourth characters to W26 to identify:
  - W26.0 *Contact with knife, sword or dagger*
  - W26.8 *Contact with other sharp object(s), not elsewhere classified*
  - W26.9 *Contact with unspecified sharp object(s)*
- W26 is no longer valid at the third character level.

L98.7 *Excessive and redundant skin and subcutaneous tissue*

- New ICD-10-AM code L98.7 *Excessive and redundant skin and subcutaneous tissue* is assigned for loose, lax, redundant or excess skin due to excessive weight loss.

Insertion of fiducial markers

- 37217-00 [1160] *Implantation fiducial marker, prostate* has been deleted.
- New ACHI code 37217-01 [1800] *Implantation of fiducial markers* is assigned for any site.

Procedures for varicose veins

- Major revision to blocks [727] *Interruption of varicose veins of lower limb* and [728] *Other destruction procedures on veins*.
- New ACHI code 32520-00 [728] *Endovascular interruption of veins* is assigned for endovenous laser therapy (ELT) and endovenous radiofrequency ablation (ERA) of varicose veins.

Biopsy of prostate or seminal vesicle

- Codes for biopsy of prostate and seminal vesicle have been combined into blocks [1163] *Closed biopsy of prostate or seminal vesicle* and [1164] *Open biopsy of prostate or seminal vesicle*.

- 37218-00 [1163] *Needle biopsy of prostate or seminal vesicle* now includes transperineal/transrectal needle biopsy of prostate or seminal vesicle.

Insertion of testicular prosthesis

- Block [1171] *Application, insertion or removal procedures on scrotum or tunica vaginalis* now includes codes for insertion and removal of testicular prosthesis.

- Block [1184] *Orchidectomy* now has a *Code also* instruction for insertion of testicular prosthesis.

Control of cervical haemorrhage

- New ACHI code 96226-00 [1274] *Control of haemorrhage of cervix*.

Compression suture of uterus for postpartum haemorrhage

- New ACHI code 96228-00 [1347] *Compression suture of uterus for postpartum haemorrhage* is assigned for B-Lynch suture and brace suture of uterus.

[1920] *Administration of pharmacotherapy – dextrose and iron*

- Extension -09 *Other and unspecified pharmacological agent* now includes dextrose and iron.

- Update of ACS 1605, Example 1 to reinforce assignment of 96199-09 [1920] *Intravenous administration of pharmacological agent, other and unspecified pharmacological agent* for IV administration of dextrose.

Endobronchial ultrasound

- 30688-00 [1949] *Endoscopic ultrasound* now includes endobronchial ultrasound (EBUS).

Procedures on the cardiovascular system

- New ACHI code 96222-00 [626] *Percutaneous mitral valvuloplasty using closure device* includes closure devices such as Evalve and MitraClip.
- Deletion of '*Code also when performed: coronary angiography*' from a number of percutaneous cardiac procedures to avoid confusion with catheter access for percutaneous procedures, which should not be assigned a separate code.
- If coronary angiography is performed in conjunction with percutaneous cardiac procedures, as a diagnostic procedure, then an additional code from [668] *Coronary angiography* can be assigned.

ACS 0049 *Disease codes that must never be assigned*

- New ACS 0049 includes:
  - Unpaired asterisk codes in the Index which should not be assigned without the appropriate dagger code.
  - Codes for arthritis unspecified as per published advice.
  - Z22.5 *Carrier of viral hepatitis*
  - Z58.7 *Exposure to tobacco smoke*
- See ACS 0049 for the full list of disease codes that must never be assigned

ACS 0050 *Unacceptable principal diagnosis codes*

- New ACS 0050 includes:
  - external causes
  - place of occurrence and activity codes
  - morphology codes
  - a number of Z codes.
- See Tabular, Appendix C for the full list of unacceptable principal diagnosis codes.

ACS 1615 *Specific diseases and interventions related to the sick neonate*

- Addition of 34524-00 [694] *Catheterisation/cannulation of other artery* to the list of interventions to be coded whenever performed.

ACS 1221 *Pressure Injury*

- The revised ICD-10-AM codes for pressure injury and guidelines within this ACS are based on the Pan Pacific Clinical Practice Guidelines for the Prevention and Management of Pressure Injury, 2012.
- Codes from category L89- *Pressure injury* capture both severity and the site of the pressure injury. Allows for multiple pressure injury codes to be assigned. Do not repeat a code in the code string for the same site and severity.
- The fifth character subdivision for use with L89.0 – L89.9 to indicate site:
    - 0 site unspecified
    - 1 head
    - 2 upper extremity
    - 3 upper back
    - 4 lower back
    - 5 ischium
    - 6 trochanter
    - 7 heel
    - 8 toe
    - 9 other site of lower extremity (except heel and toe)
- Pressure injuries which develop after admission and were not present on admission are assigned a Condition Onset Flag (COF) of 1.
- Pressure injuries present on admission which deteriorate to a higher stage are assigned COF of 2.
- Assignment of codes for stage of pressure injury should be guided by the clinical documentation of the stage. Do not code from clinical description alone. If the stage is not documented and no further information can be obtained from the clinician, assign L89.9 *Pressure injury, unspecified stage*.
- Only assign L89.4x *Pressure injury*, *unstageable, so stated* and L89.5x *Suspected deep tissue injury*, *depth unknown*, *so stated* when the pressure injury is described using those exact terms.
- If the pressure injury becomes stageable after debridement, assign a code for the specific stage. An unstageable after debridement may become stage III or IV and a suspected deep tissue injury may become a stage I to IV.
- Pressure injuries may improve or deteriorate during hospitalisation. If different stages are documented for a pressure injury of the same site, assign a code that reflects the highest stage for that site.
- Documentation of **Unstageable** is not the same as **Unspecified.**

ACS 2104 *Rehabilitation*

- Z50.9 *Care involving use of rehabilitation procedure, unspecified* can be assigned independent of care type.
- Refer to the Admission, Readmission, Discharge and Transfer Policy (ARDT) for Rehabilitation Care type criteria.
- Z50.9 *Care involving use of rehabilitation procedure, unspecified* should never be assigned as the Principal diagnosis.
- The principal diagnosis should reflect the underlying condition requiring rehabilitation.
- Z50.9 *Care involving use of rehabilitation procedure,* should only be assigned as an additional diagnosis where there is documented evidence that the patient has been provided with rehabilitation care.
- Documented evidence of rehabilitation care may be in the form of clinician entries or a care plan within the clinical record.

ACS 2116 *Palliative care*

- Z51.5 *Palliative care* may be assigned independent of the admitted patient care type.
- Refer to the ARDT for Palliative Care type criteria.
- Z51.5 *Palliative care* should never be assigned as the principal diagnosis. The principal diagnosis is determined by ACS 0001 *Principal diagnosis.*
- Z51.5 *Palliative care* should only be assigned as an additional diagnosis where there is documented evidence that the patient has been provided with palliative care.
- Do not assign Z51.5 *Palliative care* when a palliative care assessment has been performed but no actual care has been given.
- Documented evidence of palliative care can be found in the form of clinician entries or a care plan within the clinical record.

Mental Health Care Type

- The WA Coding Standard 04 *Psychiatric diagnosis with overdose or injury*, has been retired as the instruction is no longer required with the implementation of the new mental health care type.
- Refer to the ARDT for Mental Health Care type criteria.

Updates to ACS relating to Chapter 21 *Factors influencing health status and contact with health services*

ACS 2103 *Admission for post acute care*

- For classification purposes post acute care also describes aftercare or postoperative convalescence.
- Post acute care provided to patients toward the end of an acute phase of treatment, still receiving some ongoing review for their condition but they no longer require significant management.
- Applicable for patients transferred to other facilities to receive continuing care after surgery, Z48.8 O*ther specified surgical follow-up care* or medical treatment, Z51.88 O*ther specified medical care*.
- If a patient is transferred for continued active treatment of a condition, do not assign an aftercare code, instead follow ACS 0001 *Principal Diagnosis*.

ACS 2105 *Long term/nursing home type inpatients*

- For long term residents or patients receiving nursing home type care, assign Z75.41 *Unavailability and inaccessibility of residential aged care service* as the principal diagnosis. Assign additional diagnosis codes for any conditions that meet ACS 0002 *Additional diagnoses*.
- Additional diagnosis codes for social factors which affect the admission or the discharge process may be assigned if documented.

ACS 2117 *Non-acute care*

- Non-acute or maintenance care is care in which the clinical purpose or treatment goal is support for a patient with impairments, activity limitation or participation restriction due to a health condition.
- Covers convalescent care, respite care and patients awaiting placement elsewhere.
- Even though the patient will probably be receiving care for their condition(s) while in hospital, do not sequence these as the principal diagnosis as they did not occasion the patient's admission to hospital.
- Any conditions must meet ACS 0002, including social factors.

ACS 2115 *Admission for allergen challenge*

- This is a new standard which applies to allergen challenges performed to monitor the response of a patient to a particular drug, food or other allergen to test for any clinical allergic reaction.
- There are new codes to distinguish between a drug challenge and a food challenge, indexed, *Admission (for) challenge* -
- Admission for allergen challenges assign code from Z41.8x as the principal diagnosis.
- Assign codes for any manifestation(s) arising from the challenge, following the lead term *Allergy, allergic* in the Alphabetic Index.
- Procedure codes do not need to be assigned.
- Allergy skin testing is not an admission for an allergen challenge.
- Allergen desensitisation (immunotherapy) is different to allergen challenge. For desensitisation assign a code from Z51.6x *Desensitisation to allergens*.

ACS 0031 *Anaesthesia*

- Assign a code(s) from block [1909] *Conduction anaesthesia* (excluding 92513-xx [1909] *Infiltration of local anaesthetic*) for each 'visit to theatre' regardless of where is the hospital the procedure is performed, for example operating theatre, endoscopy suite, emergency department, catheter laboratory.
- When a spinal block and a regional block are performed for a procedure, they can both be coded.
- Each type of conduction anaesthesia should only be assigned once per 'visit to theatre'.
- The Anaesthesia Guidelines found on the Clinical Coding in WA website will be updated to incorporate the Ninth Edition changes for coding conduction anaesthesia.